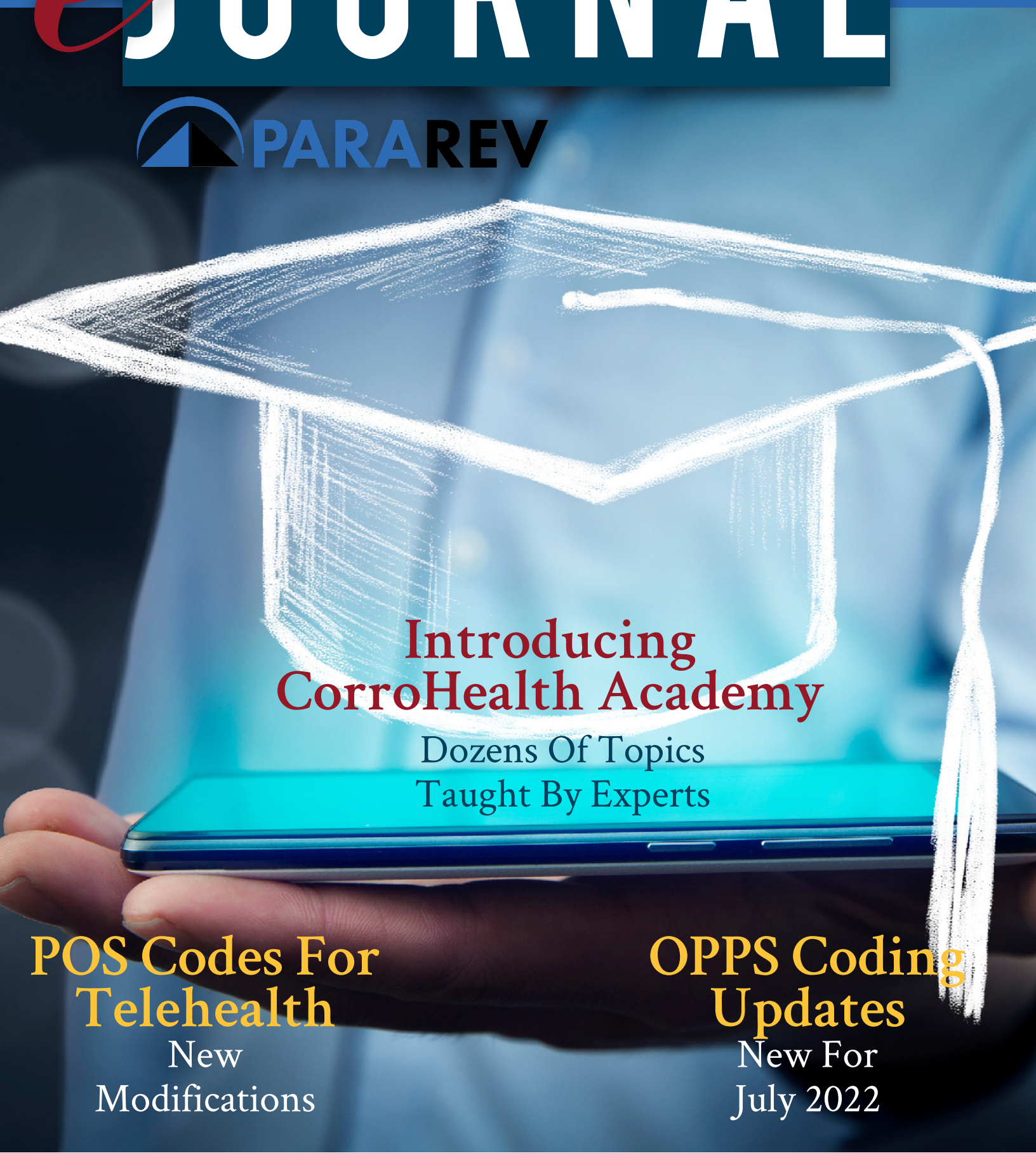
JUNE 1, 2022

eJOURNAL

PARAREV



Introducing CorroHealth Academy

Dozens Of Topics
Taught By Experts

POS Codes For Telehealth

New
Modifications

OPPS Coding Updates

New For
July 2022

DELETED HCPCS FOR CMS ONCOLOGY CARE MODEL

CORRECTION

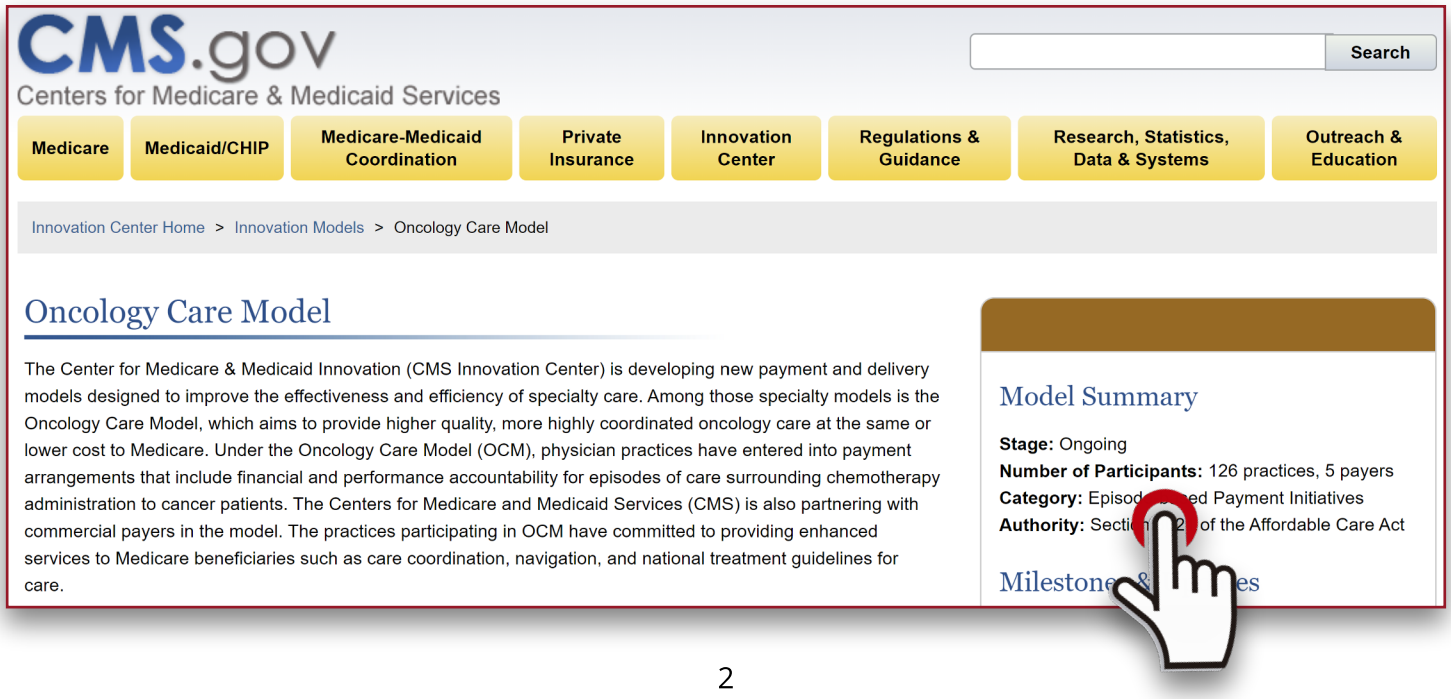
CORRECTION – PARA previously reported that G9678 was a new HCPCS effective 7/1/2022; in fact, this HCPCS will be discontinued effective 7/1/2022.The HCPCS had been used in the Oncology Care Model:

HCPC	LONG DESCRIPTION
G9678	Oncology care model (OCM) monthly enhanced oncology services (MEOS) payment for OCM enhanced services. G9678 payments may only be made to OCM practitioners for OCM beneficiaries for the furnishment of enhanced services as defined in the OCM participation agreement

The OCM was a Six-year model (2016-2022) to test innovative payment strategies that promote high-quality and high-value cancer care. Procedure code G9678 was established to represent a monthly MEOS care management payment for participating Medicare Fee-for-Service (FFS) beneficiaries. The model was originally scheduled to end in June 2021, but the timeline was extended through June 2022 due to COVID.

Details regarding the OCM are available on the CMS Innovation Center webpage at the link below:

https://innovation.cms.gov/innovation-models/oncology-care



PLACE OF SERVICE CODES FOR TELEHEALTH

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

New/Modifications to the Place of Service (POS) Codes for Telehealth

MLN Matters Number: MM12427 Revised	Related Change Request (CR) Number: 12427
Related CR Release Date: May 27, 2022	Effective Date: January 1, 2022
Related CR Transmittal Number: R11437CP	Implementation Date: April 4, 2022

Note: We revised this Article due to a revised CR 12427. The CR revision didn't affect the substance of the Article. We did revise the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

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

Provider Action Needed

CR 12427 provides updates to the current POS code set by revising the description of existing POS code 02 and adding new POS code 10. Make sure your billing staff knows of the updates.

Background

The POS code set provides setting information necessary to pay claims correctly. At times, the health care industry has a greater need for specificity than Medicare. While Medicare doesn't always need this greater specificity to appropriately pay claims, it adjudicates claims with the new codes. This eases coordination of benefits and gives other payers the setting information they need. The POS Workgroup is revising the description of POS code 02 and creating a new POS code 10 to meet the overall industry needs, as follows:

1. **POS 02: Telehealth Provided Other than in Patient's Home**

   Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

2. **POS 10: Telehealth Provided in Patient's Home**

   Descriptor: The location where health services and health related services are provided

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

JULY 2022 OPPS CODING UPDATE

THIS PAPER SUMMARIZES THE JULY 2022 OPPS UPDATE AS CONVEYED IN THE CMS TRANSMITTAL DATED MAY 26, 2022. FOR A DETAILED LISTING OF THE OPPS CODES, STATUS INDICATORS, AND CODING UPDATES, VISIT THE OPPS TRANSMITTAL AT:

https://www.cms.gov/files/document/r11435cp.pdf

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11435	**Date: May 26, 2022**
	Change Request 12761

SUBJECT: July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the July 2022 OPPS update. The July 2022 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR. This Recurring Update Notification applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

The July 2022 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July 2022 I/OCE CR.

Readers are advised that the July 2022 update to the OPPS Addendum A and Addendum B files was not available as of the date of this publication. The status indicator and payment information reported herein was derived entirely from the transmittal cited above.

Table of Contents

JULY 2022 OPPS CODING UPDATE

Summary of Changes

The update includes HCPCS additions, HCPCS changes, and payment policy indicators are generally described below; where the list of included HCPCS codes was lengthy, the list is provided on separate pages at the end of this paper.

- **Proprietary Lab Analysis Codes** – added 9 new codes for lab tests that are proprietary – in other words, the test method applicable to that CPT® is owned by the patent holder for the test

- **Advanced Diagnostic Lab Test** - 1 new code was retroactively approved as an Advanced Diagnostic Lab Test (ADLT) to 3/24/2022. The "TissueCypher Barrett's Esophagus Assay", CPT® 0108U, is OPPS Status Indicator A (paid under a fee schedule)

- **24 new CPT Category III** - codes have been added effective 7/1/2022. The AMA releases new codes in July and January of each year; Category III codes are temporary codes for emerging technology, services, procedures, and service paradigms

- **Procedures assigned to New Technology APC's** were updated:
  - Added CPT® 0721T -- The Optellum Lung Cancer Prediction (LCP) Procedure, which applies an algorithm to a patient's CT scan to produce a raw risk score for a patient's pulmonary nodule.Status indicator S, APC 1508 ($600-$700); effective 7/1/2022

  - Added CPT® 0723T – Quantitative Magnetic Resonance Cholangiopancreatography Procedure, which produces a three-dimensional reconstruction of the biliary tree, pancreatic duct, along with volume and duct metrics.Status indicator S, APC 1511 (Level 11, $900-$1,000), effective July 1, 2022

  - Excluded the Argus®II Retinal Prosthesis implant codes, as the device is no longer available in the marketplace. The implantation procedure and programming procedures (0100T, 0472T, 0473T, C1841) will be assigned status E2, excluded from coverage, effective July 1, 2022

  - Updated the description for HCPCS C9782 (CardiAMP cell therapy IDE study), which was established 4/1/2022.CMS revised the HCPCS description to specify inclusion of the device within the procedure code; assigned Status Indicator T, New Technology - Level 39 ($15,001-$20,000.)

