Welcome to the WVCAH Quarterly Revenue Cycle Call

WARBIRD
CONSULTING PARTNERS

Uniquely Qualified

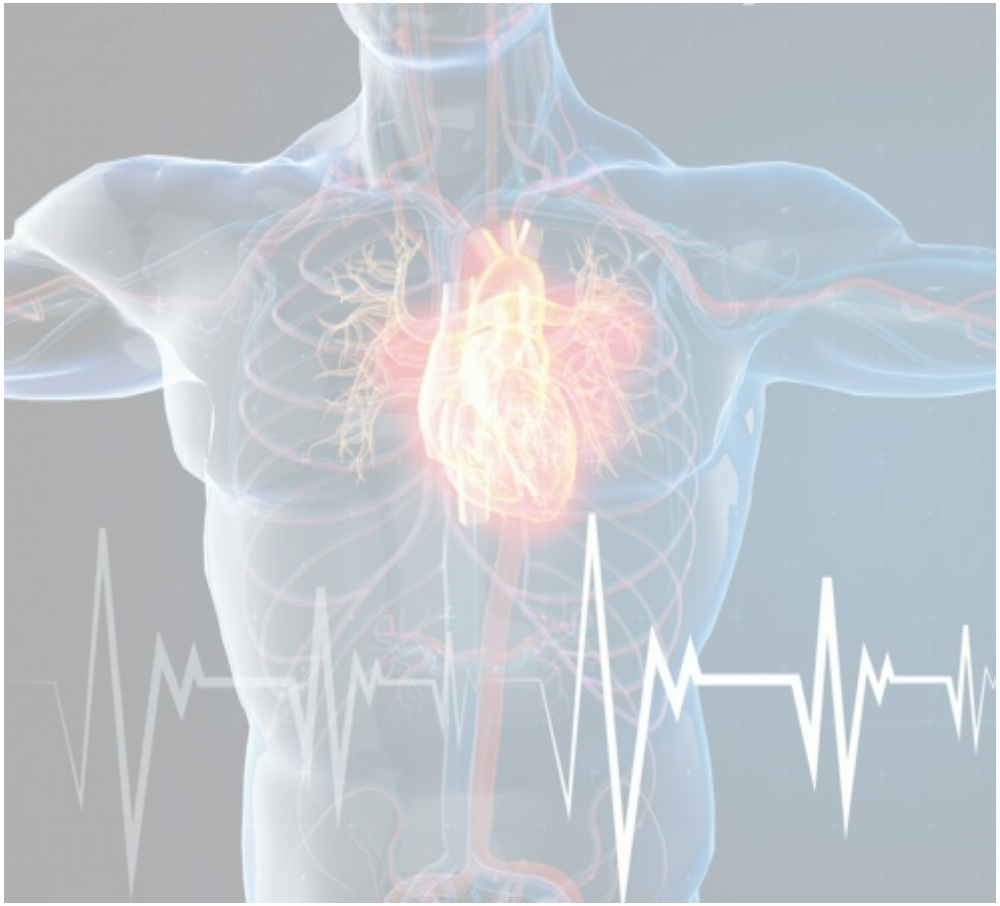
We will be starting momentarily

Agenda

- 2021 E&M Changes
- 2021 Pricing Transparency requirements
- 2021 CPT and HCPCS changes
- Relevant OPPS 2021 Proposed Rule

2021 Documentation and Coding Outpatient Office Evaluation and Management Services

2021 Office Visit E/M Changes



- AMA Recognized MDM is the heart of medicine but difficult to quantify
  - Some conditions require minimal History and Exam, but complex Medical Decision Making
- Ensure that payment for E/M is resource-based
- Decrease
  - Administrative burden of documentation and coding
  - Need for audits
  - Unnecessary documentation not pertinent to the patient's care

2021 Office Visit E/M Change Objectives

- Sought to unify CMS regional documentation guideline variations
  - Palmetto does not accept “non-contributory, unremarkable or negative as ROS
  - Novitas accepts non-contributory as ROS
  - Inconsistent interpretation of 95 exam rules
    - Limited exam of 2-7 OS or BA is EPF Exam
    - Extended exam 2-7 BA or OS is Detailed Exam
  - Some MACs consider 1995 Guidelines
    - Limited exam 2-5 BA or OS (EPF)
    - Extended exam 6-7 BA or OS (Detailed)

2021 Office Visit E/M Changes

- No changes for non-Office or outpatient- based E/M services
  - Additional changes possible in the future
- CPT 99201 deleted
- Documentation/coding changes impact CPT Ranges
  - 99202-99205
  - 99211-99215
- Includes all outpatient settings that utilize these codes

2021 Office Visit E/M Changes

Eliminate History and Exam elements for assessing CPT level

- Still required to document relevant components to support MDM, diagnoses

Documented Time

- Include minimal time, removes “typical time”
- Includes total time for E/M services