JULY 2022 OPPS CODING UPDATE

- **Skin Substitutes -** Four Skin Substitute codes are newly assigned to the High Cost skin substitute group effective July 1, 2022.Among the four,A2001 (Innovamatrix ac, per square centimeter), will be retroactively payable as High-Cost effective April 1, 2022

HCPCS Code	CY 2022 Short Descriptor	Skin Substitute Group
A2001	Innovamatrix ac, per sq cm	High
A2002	Mirragen adv wnd mat per sq	High
Q4229	Cogenex amnio memb per sq cm	High
Q4258	Enverse, per sq cm	High

- **Drugs, Biologicals, and Radiopharmaceuticals** -- Sixteen new drug codes were established effective July 1, 2022 – of those, nine new codes were assigned pass-thru status, and four existing drugs with prior HCPCS assigned to pass-through status will have HCPCS updates to a new code:

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
A9596	NA	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie	G	9443
A9601	NA	Flortaucipir f 18 injection, diagnostic, 1 millicurie	E2	NA
C9094	NA	Inj, sutimlimab-jome, 10 mg	G	9444
C9095	NA	Inj, tebentafusp-tebn, 1 mcg	G	9446
C9096	NA	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram	G	9447
C9097	NA	Inj, faricimab-svoa, 0.1 mg	G	9496
C9098	NA	ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9498
J0739	NA	Injection, cabotegravir, 1 mg	E1	N/A
J1306	NA	Injection, inclisiran, 1 mg	G	9004
J1551	NA	Injection, immune globulin (cutaquig), 100 mg	K	9007
J2356	NA	Injection, tezepelumab-ekko, 1 mg	G	9008
J2779	C9093	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	G	9439
J2998	C9090	Injection, plasminogen, human-tvmh, 1 mg	G	9206
J3299	C9092	Injection, triamcinolone acetonide (xipere), 1 mg	G	9358
J9331	C9091	Injection, sirolimus protein-bound particles, 1 mg	G	9241
J9332	NA	Injection, efgartigimod alfa-fcab, 2mg	G	9010

JULY 2022 OPPS CODING UPDATE

- J0879 (Injection, Difelikeafalin, 0.1 microgram (for End Stage Renal Disease on dialysis)) will become retroactively payable as status K under OPPS effective April 1, 2022.

- **Covid-19 Laboratory tests and services (and one other lab code)**

  - CMS provided a comprehensive list of COVID-19 lab tests and related services and OPPS status indicators. CPT® 87913 is relatively new, having been added in February 2022

  - One lab code listed along with the COVID test codes, 0014M, is listed in this section, although it is not a COVID-19 lab test.It had been inadvertently omitted in the April OPPS update

  - HCPCS K1034 (Over-the-Counter Covid-19 Tests Demonstration) for providers who wish to supply home COVID-19 test kits to Medicare beneficiaries.HCPCS K1034 has been available to report dispensed test kits since April 4, 2022

- **New Covid-19 Vaccine and Administration codes**

  - Effective 3/29/2022, CMS will recognize and reimburse the Moderna COVID-19 vaccine booster dose (91309) and its administration (0094A), which coincides with the date this vaccine received an Emergency Use Authorization (EUA) from the FDA

  - Several other new CPT ® codes were established by the AMA but cannot be billed to Medicare until they receive an Emergency Use Authorization (EUA), including the Sanofi Pasteur booster vaccine for adults 18 years and older, and the Pfizer booster code for pediatric patients 5-11 years old

JULY 2022 OPPS CODING UPDATE

Table: New Proprietary Lab Test Codes

CPT Code	Long Descriptor	OPPS SI
0323U	Infectious agent detection by nucleic acid (DNA and RNA), central nervous system pathogen, metagenomic next-generation sequencing, cerebrospinal fluid (CSF), identification of pathogenic bacteria, viruses, parasites, or fungi	Q4
0324U	Oncology (ovarian), spheroid cell culture, 4-drug panel (carboplatin, doxorubicin, gemcitabine, paclitaxel), tumor chemotherapy response prediction for each drug	A
0325U	Oncology (ovarian), spheroid cell culture, poly (ADP- ribose) polymerase (PARP) inhibitors (niraparib, olaparib, rucaparib, velparib), tumor response prediction for each drug	A
0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	A
0327U	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed	A
0328U	Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service	Q4
0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations	A
0330U	Infectious agent detection by nucleic acid (DNA or RNA), vaginal pathogen panel, identification of 27 organisms, amplified probe technique, vaginal swab	Q4
0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alternations	A

JULY 2022 OPPS CODING UPDATE

Table: New CPT® Category III Codes

CPT Code	Long Descriptor	OPPS SI	OPPS APC
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance	J1	5375
0715T	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	N	N/A
0716T	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score	Q1	5733
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs	E1	N/A
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	E1	N/A
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	E1	N/A
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	S	5722
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	S	1508
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	N	N/A
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session	S	1511
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	N	N/A

JULY 2022 OPPS CODING UPDATE

New Category III CPT® Codes - Continued

CPT Code	Long Descriptor	OPPS SI	OPPS APC
0725T	Vestibular device implantation, unilateral	E1	N/A
0726T	Removal of implanted vestibular device, unilateral	E1	N/A
0727T	Removal and replacement of implanted vestibular device, unilateral	E1	N/A
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming	E1	N/A
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming	E1	N/A
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	E1	N/A
0731T	Augmentative AI-based facial phenotype analysis with report	S	5733
0732T	Immunotherapy administration with electroporation, intramuscular	E1	N/A
0733T	Remote body and limb kinematic measurement-based real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	Q1	5741
0734T	Remote body and limb kinematic measurement-based therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month	B	N/A
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	N	N/A
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	Q1	5733
0737T	Xenograft implantation into the articular surface	E1	N/A

JULY 2022 OPPS CODING UPDATE

Table: COVID-19 Lab Tests and Other Laboratory Test Codes

HCPCS Code	Long Descriptor	Add Date	OPPS SI	OPPS APC
U0001	CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel	02/04/2020	A	N/A
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC	02/04/2020	A	N/A
C9803	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source	03/01/2020	Q1	5731
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source	03/01/2020	B	N/A
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source	03/01/2020	B	N/A
86328	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04/10/2020	A	N/A
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen	08/10/2020	A	N/A
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer	08/10/2020	A	N/A
86413	Severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative	09/08/2020	A	N/A
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04/10/2020	A	N/A

JULY 2022 OPPS CODING UPDATE

COVID-19 Lab Tests and Other Laboratory Test Codes - continued

HCPCS Code	Long Descriptor	Add Date	OPPS SI	OPPS APC
87426	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])	06/25/2020	A	N/A
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique	03/13/2020	A	N/A
87913	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)	02/21/2022	A	N/A
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R	04/14/2020	A	N/A
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R	04/14/2020	A	N/A
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	05/20/2020	A	N/A
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	06/25/2020	A	N/A
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	06/25/2020	A	N/A

JULY 2022 OPPS CODING UPDATE

COVID-19 Lab Tests and Other Laboratory Test Codes - continued

HCPCS Code	Long Descriptor	Add Date	OPPS SI	OPPS APC
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	08/10/2020	A	N/A
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum	08/10/2020	A	N/A
0014M *	Liver disease, analysis of 3 biomarkers (hyaluronic acid [ha], procollagen iii amino terminal peptide [piiinp], tissue inhibitor of metalloproteinase 1 [timp-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years	04/01/2020	Q4	N/A

*0014M is not a COVID-19 test, but was included in this update because it had been inadvertently left out of the April 1, 2022 OPPS update.)

JULY 2022 OPPS CODING UPDATE

Table: Covid-19 Vaccine Product and Administration CPT Codes

CPT Code	Type	Labeler	Long Descriptor
91300	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
0001A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose
0002A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose
0003A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; third dose
0004A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; booster dose
91301	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use

JULY 2022 OPPS CODING UPDATE

Table: Covid-19 Vaccine Product and Administration CPT Codes - continued

CPT Code	Type	Labeler	Long Descriptor
0011A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose
0012A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose
0013A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage; third dose
91302	Vaccine/ Product Code	AstraZeneca/ University of Oxford	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID- 19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use
0021A	Administration/ Immunization Code	AstraZeneca/ University of Oxford	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose
0022A	Administration/ Immunization Code	AstraZeneca/ University of Oxford	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose

JULY 2022 OPPS CODING UPDATE

Table: Covid-19 Vaccine Product and Administration CPT Codes - continued

CPT Code	Type	Labeler	Long Descriptor
91303	Vaccine/ Product Code	Janssen/Johnson &Johnson	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use
0031A	Administration/ Immunization Code	Janssen/Johnson &Johnson	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; single dose
0034A	Administration/ Immunization Code	Janssen/Johnson &Johnson	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; booster dose
91304	Vaccine/ Product Code	Novavax	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage, for intramuscular use
0041A	Administration/ Immunization Code	Novavax	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; first dose
0042A	Administration/ Immunization Code	Novavax	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; second dose
91305	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, trissucrose formulation, for intramuscular use

JULY 2022 OPPS CODING UPDATE

Table: Covid-19 Vaccine Product and Administration CPT Codes - continued

CPT Code	Type	Labeler	Long Descriptor
0051A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; first dose
0052A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; second dose
0053A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; third dose
0054A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; booster dose
91306	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use
0064A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, booster dose
91307	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use

JULY 2022 OPPS CODING UPDATE

Table: Covid-19 Vaccine Product and Administration CPT Codes - continued

CPT Code	Type	Labeler	Long Descriptor
0071A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose
0072A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose
0073A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; third dose
0074A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV- 2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; booster dose
91308	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use
0081A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose

JULY 2022 OPPS CODING UPDATE

Table: Covid-19 Vaccine Product and Administration CPT Codes - continued

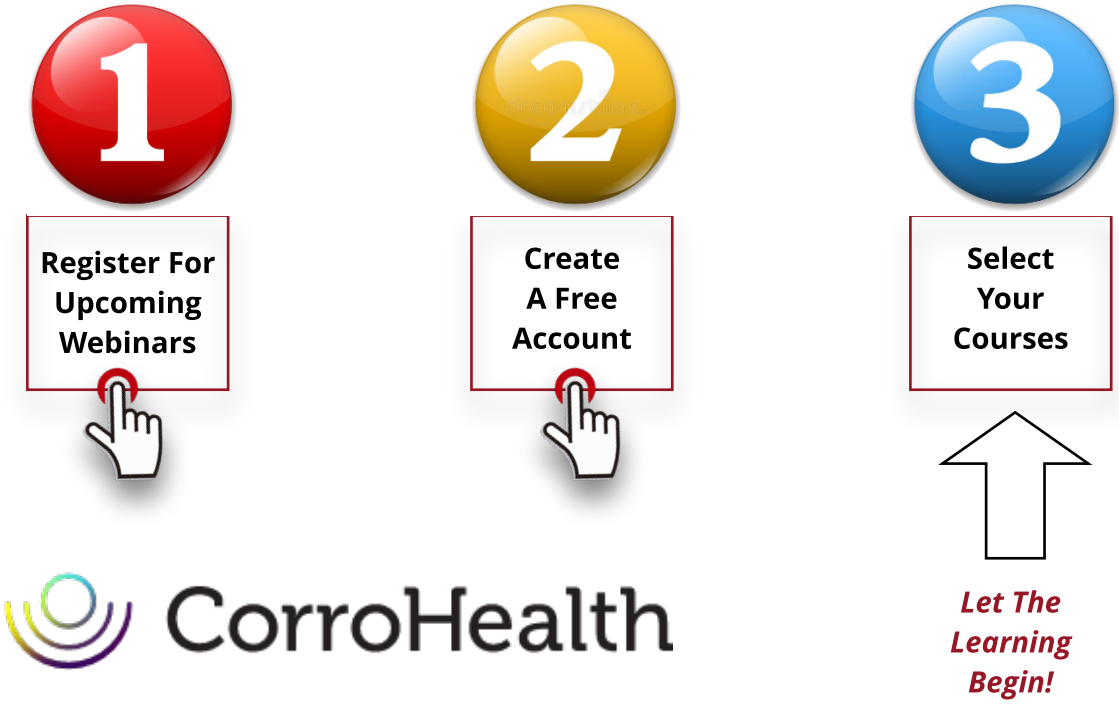
CPT Code	Type	Labeler	Long Descriptor
0082A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose
91309	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use
0094A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose
91310	Vaccine/ Product Code	Sanofi Pasteur	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use
0104A	Administration/ Immunization Code	Sanofi Pasteur	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, booster dose

INTRODUCING: CORROHEALTH ACADEMY

Introducing, **Corrohealth Academy.** It's a library of on-demand learning sessions that provides insight and knowledge of the coding industry. **Corrohealth Academy** is a series of webinars and learning opportunities designed to dramatically improve the confidence, proficiency and expertise of healthcare providers, revenue cycle professionals and finance executives.

There are literally dozens of topics from which to choose. And, we make the learning easy and on your terms.

There are THREE easy steps on your path to mastery:



CMS ESTIMATES BURDEN OF PROVIDING GFE TO UNINSURED

While some provisions of the NSA are not being enforced in 2022, the requirement to present a Good Faith Estimate (GFE) to an uninsured (or self-pay) individual is being enforced. HHS estimates that it will take an average of one hour for a business operations specialist to determine a patient's insurance status, inform uninsured (or self-pay) individuals of their right to receive a GFE of expected charges, and provide a GFE. CMS published a report on the estimated costs for providers.

The report can be found at this link: CMS-10791 | CMS

Supporting Statement—Part A
Requirements Related to Surprise Billing; Part II
CMS-10791/OMB control number-
1210-0169

A. Background

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA), which includes the No Surprises Act, was signed into law. The No Surprises Act provides Federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise bills arise most frequently.

CMS ESTIMATES BURDEN OF PROVIDING GFE TO UNINSURED

Within the Supporting Statement, Medicare provides tables which offer an example of some of the costs and burdens associated with providing a GFE. Here are a couple of examples:

TABLE 2: Estimated One-Time and Hour Burden for Providers Associated with Facilities to Enter into Agreements to Provide Notice of Right to a Good Faith Estimate

Year	Estimated Number of Respondents	Estimated Number of Responses	Burden Per Response (Hours)	Total Burden (Hours)	Total Estimated Cost
2021	245,336	245,336	4	981,344	$91,770,384

HHS assumes that the associated facility will draft the notices informing uninsured (or self-pay) individuals of their right to receive a good faith estimate of expected charges. Information regarding the availability of good faith estimates for uninsured (or self-pay) individuals must be written in a clear and understandable manner and made available in accessible formats and in the language(s) spoken by

TABLE 5: Estimated One-Time Cost and Hour Burden for Individual Physician Practitioners to Draft and Post Notice of Good Faith Estimate Notice*

Year	Estimated Number of Respondents (Occupation Type)	Estimated Number of Responses	Burden Per Response (Hours)	Total Annual Burden (Hours)	Printingand MaterialCosts	Total Estimated Cost
2021	145,887(All Physicians)	145,887	2.5	364,717	$14,589*	$61,797,674
2021	116,709** (Additional burden for Subset of Physicians with Websites)	116,709	1	116,709	-	$13,278,038
Total	-	-	3.5	481,426	-	$75,075,712***

*HHS estimates that 80 percent (116,709) of individual physician practitioners have a website. Therefore, estimated cost includes computer programming cost to update individual physician practitioners' websites with right to good faith estimate notice to uninsured (or self-pay) individuals. HHS assumes that each individual physician practitioner will incur a printing cost of $0.05 per page and materials for a total equivalent cost of $0.10. Total printing and material costs of $14,589 are included.

**Note that the 116,709 computer programmers are accounted for in the total number of 145,887 individual physician practitioners that must comply with the requirement.

*** This is calculated as the sum of $75,075,712(cost for individual physician practitioners to draft notice of right to GFE) + $13,278,038 (cost for computer programmers to post notice of right to

CMS ESTIMATES BURDEN OF PROVIDING GFE TO UNINSURED

The **PARA Data Editor** offers a feature to enable **ParaRev** clients to create estimates and print the documents required for compliance with the new rules. The knowledgeable **ParaRev** team can get your staff educated and up-to-date on the provisions of the NSA which are being enforced in 2022 so you can be compliant.

ParaRev is developing further enhancements to assist clients with additional No Surprises Act requirements which will be enforced in 2023. Providers will be required to work with facilities to provide one consolidated GFE for scheduled services to the uninsured (or self-pay) individual.

In addition, new rules which require all health care providers (facilities and practitioners) to provide a GFE to the individual's health plan will be enforced in 2023. This will allow the plan to send an advanced EOB to the insured individual. The GFE and Advanced EOB will be provided to all insured individuals regardless of contract status between the plan and provider.

Contact one of **ParaRev's Account Executives** for more information about the NSA tool available to cut labor costs when providing estimates to individuals or health plans.

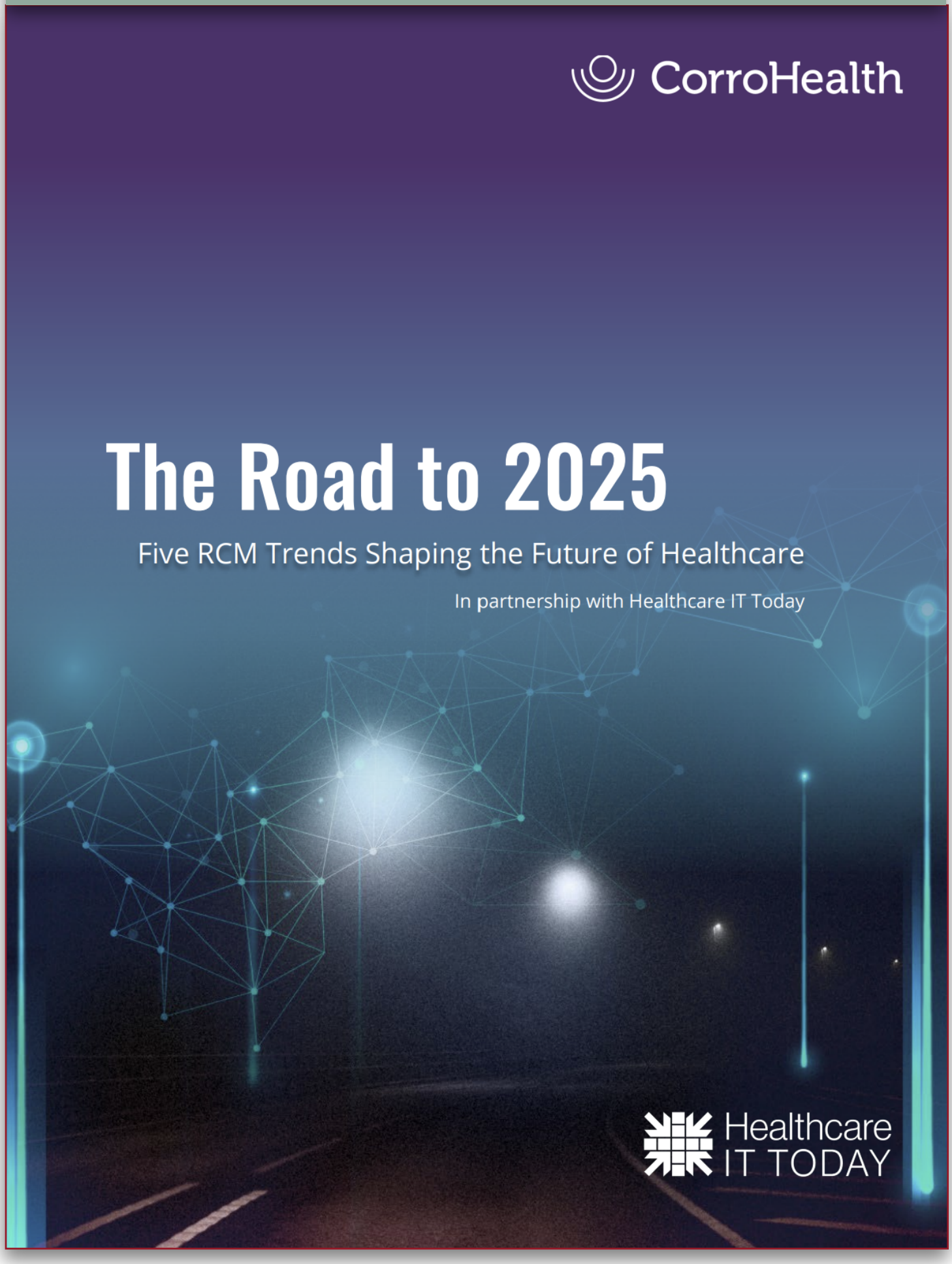
Violet-Archuleta-Chiu
Senior Account Executive

800.999.3332 X219

Sandra LaPlace
Account Executive

800.999.3332 X225

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE



FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

Contents

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

Executive Summary

By 2025, Revenue Cycle Management (RCM) will shift from being a back-office function to a core integrated component of care delivery.

This is a good thing.

Coding and claims processing will no longer be the sole focus of the RCM department. Instead, RCM professionals and coders will be working closely alongside their clinical counterparts to help proactively mitigate risks in patient populations in the most cost-effective manner possible.

This transformation of RCM will not happen overnight, but gradually over the next several years as the result of five key market forces:

1. Continued labor challenges
2. Advances in artificial intelligence
3. Prior Authorization requirements
4. The march to new payment models
5. The increasing value of and complexity with patient payments

A wait-and-see approach is not advisable. Instead, there is a unique opportunity for healthcare and RCM leaders to lean into the upcoming changes. Those who get ahead of the curve will enjoy lower staff turnover, increased patient loyalty, better online ratings, and smoother operations.

The key is to make small incremental changes over time rather than disruptive changes at the last minute. It will be important for healthcare organizations to each find the right mix of process changes, technologies, and strategic partners to make the transition easy.

One technology, in particular, holds tremendous potential for RCM in 2025 – artificial intelligence...not as a replacement for RCM professionals or coders, but rather as a way to augment and "upskill" their efforts.

Introduction to eBook

Big changes are coming in Revenue Cycle Management (RCM). Fundamental shifts are happening which will transform RCM from a back-office function to a core strategic department in just a few years.

As we scan the healthcare landscape, talk to industry insiders, and directly to RCM leaders, we see tremendous opportunities for healthcare organization to differentiate themselves through improved RCM processes and approaches.

We want to share our observations, insights, and perspective with you in this eBook.

Just for you

If you are looking to modernize your RCM processes and put your organization in a strong position to thrive during this tumultuous period, this eBook is for you.

Inside you will find:

- Definitions of RCM, Prior Authorization, Artificial Intelligence, and other terms that will be important on the road to 2025
- Information on pitfalls to avoid
- Guidance on how to seize the opportunities coming down the road
- Practical advice on how to position yourself and the RCM department for success in the future

Who should use this eBook

This eBook is written with the following audiences in healthcare provider organizations and payers:

- CFOs
- VPs of Finance
- RCM Directors
- Coding Specialists
- RCM Professionals
- RCM Team Leaders
- Patient Experience Leaders

How to use this eBook

This eBook is meant to be a reference. We want to present you with new perspectives and highlight potential opportunities that are available. We have no problem with you copying the words, statistics, or graphics to use in your internal materials. We just ask that you would cite the original source.

If after reading this eBook you have questions, comments, or would like to find out more, we would be happy to connect with you. Just email us at RevCycle2025@healthcareittoday.com

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

Introduction to RCM

RCM Definition

RCM is the administration of financial transactions that result from the medical encounters between a patient and a healthcare provider. It includes all the administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.

According to the Healthcare Financial Management Association (HFMA), this is what is involved in the revenue cycle:

- Charge capture: Rendering medical services into billable charges.
- Claim submission: Submitting claims of billable fees to insurance companies.
- Coding: Properly coding diagnoses and procedures.
- Patient collections: Determining patient balances and collecting payments.
- Preregistration: Collecting preregistration information, such as insurance coverage, before a patient arrives for inpatient or outpatient procedures.
- Registration: Collecting subsequent patient information during registration to establish a medical record number and meet various regulatory, financial, and clinical requirements.
- Remittance processing: Applying or rejecting payments through remittance processing.
- Third-party follow up: Collecting payments from third-party insurers.
- Utilization review: Examining the necessity of medical services.

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

Source: https://blog.pmmconline.com/blog/revenue-cycle-management-explained

Coding, Clinical Documentation Improvement and RCM Specialists

The American Health Information Management Association (AHIMA[i]), defines *Coding Specialists* as professionals who "create coded data used by hospitals and medical providers to obtain reimbursement from insurance companies or government programs such as Medicare and Medicaid." They do this by reviewing patient records and assigning numeric *codes* for each diagnosis and procedure. These codes then become the basis for reimbursement *claims* made by providers to insurance companies.

The Association of Clinical Documentation Integrity Specialists (ACDIS[ii]), defines *CDI Specialists* as those serving as an essential resource[iii] for clinical teams to ensure that all relevant conditions requiring healthcare resources throughout the patient's hospitalization are accurately captured in the final coded data.

Revenue Cycle Management Professionals are responsible for the management and oversight of business, administrative and clinical functions that contribute to patient revenue. This includes everything from appointment booking to patient intake to processing claims to collections.

Prior to the COVID-19 pandemic, RCM professionals and Coding Specialists were one of the top 20 most in-demand jobs[iv] in the US according to the Bureau of Labor Statistics (BLS[v]).

Why is RCM important?

RCM is key to a functioning healthcare system. Timely reimbursement and collection of revenue are needed to pay physicians, nurses, and other staff who care for patients. It is also vital to the maintenance and purchase of vital medical equipment.

Disruptions to or inefficiencies in the RCM process do not just impact provider operations. It can also have a negative impact on the overall patient experience. If copays, prior authorizations, or medical bills are not processed quickly, patients may not be informed of the cost of their care in a timely manner – a significant factor in overall satisfaction.

Current State of RCM

When it comes to RCM, healthcare leaders are focused on eliminating inefficiencies in order to make payments as smooth as possible.

> *There is absolutely recognition that automation and AI are needed in order to do more with less. There is also recognition that we need to up-skill individuals in combination with AI to optimize healthcare workforces in light of the challenges of recruiting new staff.*
>
> *– Patrick Leonard, CEO at CorroHealth*

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

The Medical Group Management Association[vi] recently polled healthcare leaders[vii] to find out their biggest RCM challenges. A majority (48%) responded "claims payment," while 23% reported "other" revenue cycle issues that included denials and prior authorizations. These results are consistent with other polls over the past several years.

This focus on inefficiency is not surprising when you consider that an estimated 15% of every healthcare dollar goes toward revenue cycle inefficiencies, according to a McKinsey research[viii].

The CAQH Index[ix] tracks automation, spending and savings opportunities for administrative transactions related to verifying patient insurance coverage and cost sharing, obtaining authorization for care, submitting claims and supplemental information and sending and receiving payments.

CAQH estimates that an additional $16.3 Billion can be saved through further RCM automation.

While the industry has already avoided $122 billion annually by automating these transactions, up $20 billion from last year, the Index pinpointed opportunities for additional savings. For example, each fully automated claims status inquiry costs $11.71 less than the same transaction conducted manually for the medical industry. Similarly, every eligibility and benefit verification converted from manual to electronic saves the medical industry $8.64. Considering the millions of times these transactions occur every day, the savings potential across the healthcare economy is significant.

1. Labor Challenges

The demand for Coding Specialists, CDI Specialists, and RCM professionals has always been high. The Bureau of Labor Statistics (BLS) placed these roles in the top 20 most in-demand jobs[x]. The "Great Resignation" has been sweeping across the United States and has made it even harder for healthcare organizations to attract and retain RCM talent.

According to Morning Consult[xi], an astounding 18% of health care workers have already quit their jobs during the COVID-19 pandemic. That is nearly 1 in 5!

Staff at a tipping point

This data is corroborated by an ADP survey[xii] involving Hybrid Workers in healthcare – this data represents those who use a level of expertise to solve similar problems each day (the exact type of work done by RCM professionals):

- 43% are not actively looking but would consider a new organization if contacted by a recruiter or saw an opportunity
- 15% are actively looking for a new job
- 6% are actively engaged in the interview process for a new job

On a team of 15 RCM professionals (typical of a mid-sized hospital in the US), this would mean that:

- 6 are one phone call, email, or website click away from being tempted to leave
- 2 are actively searching for a job elsewhere
- 1 is actively interviewing for a job elsewhere

...leaving just 6 members of the team who plan to stay. It is no wonder that a recent MGMA study[xiii] found that Staffing Challenges are by far, the #1 concern of 73% of healthcare leaders in 2022.

On top of this, executives are competing for staff not just against other healthcare providers in their local regions, but against providers nationwide. Remote RCM workers can work for any organization, anywhere.

Road to 2025

On the road to 2025, Coding Specialists, CDI Specialists, and RCM professionals will continue to be difficult to attract. Healthcare organizations must therefore find ways to do more with the people they have and actively work to keep them.

One proven retention strategy is investing in process improvements that allow your RCM team to "function at the top of their ability". This means eliminating repetitive tasks and bottlenecks so that team members can focus on duties that fully leverage their skills and experience.

2. AI + RCM

The English Oxford Living Dictionary[xiv] defines Artificial Intelligence (or AI) as:

"The theory and development of computer systems able to perform tasks normally requiring human intelligence, such as visual perception, speech recognition, decision-making, and translation between languages."

AI includes a basket of technologies: machine learning (ML), predictive analytics, robotic process automation (RPA), natural language processing (NLP), visual recognition, and optical character recognition (OCR).

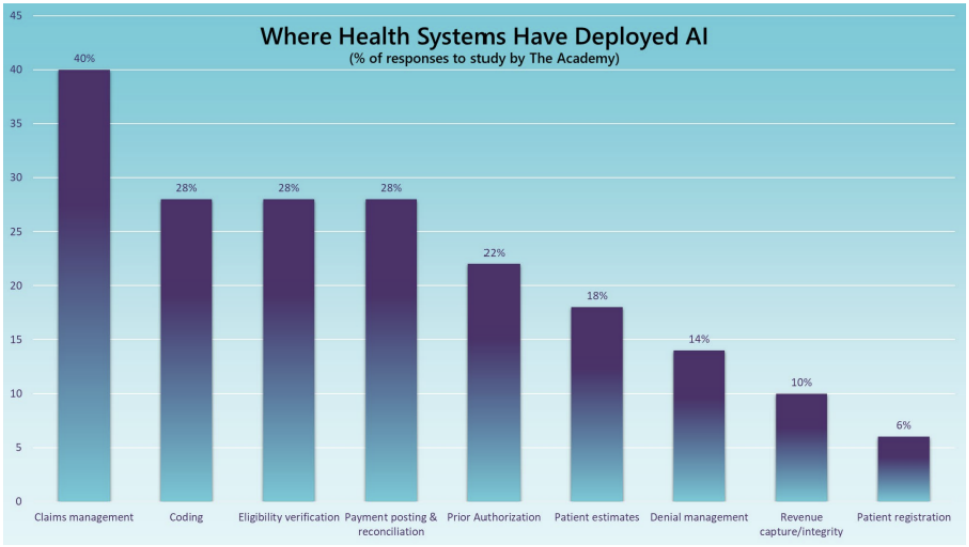
The revenue cycle process in healthcare is a prime candidate for the application of AI.

There are many routine RCM tasks where machine learning (ML), natural language processing (NLP), and robotic process automation (RPA) can eliminate bottlenecks and reduce manual effort. Implementing these technologies can free staff to work on tasks that require more of their skills and experience (read: more engaging work).

Adopters of AI in RCM have already realized significant benefits including:

- Faster time-to-revenue
- Mitigating preventable revenue leakage
- Improving overall patient experience
- Improving staff morale
- Reducing labor costs

According to a recent study[xv], more than 80% of leading health systems that are using AI for RCM say their primary reason for investing in the technology was improving financial performance, but once the technology was in use, they said efficiency was the top benefit. That same study found that leading health systems have deployed AI for:



FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

"By applying special natural language processing algorithms we can automate the charge capture part of the RCM process. This autonomous coding means that Coding Specialists can be elevated to the role of auditor. The software can now be the coder leaving the Specialist to deal with edge cases, exceptions and unexpected changes. This type of work is far more engaging and stimulating. In addition, autonomous coding helps reduce rejections because the technology produces consistent results. Fewer claims issues means more revenue faster and less headaches."

– Neal Somaney, Executive Vice President CorroHealth

*Source: Pecci, Alexandra Wilson. "Leaders Say Efficiency, Not Finances, Is Top Rev Cycle RPA/AI Benefit", Health Leaders, 14 October 2021, https://www.healthleadersmedia.com/revenue-cycle/leaders-say-efficiency-not-finances-top-rev-cycle-rpaai-benefit, accessed 29 January 2022

Although 82% of leading health systems reduced their RCM workforce following the implementation of AI, 62% of executives reallocated staff to different roles and less than a quarter reduced their RCM workforce by more than 10%.

"It's not about replacing people with automation. Not everything is going to be automated, not every decision is going to be made by AI. We need a blend of AI and people power."

– Patrick Leonard, CEO CorroHealth

Road to 2025

The benefits of AI in RCM are clear and will drive the adoption of AI technology in the year ahead. By 2025, AI will be as prevalent in RCM as email is today. Healthcare organizations should prepare themselves to exit the comfort of their legacy RCM systems and be ready to step forward with newer technologies.

Those that make the transition early to AI-powered RCM, will be better able to meet the challenges and complexities of RCM in 2025.

3. Prior Authorization

The American Medical Association (AMA) defines "Prior Authorization" as:

A process requiring health care providers (physicians, pharmacists, medical groups, and hospitals) to obtain advance approval from health plans before a prescription medication or medical service is delivered to the patient.

While health plans and benefit managers see prior authorizations as key to controlling costs, healthcare providers find prior authorizations to be challenging and disruptive to the delivery of necessary patient care.

Prior Authorizations creating additional work

An AMA study[xvi] revealed:

- 83% of physicians report that the number of required prior authorizations has increased significantly over the last 5 years
- 87% of physicians report that prior authorizations interfere with continuity of care
- Less than 25% of physicians have an electronic means to obtain a prior authorization via their EHR

Significant time is spent managing prior authorizations. It can require navigating multiple payers using inconsistent communication channels including phone calls, faxes, and electronic notifications. Getting a definitive answer on a prior authorization is not usually a one-and-done process, and there are often back-and-forth communications which can last several hours (and even days).

The AMA study found:

- 40 prior authorizations are required per physician per week on average
- It takes 2 business days (16 hrs) each week to complete those prior authorizations
- 40% of healthcare organizations have staff who work exclusively on prior authorizations

Electronic Prior Authorization + robust RCM

The Council for Affordable Quality Healthcare (CAQH) found in 2019 that, on average, providers spend nearly $11 on each prior authorization completed manually. Prior authorization costs were lower for partially electronic transactions ($4) and fully electronic transactions ($2). However, many organizations have not yet adopted electronic prior authorization.

Implementing software to help with prior authorization is prudent, but this technology alone is not enough. Claims with prior authorizations can still be denied for many reasons including (but not limited to):

- Missing information such as service code or date of birth
- Sending the claim to the wrong insurance company
- Expired approval (normally 30 days)

It is critical, therefore, to couple electronic prior authorization with a robust RCM process. This ensures the work upfront to obtain a prior authorization is not ruined by a misstep in the final steps of reimbursement. A robust RCM process also means that when a claim is denied, it can be remedied quickly.

Road to 2025

Prior Authorizations will only grow in importance and complexity on the road to 2025. As the guidelines, requirements, and processes for prior authorizations change, it will be key for healthcare organizations to have an RCM team that is ready and capable of responding. That means investing now to reduce their operational burden so that they have the flexibility to act when needed.

4. Value-Based Care

Healthcare is transitioning (slowly) from a fee-for-service model where providers are paid for services rendered to a value-based model where they are paid based on the quality of patient care.

In the world of value-based-care (VBC), providers are responsible for the health of patients beyond the brief encounters at their facilities. They must work to ensure patients remain healthy between visits since reimbursement is tied to achieving specific quality measures.

Shift to minimizing risk

To succeed with VBC, RCM teams need to shift away from narrowly focusing on minimizing denials to minimizing risk. In the fee-for-service model, financial downside takes the form of payer denials, so RCM professionals worked hard to ensure their claims are clean and shepherded them carefully through the entire reimbursement process. With VBC, there are new risk factors that can negatively impact revenue, which may require projecting reimbursement levels under different performance scenarios under the Merit-Based Incentive Payment System (MIPS).

With VBC, RCM can no longer be a back-office function and must work much closer with their clinical counterparts. Why? Because of the importance of accurate clinical documentation. In the fee-for-service model, clinical documentation errors and omissions could be caught as part of the RCM process. Once identified, the problems could be fixed. If addressed quickly, the issue would not have a significant impact on reimbursement.

Attention to detail

In a VBC model, clinical documentation for the entire episode of care must be accurate, complete, and requires a much finer attention to detail. This is because the measures upon which VBC reimbursement is based, demand more resolution in the clinical record. Because providers are assuming more risk with VBC, key health measures must be monitored in real time so that appropriate actions can be taken to avoid costly readmissions.

It will be incumbent upon the RCM team to educate their clinicians on what needs to be documented (and how) in order to capture the bonuses and avoid the penalties in a typical VBC contract. There will be resistance, frustration, and trepidation during the transition to VBC, but with persistence (and patience), these challenges can be overcome.

> *The big change is where in the process primary coding happens. In a fee-for-service model, Coding Specialists would abstract and provide a code based on documentation during the tail-end of the process. With VBC, that coding needs to happen much earlier in the process so that corrections to the documentation can happen earlier. This means that a higher degree of bi-directional communication is needed between physicians and RCM professionals.*
>
> *– Dr. Andres Jimenez,*
> *Chief Medical Information Officer, CorroHealth*

Road to 2025

This transition to VBC will not happen overnight. It is very likely that between now and 2025, healthcare organizations will be faced with a hybrid of fee-for-service and VBC models. RCM teams will need to be adaptable and nimble to help their organizations navigate this confusing time.

It is vital that RCM professionals and clinicians travel alongside each other on the road to value-based-care.

5. Patient Payments

Over the past several years, the healthcare payment landscape has changed dramatically. Gone are the days when patients were only responsible for nominal co-pays and the bulk of fees were collected from insurance companies directly. Today we live in a world of high co-payments, high deductibles, charges for non-covered expenses, and paying out-of-pocket. In other words, the patient is shouldering an increasing % of their own medical bills.

High deductible plans

According to the Kaiser Family Foundation[xvii], 31% of covered workers in the US were enrolled in High Deductible Health Plans (HDHPs) in 2020. That's up from 24% in 2015. As employers look to continue cutting costs, this upward trajectory of HDHPs will continue.

By 2025 more patients will be bearing a greater % of the responsibility for paying medical bills than today.

Healthcare providers have had to adapt by offering:

- Multiple payment methods to patients (check, credit card, direct debit, and even PayPal)
- Payment plans
- Financing options
- Early payment discounts

Helping patients

Patients have also had to adapt to this new reality. They suddenly find themselves responsible for paying a significant portion of medical bills that are difficult to understand.

Healthcare providers can help their patients, and themselves, by recognizing they need to:

1. Help patients understand what they owe versus what their insurance company will pay
2. Actively encourage patients to pay in a timely fashion
3. Make it easier for patients to pay
4. Provide guidance and education at every step in the payment process

In 2025, the providers who recognize that they must offer a seamless and frictionless financial experience, alongside a good clinical experience, will be the ones who succeed. It will take investing in payment infrastructure and communication channels as well as a shift from a back-office efficiency mindset to one of customer-service.

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

No Surprise Billing

On January 1st, 2022, the "No Surprises Act[xviii]" consumer protection law went into effect. This legislation establishes protections for patients against surprise medical bills. Today this occurs most often when a patient inadvertently and unknowingly receives care from an out-of-network organization, doctor, or other care provider they did not choose, even though the patient is at an in-network facility.

Studies by the Kaiser Family Foundation reveal that surprise billing happens in about 20% of emergency room visits and 9-16% of in-network hospitalizations for non-emergency care. The federal government estimates this Act will apply to 10 million surprise medical bills each year.

Complying with this Act will add complexity to existing RCM processes. Not only will additional care be needed when billing patients, but RCM teams will need to work with their call-center counterparts to help answer the questions from patients who are suddenly on the lookout for surprise billing on their statements.

Road to 2025

As we head on the road to 2025, we expect to see more patient protections become the norm – some through legislation, and some as voluntary best practices. In either case, RMC teams will need to be flexible, well-resourced, and more collaborative with other departments to comply with these new protections.

FIVE RCM TRENDS SHAPING THE FUTURE OF HEALTHCARE

Opportunities for 2025

In this eBook we have presented many ideas for what RCM will look like in 2025 based on statistics and the current state of healthcare. At first glance, the road to 2025 may appear to be a daunting uphill climb. It is not our intent to scare you. In fact, quite the opposite.

During this time of transition, there are tremendous opportunities for healthcare organizations and, in particular, RCM teams. By 2025, RCM teams that have made the technology investments, retained their talented staff, and adjusted their processes will find themselves helping their organizations make important strategic operational decisions.

By 2025, RCM will shift from being a back-office function to a core, integrated component of care delivery. Coding and claims processing will no longer be the sole focus of the RCM department. Instead, RCM professionals, coders, and CDI Specialists will be working closely alongside their clinical counterparts to help proactively mitigate risks in patient populations in the most cost-effective manner possible.

The RCM department of the future will also be collaborating with those responsible for patient experience. As patient payments continue to rise, the financial experience patients have with a healthcare provider will become almost as important as their clinical experience. There is an opportunity for forward-thinking RCM teams to help their organizations stand out.

It will be very interesting to journey on this road to 2025.

References

[i] The American Health Information Management Association (AHIMA), https://www.ahima.org/

[ii] The Association of Clinical Documentation Integrity Specialists (ACDIS), https://acdis.org/

[iii] "Defining the CDI specialist's roles and responsibilities", ACDIS Positioning Paper, *ACDIS*, 1 April 2014, https://acdis.org/resources/defining-cdi-specialist%E2%80%99s-roles-and-responsibilities, accessed 2 February 2022.

[iv] Newburger, Emma. "21 of the most in-demand jobs in the US — and how much they'll pay", *CNBC*, 29 January 2019, https://www.cnbc.com/2019/01/29/21-in-demand-jobs-for-2019--and-what-they-pay-.html, accessed 2 February 2022.

[v] US Bureau of Labor Statistics, https://www.bls.gov/

[vi] Medical Group Management Association, https://www.mgma.com/

[vii] "Healthcare leaders point to their biggest revenue cycle challenges", *MGMA*, 14 November 2019, https://www.mgma.com/data/data-stories/healthcare-leaders-point-to-their-biggest-revenue, accessed 29 January 2022.

[viii] Bayley, M., Calkins, S., Levine, E, et al, "Hospital revenue cycle operations: Opportunities created by the ACA," *McKinsey*, May 2013, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/hospital-revenue-cycle-operations-opportunities-created-by-the-aca, accessed 29 January 2022

[ix] "CAQH 2020 Index: Automating Healthcare Administrative Transactions Has Reduced Annual Costs by $122 Billion, $16.3 Billion More Can Be Saved Through Further Automation", *CAQH*, 3 February 2021, https://www.caqh.org/about/press-release/caqh-2020-index-automating-healthcare-administrative-transactions-has-reduced, accessed 2 February 2022.

[x] Newburger, Emma. "21 of the most in-demand jobs in the US — and how much they'll pay", *CNBC*, 29 January 2019, https://www.cnbc.com/2019/01/29/21-in-demand-jobs-for-2019--and-what-they-pay-.html, accessed 2 February 2022.

[xi] Galvin, Gaby. "Nearly 1 in 5 Health Care Workers Have Quit Their Jobs During the Pandemic", *Morning Consult*, 4 October 2021, https://morningconsult.com/2021/10/04/health-care-workers-series-part-2-workforce/, accessed 25 January 2022.

[xii] Hayes, Mary Dr., Chumney, Frances Dr., and Buckingham, Marcus. "Eight Things to Know about "The Great Resignation" in Healthcare", *ADP Research Institute*, November 2021, https://www.adpri.org/wp-content/uploads/2021/11/04141951/Healthcare_DataSpotlight_1121_v1.pdf, accessed 29 January 2022

[xiii] "Staffing, uncertainty among top pandemic challenges for medical groups heading into 2022", *MGMA*, 22 September 2021, https://www.mgma.com/data/data-stories/staffing,-uncertainty-among-top-pandemic-challenge, accessed 29 January 2022

[xiv] Artificial Intelligence, *Lexico*, https://www.lexico.com/definition/artificial_intelligence, accessed 25 January 2022.

[xv] Pecci, Alexandra Wilson. "Leaders Say Efficiency, Not Finances, Is Top Rev Cycle RPA/AI Benefit", *Health Leaders,* 14 October 2021, https://www.healthleadersmedia.com/revenue-cycle/leaders-say-efficiency-not-finances-top-rev-cycle-rpaai-benefit, accessed 29 January 2022

[xvi] "Measuring Progress in Improving Prior Authorization", *American Medical Association,* May 2021, https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf, accessed 25 January 2022.

[xvii] "2020 Employer Health Benefits Survey", *Kaiser Family Foundation*, 8 October 2020, https://www.kff.org/report-section/ehbs-2020-section-8-high-deductible-health-plans-with-savings-option/, accessed 25 January 2022.

[xviii] "Surprise billing & protecting consumers", *CMS*, https://www.cms.gov/nosurprises/Ending-Surprise-Medical-Bills, accessed 25 January 2022

CMS CORRECTS PART-B ONLY CAH CLAIMS PROCESSING

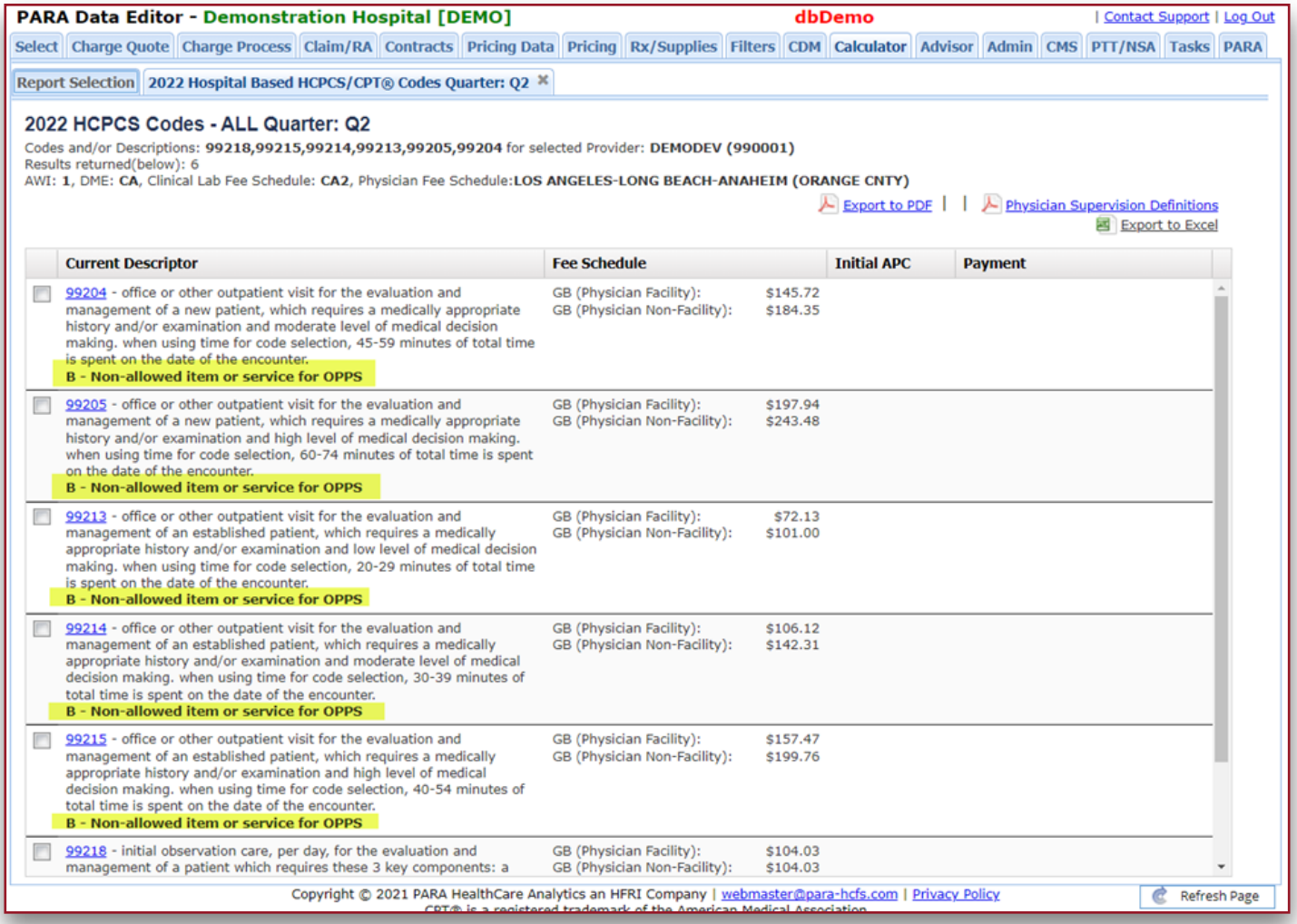
Medicare recently published Change Request 12636 directing Medicare Administrative Contractors to correct reimbursement processing for Critical Access Hospital (CAH) claims billed on Type of Bill (TOB) 12X for inpatient care provided to a beneficiary with Part B coverage only.

The MACs are not required to change claims processing, however, until October 1, 2022.The Change Request instructs contractors to allow payment for CAH ancillary services, including status B facility fees, using the reasonable cost (percent of charges) methodology.

The Change Request indicates that CAHs may have been improperly denied reimbursement for certain facility fee HCPCS billed on TOB 12X, specifically HCPCS which have been assigned OPPS Status Indicator B.

OPPS Status Indicator B codes can be valid for CAH claims, but are not recognized by OPPS when submitted on an outpatient OPPS hospital type of bill 12x or 13x. Typically, status B codes are not eligible for OPPS hospital claims because an alternate code may be reported (such as G0463 -HOSPITAL OUTPATIENT CLINIC VISIT FOR ASSESSMENT AND MANAGEMENT OF A PATIENT) for facility fees.Medicare permits CAHs to report OPPS status B HCPCS for facility fees.

Here are a few HCPCS examples:



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

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

Report Selection | 2022 Hospital Based HCPCS/CPT® Codes Quarter: Q2

2022 HCPCS Codes - ALL Quarter: Q2

Codes and/or Descriptions: **99218,99215,99214,99213,99205,99204** for selected Provider: **DEMODEV (990001)**
Results returned(below): 6
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)**

Export to PDF | Physician Supervision Definitions | Export to Excel

Current Descriptor	Fee Schedule		Initial APC	Payment
99204 - office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$145.72 $184.35		
99205 - office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. when using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$197.94 $243.48		
99213 - office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. when using time for code selection, 20-29 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$72.13 $101.00		
99214 - office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$106.12 $142.31		
99215 - office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. when using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$157.47 $199.76		
99218 - initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a	GB (Physician Facility): GB (Physician Non-Facility):	$104.03 $104.03		

Copyright © 2021 PARA HealthCare Analytics an HFRI Company | webmaster@para-hcfs.com | Privacy Policy
CPT® is a registered trademark of the American Medical Association

Refresh Page

CMS CORRECTS PART-B ONLY CAH CLAIMS PROCESSING

Medicare's Change Request instructs MACs to pay CAH claims for OPPS status B ancillary *facility* services at 101% of the reasonable cost of those service – in other words, on the percent-of-charges methodology otherwise applicable to most covered CAH outpatient facility fees.

(The instruction points out that professional fees billed by a CAH on the UB/837iunder revenue codes 096x, 097x, or 098x are paid under the Medicare Physician Fee Schedule – there is no change to claims processing for professional fees.)

Furthermore, Medicare stipulated that "Medicare contractors should not search their files to retroactively pay claims. However, contractors shall adjust claims brought to their attention."

The CAH ancillary service(s) TOB 12x must include the appropriate revenue codes to distinguish facility fees from professional fees. Most covered facility fees services on a CAH TOB 012X should be paid at 101 percent of the reasonable costs of the services. There are a few exceptions, such as mammography, which are paid under the Medicare Physician Fee Schedule when billed by a CAH or OPPS facility.

Consequently, this new guidance indicates that some Part-B only claims on TOB 012X may have been short paid due to improper line-item denials.

A link and an excerpt from the transmittal is provided below:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11339otn

Critical Access Hospitals which have submitted Part B-Only inpatient claims on TOB 12X should keep an eye on reimbursement and resubmit the claim for corrected processing after 10/1/2022.

EFFECTIVE DATE: October 1, 2022 - Unless otherwise specified, the effective date is for claims processed on or after CR implementation.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022

I. GENERAL INFORMATION

A. Background: Medicare allows for ancillary services when provided in a CAH. CAH ancillary services are submitted on a TOB 12X and based on 101 percent of reasonable costs like TOB 85x, excluding professional services that are separately billable by the performing clinician. It has been brought to CMS' attention when a CAH submits a TOB 12x no-reimbursement is being made for all ancillary services which have a pricing indicator 'B'.

This change request instructs contractors to allow for CAH ancillary services at reasonable cost when appropriate. The CAH ancillary service(s) TOB 12x should include the appropriate revenue codes. For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. Services are paid based on the Medicare Physician Fee Schedule only when the physician or other practitioner has reassigned their benefits, and should be billed on TOB 85x with the appropriate Healthcare Common Procedure Coding System (HCPCS) code and revenue codes of 096x, 097x or 098x.

The Part A Medicare Administrative Contractor will not correct the claim payment unless brought to their attention:

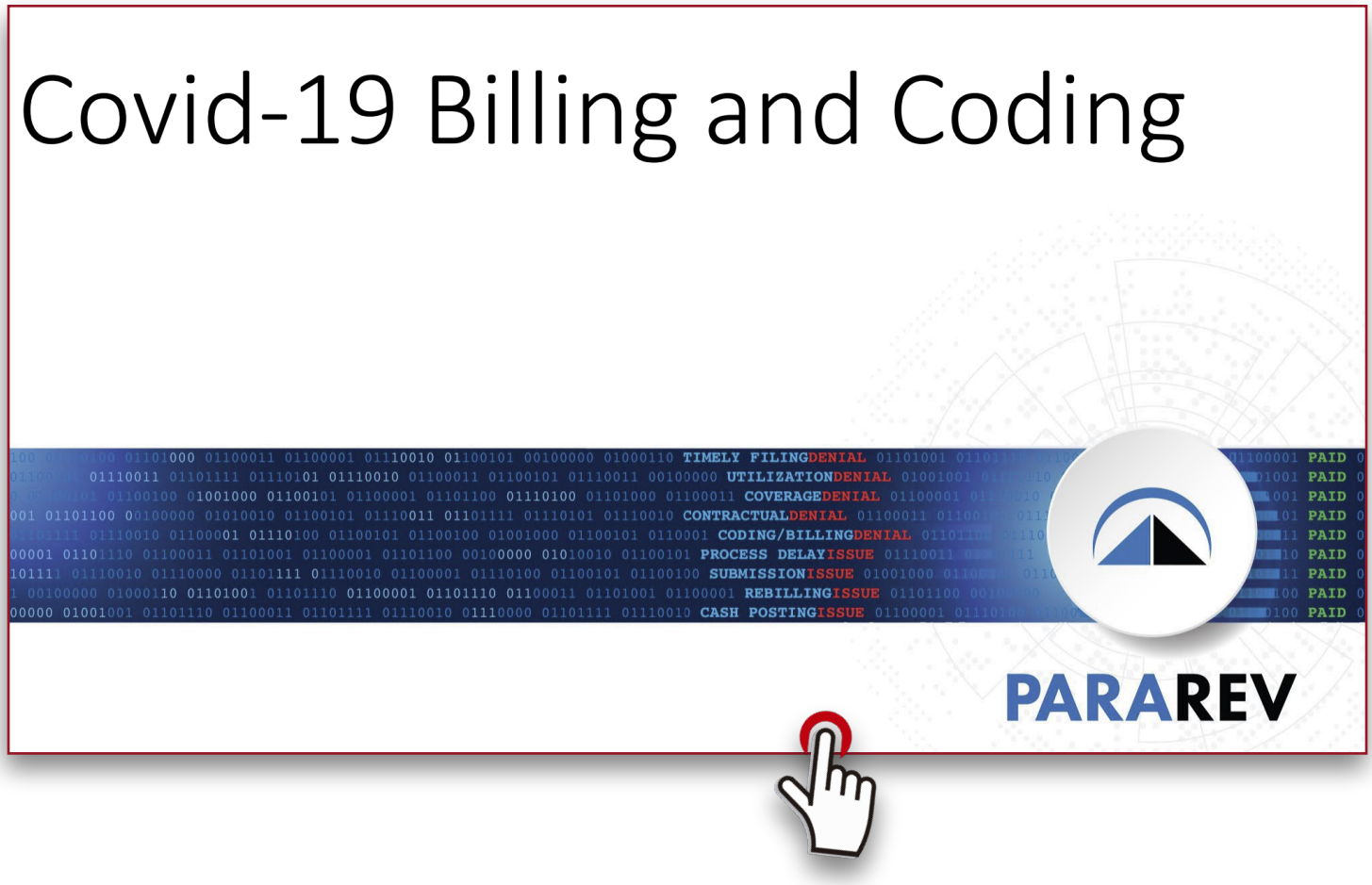
12636.2	Medicare contractors should not search their files to retroactively pay claims. However, contractors shall adjust claims brought to their attention.

NEW PRESENTATION: COVID-19 BILLING AND CODING DETAILED GUIDANCE

ParaRev has created a new, informative presention filled with details on the proper and effective COVID-19 billing and coding.

And, now it's here for you to download and review.

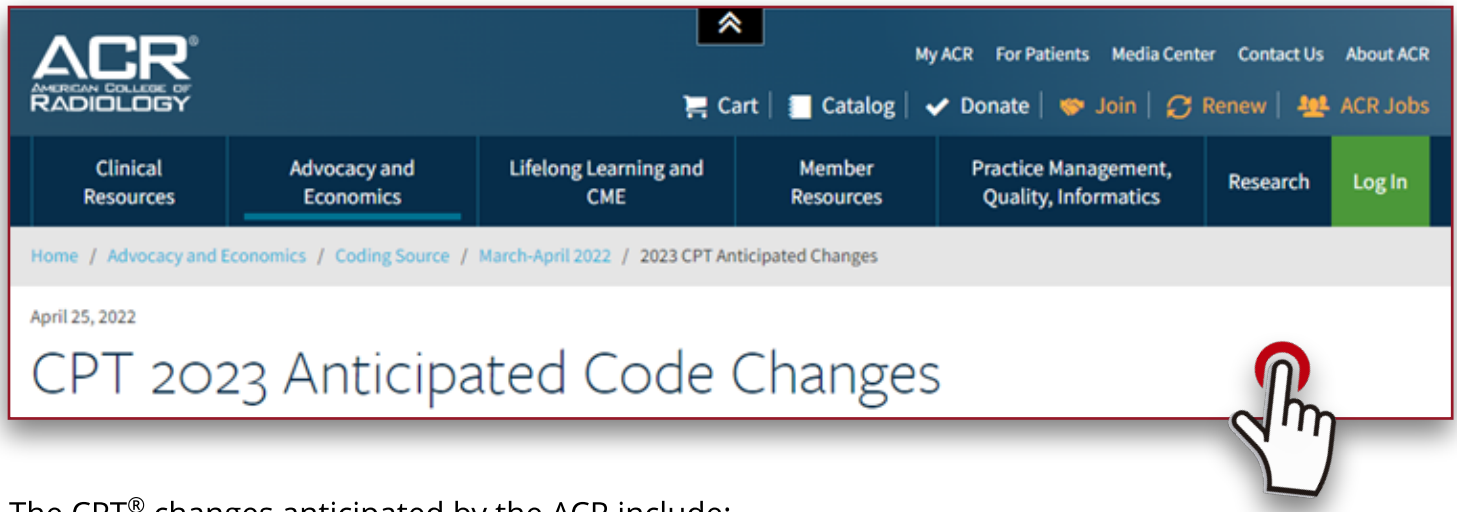
Then contact one of our Account Executives for more information and details on how ParaRev can help.



ACR REPORTS 2023 ANTICIPATED CODE CHANGES

The *ACR Radiology Coding Source*™section of the American College of Radiology website offers a narrative of anticipated coding changes in both radiology and evaluation and management CPT® codes for 2023. The article is available at the following link:

https://www.acr.org/Advocacy-and-Economics/Coding-Source/March-April-2022/2023-CPT-Anticipated-Changes



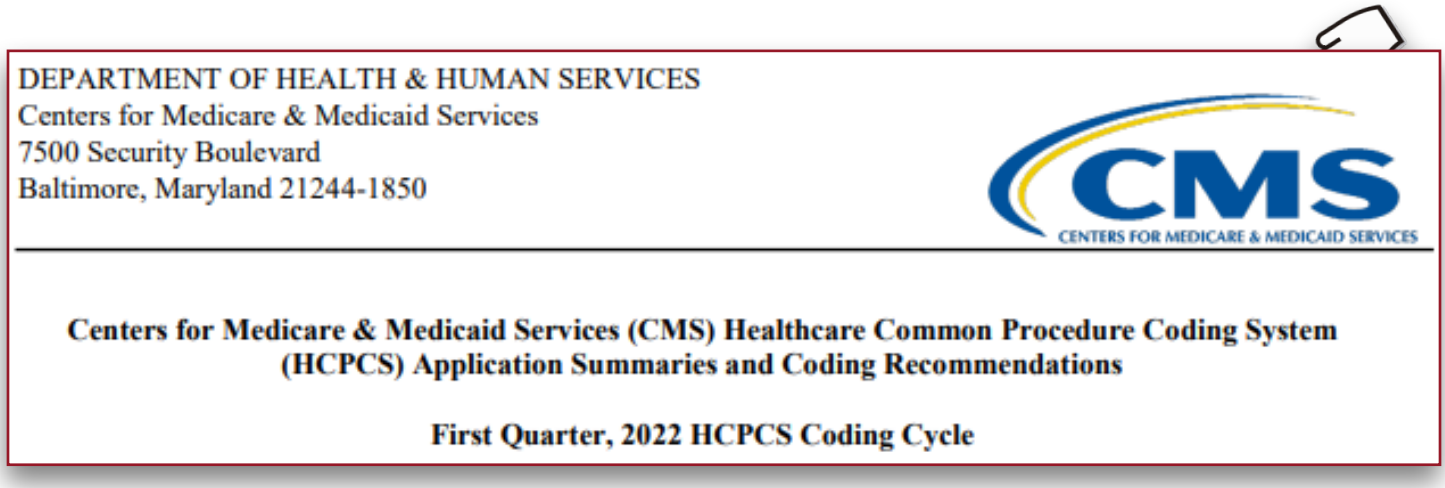
The CPT® changes anticipated by the ACR include:

- New Category I codes for percutaneous arteriovenous fistula creation and neuromuscular ultrasound
- Category III codes which will be released on July 1, 2022 for CT Tissue Characterization (formerly 0689T and 0690T) and Quantitative Magnetic Resonance Cholangiopancreatography (MRCP)
- Revision of the E/M Services Guidelines to reflect changes to the Inpatient and Observation Care Services, Consultations, Emergency Department Services, Nursing Facility Services, Home and Residence Services, and Prolonged Services subsections
- Revised codes for somatic nerve injections, pulmonary angiography, and paravertebral spinal nerves and branches.

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

CMS ISSUED A DOCUMENT REPORTING HCPCS CODING DECISIONS IN RESPONSE TO MANUFACTURER APPLICATIONS FOR NEW CODE ASSIGNMENT EACH QUARTER. THE FIRST QUARTER 2022 REPORT INCLUDES A NUMBER OF HCPCS FOR DRUGS AND BIOLOGICS, WHICH WILL BECOME EFFECTIVE JULY 1, 2022.

https://www.cms.gov/files/document/2022-hcpcs-application-summary-quarter-1-2022-drugs-and-biologicals.pdf



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries and Coding Recommendations

First Quarter, 2022 HCPCS Coding Cycle

A summary of the decisions is provided below in three sections – Medicine, Wound Care, and Radiopharmaceuticals.

Medicine

- **FYARRO®** -- which is currently reported with temporary HCPCS C9091, will be assigned HCPCS J9331 – "Injection, sirolimus protein-bound particles, 1 mg." This drug is used to treat advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa)

- **LEQVIO®** -- will be assigned HCPCS J1306 – Injection, inclisiran, 1 mg. LEQVIO® is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH)] or clinical atherosclerotic cardiovascular disease (ASCVD), who require additional lowering of low-density lipoprotein cholesterol (LDL-C)

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

- **SUSVIMO™**, an intraocular injection used to treat patients with age-related macular degeneration, will be assigned two HCPCS, one for the injection, and another for the implant. The recommended dose of SUSVIMO™ is 2 mg (0.02 mL of 100mg/mL solution) continuously delivered via the SUSVIMO™ ocular implant with refills administered every 24 weeks (approximately 6 months). The new HCPCS are: J2779 "Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg", and C9093 "Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg"

- **RYPLAZIM®**, which is indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplaminogenemia), will be assigned HCPCS J2998 "Injection, plasminogen, human-tvmh, 1 mg". Apparently this medication is considered a self-administered drug unless delivered by IV infusion; modifier JA "administered intravenously" must be appended when delivered by IV infusion to qualify for Medicare coverage

- **XIPERE™** (Triamcinolone acetonide) is a synthetic glucocorticoid (glucocorticoids are often referred to as corticosteroids) with immunosuppressive and anti-inflammatory activity. The newly assigned HCPCS will be J3299 "Injection, triamcinolone acetonide (xipere), 1 mg"

- **VYVGART™**, is indicated for the treatment of adult patients with generalized myasthenia gravis who are anti-acetylcholine receptor antibody positive. This drug may have been reported with miscellaneous/unclassified codes previously. The newly assigned HCPCS is J9332 "Injection, efgartigomod alfa-fcab, 2 mg"

- **cutaquig®**, which prevents infections of a wide variety of bacterial and viral agents in immunodeficient adults by temporarily restoring IgG levels in circulating plasma, will be assigned HCPCS J1551, "Injection, immune globulin (cutaquig), 100 mg"

- **TEZSPIRE™** is an add-on maintenance treatment of adult and pediatric patients aged 12 years and older with uncontrolled asthma while receiving treatment with medium- or high-dose inhaled corticosteroids (ICS) plus at least one additional controller medication with or without oral corticosteroids (OCS). The newly assigned HCPCS will be J2356, "Injection, tezepelumab-ekko, 1 mg"

- **APRETUDE**, which reduces the risk of sexually acquired HIV-1 infection, is an intramuscular injection kit that must be administered by a healthcare provider. The new HCPCS assigned by CMS will be J0739, "Injection, cabotegravir, 1 mg".

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

Skin Substitutes and Wound Care Products

- **Celera™ Dual Membrane and Celera™ Dual Layer** skin substitutes will be assigned new HCPCS Q4259 "Celera dual layer or celera dual membrane, per square centimeter." Previously, this product may have been reported with Q4100 "Skin Substitute, Not Otherwise Specified."

- **Signature APatch**, a wound protection barrier/cover will be assigned HCPCS Q4260 "Signature APatch, per square centimeter"

- **TAG,** a wound protection barrier/cover, will be assigned HCPCS Q4261, "Tag, per square centimeter".

Radiopharmaceuticals

- **Illucix®**, a radioactive prostate cancer PET imaging product, will be assigned HCPCS A9596 "Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie". Providers using this agent in PET scans are hopeful that the new HCPCS will offer better reimbursement for this expensive radiopharmaceutical. (The payment status will be announced with the next update to the OPPS Addendum B, expected in June, 2022.)

- **TAUVID™**, a radioactive diagnostic agent used in PET imaging of the brain to evaluate patients for Alzheimer's disease will be assigned HCPCS A9601 "Flortaucipir f 18 injection, diagnostic, 1 millicurie"

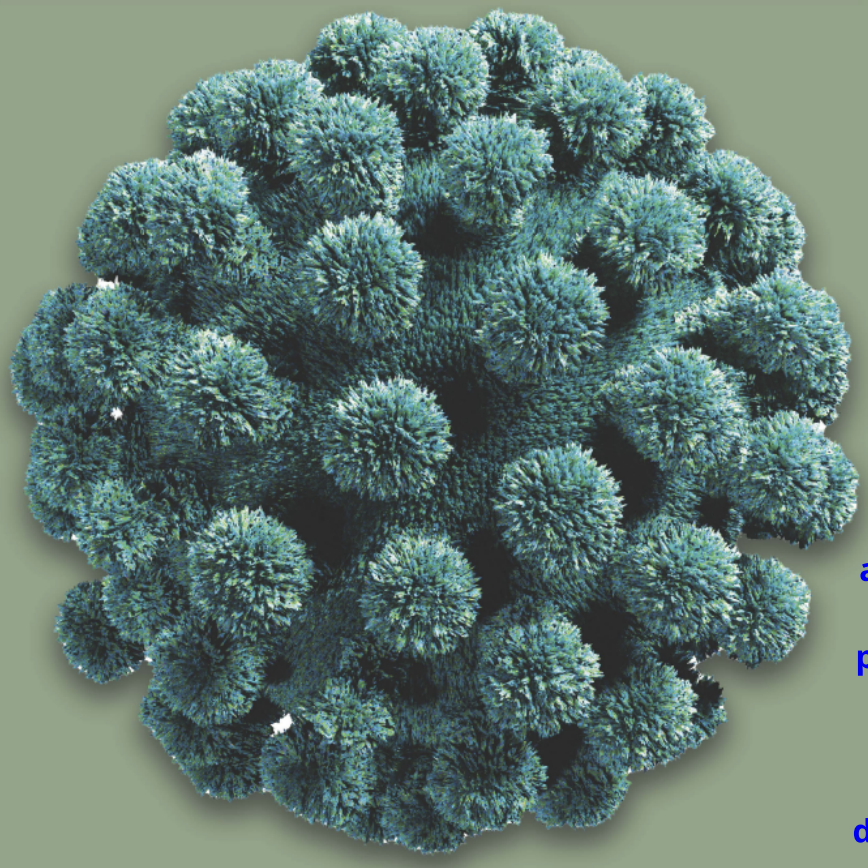
CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

The CMS document also listed the applications for which it declined to assign a HCPCS for various reasons:

- **RETHYMIC®** - used only in inpatient settings
- **Lidocidex™** - a compounded drug (CMS does not issue HCPCS for compounded drugs)
- **Cocoon Dual-Layer and Single-Layer Membranes** – due to differences in the HCPCS application and information submitted to the FDA
- **PalinGen® Dual Layer Membranes** are dehydrated, human allografts derived from the placenta – due to differences in the HCPCS application and information submitted to the FDA
- **Esano AAA**, a triple layer decellularized, dehydrated human amniotic membrane allograft for wound care, due to differences in the HCPCS application and information submitted to the FDA
- **Sanopellis** are dehydrated, human allografts derived from the placenta for wound care, due to differences in the HCPCS application and information submitted to the FDA
- **3L Biovance® Tri-Layer and 3L Biovance®**, a human amniotic membrane allograft for wound care, due to differences in the HCPCS application and information submitted to the FDA
- **Pemetrexed**, a single agent in the treatment of locally advanced and metastatic non-squamous non-small cell lung cancer, due to an incomplete HCPCS application.

UPDATED 3/15/22

2022 COMPREHENSIVE COVID-19 Guide



Click anywhere on this page to be taken to the full online document.

PARAREV

MLN CONNECTS

PARA invites you to check out the mlnconnects page available from the Centers For Medicare and Medicaid (CMS). It's chock full of news and information, training opportunities, events and more! Each week PARA will bring you the latest news and links to available resources. Click each link for the PDF!

Thursday, May 26, 2022

News

- COVID-19: New Administration Code for Pfizer Pediatric Vaccine Booster Dose
- Biosimilars: Interchangeable Products May Increase Patient Access
- Critical Care Evaluation & Management Services: Comparative Billing Report in May

Compliance

- Surgical Dressings: Medicare Requirements

Publications

- Screening Pap Tests & Pelvic Exams — Revised

TRANSMITTALS

6

There were SIX new or revised Transmittal released this week.

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

TRANSMITTAL R11437CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11437	**Date: May 27, 2022**
	Change Request 12427

Transmittal 11045, dated October 13, 2021, is being rescinded and replaced by Transmittal 11437, dated, May 27, 2022 to adjust table in the IOM of section 10.5 for POS 32 and POS 34. All other information remains the same.

SUBJECT: New/Modifications to the Place of Service (POS) Codes for Telehealth

I. SUMMARY OF CHANGES: This Change Request implements a new POS code (10) for Telehealth, as well as modifies the description for the existing POS code (02) for Telehealth.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2022

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	26/10/10.5/Place of Service Codes (POS) and Definitions

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

TRANSMITTAL R11436CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11436	**Date: May 26, 2022**
	Change Request 12756

SUBJECT: October 2022 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to remind Medicare contractors to download the updated HCPCS file when it becomes available. The complete HCPCS file is updated and released quarterly to the Medicare contractors. The file contains existing, new, revised and discontinued HCPCS codes for the October 2022 quarter. Contractors must download the file via the CMS mainframe in September 2022. This recurring update notification applies to chapter 23, section 20 of the Medicare Claims Processing Manual.

EFFECTIVE DATE: October 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022

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

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

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

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

IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11435CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11435	**Date: May 26, 2022**
	Change Request 12761

SUBJECT: July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the July 2022 OPPS update. The July 2022 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR. This Recurring Update Notification applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

The July 2022 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July 2022 I/OCE CR.

EFFECTIVE DATE: July 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2022

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/10.2.3/Comprehensive APCs

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

IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11434CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11434	**Date: May 26, 2022**
	Change Request 12759

SUBJECT: July 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.2

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized 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 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 publication 100-04, chapter 4, section 40.1.

EFFECTIVE DATE: July 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2022

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

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

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

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

IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11433OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11433	**Date: May 26, 2022**
	Change Request 12703

SUBJECT: Update to Addition of Disposition Category "U" to Recovery Audit Contractor Data Warehouse (RACDW) Appeals Layout File - This CR Rescinds and Fully Replaces CR 12528.

I. SUMMARY OF CHANGES: This Change Request (CR) is to implement a series of updates and additional Business Requirements to CR 12528.

EFFECTIVE DATE: October 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022

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

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

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

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

IV. ATTACHMENTS:

One Time Notification

TRANSMITTAL R11432PI

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11432	**Date: May 26, 2022**
	Change Request 12749

SUBJECT: Transition of Enrollment and Certification Activities for Various Certified Provider and Supplier Types and Transactions

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of CMS Publication (Pub.) 100-08, Program Integrity Manual, with instructions regarding the processing of various certified provider and supplier enrollment transactions.

EFFECTIVE DATE: May 27, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 27, 2022

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

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

MEDLEARNS

3

There were THREE new or revised MedLearn released this week.

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

MEDLEARN MM12427

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

New/Modifications to the Place of Service (POS) Codes for Telehealth

MLN Matters Number: MM12427 Revised | Related Change Request (CR) Number: 12427

Related CR Release Date: May 27, 2022 | Effective Date: January 1, 2022

Related CR Transmittal Number: R11437CP | Implementation Date: April 4, 2022

Note: We revised this Article due to a revised CR 12427. The CR revision didn't affect the substance of the Article. We did revise the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

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

Provider Action Needed

CR 12427 provides updates to the current POS code set by revising the description of existing POS code 02 and adding new POS code 10. Make sure your billing staff knows of the updates.

Background

The POS code set provides setting information necessary to pay claims correctly. At times, the health care industry has a greater need for specificity than Medicare. While Medicare doesn't always need this greater specificity to appropriately pay claims, it adjudicates claims with the new codes. This eases coordination of benefits and gives other payers the setting information they need. The POS Workgroup is revising the description of POS code 02 and creating a new POS code 10 to meet the overall industry needs, as follows:

1. **POS 02: Telehealth Provided Other than in Patient's Home**

   Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

2. **POS 10: Telehealth Provided in Patient's Home**

   Descriptor: The location where health services and health related services are provided

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | Medicare Learning Network®

MEDLEARN MM12761

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM12761	Related Change Request (CR) Number: 12761
Related CR Release Date: May 26, 2022	Effective Date: July 1, 2022
Related CR Transmittal Number: R11435CP	Implementation Date: July 5, 2022

Provider Types Affected

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

Provider Action Needed

Make sure your billing staff knows about these changes:

- New COVID-19 CPT vaccines and administration codes
- CPT proprietary laboratory analyses (PLA) coding changes effective July 1, 2022
- New CPT Category III codes effective July 1, 2022

Background

CR 12761 describes changes to and billing instructions for various payment policies in the July 2022 OPPS update. The July 2022 Integrated Outpatient Code Editor (I/OCE) will show the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 12761.

Note: The July 2022 I/OCE data files, instructions, and specifications are in CR 12759.

The July 2022 OPPS changes are:

1. COVID-19 Laboratory Tests and Services and Other Laboratory Tests Coding Update

Since February 2020, CMS has recognized several COVID-19 laboratory tests and related services. Those codes and their OPPS status indicators are listed in Table 1 of CR 12761. The codes, short descriptors, and status indicators are also in the July 2022 OPPS Addendum B.

2. Over the Counter (OTC) COVID-19 Test Demonstration

In response to the COVID-19 Public Health Emergency (PHE), we're implementing the

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

MEDLEARN MM12667

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Update to 'J' Drug Code List for Billing Home Infusion Therapy (HIT) Services

MLN Matters Number: MM12667 | Related Change Request (CR) Number: 12667

Related CR Release Date: May 24, 2022 | Effective Date: July 1, 2022

Related CR Transmittal Number: R11430OTN | Implementation Date: July 5, 2022

Provider Types Affected

This MLN Matters Article is for qualified Home Infusion Therapy (HIT) suppliers who bill Part B Medicare Administrative Contractors (MACs) for professional HIT services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about these changes:

- Updates due to Section 5012(d) of the 21st Century Cures Act detailing necessary changes to those systems and processes to include a newly assigned HCPCS drug code for payment beginning July 1, 2022.
- Updates the list of home infusion drugs to add J1551 to payment category 2. The corresponding G-codes for category 2 drugs are G0069 or G0089.

Background

Section 5012(d) of the 21st Century Cures Act (Pub. L 144-255) amended sections 1861(s)(2) and 1861(iii) of the Social Security Act (the Act). This added a new Medicare HIT services benefit. The HIT services benefit covers the:

- Professional services, including nursing services, you provide in accordance with the plan of care
- Patient training and education (not otherwise covered under the durable medical equipment benefit)
- Remote monitoring and monitoring services for the provision of HIT services
- Home infusion drugs that qualified HIT supplier provides

Section 1861(iii)(3)(C) of the Act defines "home infusion drug" as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that's an item of durable medical equipment

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®