Shorter Prolonged Service code in 15-minute increments

Medical Decision Making

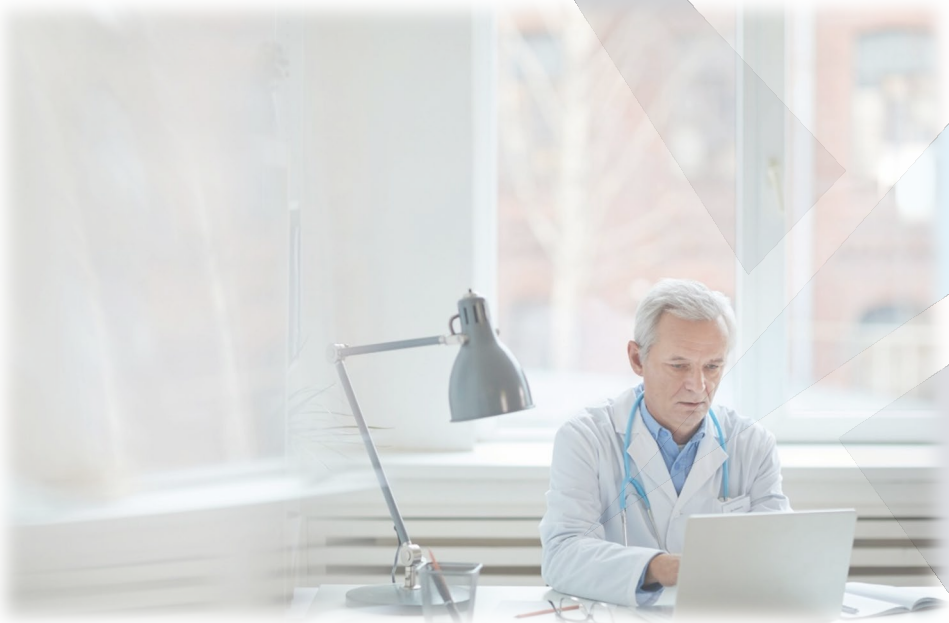
- Extensive edits and clarifications
  - Remove ambiguous terms such as mild
  - Eliminate counting tasks, and focus on tasks impacting management of the patient
  - Define previously ambiguous concepts

2021 Office Visit E/M Changes

- Comorbidities are not considered in selecting a level of E/M services unless they are addressed, *and* documentation increases:
  - The amount and/or complexity of data to be reviewed and analyzed *or*
  - The risk of complications and/or morbidity or mortality of patient management
- Final diagnosis for a condition does not in itself determine the complexity or risk
- Extensive evaluation may be required to reach the conclusion that the signs or symptoms do (or do not) represent a highly morbid condition.
- Multiple problems of a lower severity may create higher risk due to interaction

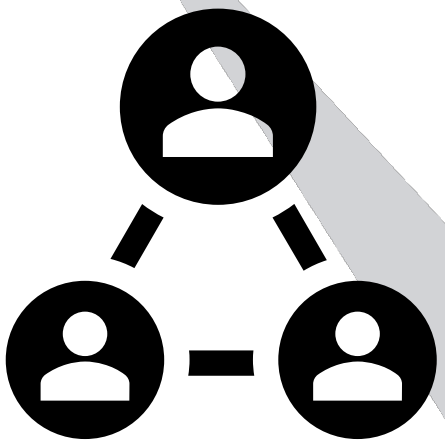
2021 Office Based E/M Changes - MDM

- Measures conditions evaluated or treated at the encounter by the physician or NPP reporting the service
- Includes consideration or further testing or treatment that may not be elected by virtue of risk-benefit analysis or patient/parent/guardian/surrogate choice
  - Document conditions, options and decisions
- Condition managed by another provider cannot be counted unless documentation supports how condition or other treatment affects plans or management in current visit



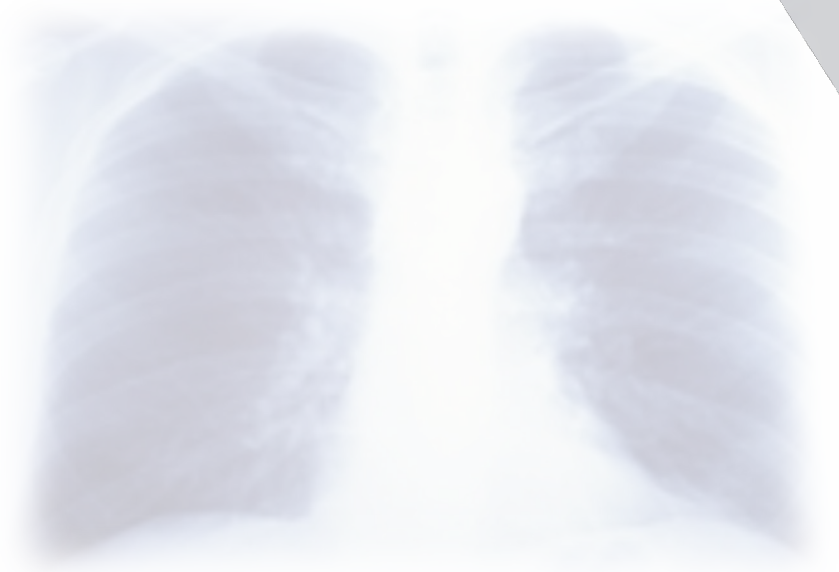
2021 New vs. Established Definitions

- A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years
- When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician
- Where a physician/qualified health care professional is on call for or covering for another physician/ qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available.



2021 Office Based E/M Changes - MDM

- Medical Decision Making reported by other separately reported CPTs or HCPCS cannot be counted
  - No points for ordering each test if performed and billed by practice
    - Rapid Flu
    - Any labs
    - Radiology
    - EKG



2021 Office Visit E/M Definitions

- Independent Historian – person speaking for patient that cannot speak for themselves
  - Child, infant
  - Dementia patient
  - Unresponsive

2021 Medical Decision Making

- Must meet or exceed 2 of the 3 to assign level

2020	2021
Presenting Problems to the Treating Provider	Number and Complexity of Problems Addressed
Amount and/or Complexity of Data Reviewed	Amount and/or Complexity of Data to be Reviewed and Analyzed
Risk of Complications/Mortality/ Morbidity	Risk of Complications/Mortality/ Morbidity of Management Options Considered

Definitions Number, Complexity of Problems

- Minimal – Not requiring presence of physician or NPP
- Self limited or minor - not likely to permanently alter health status
- Chronic illness - Expected duration of at least a year, or until death
  - Stable - Achieved treatment goal
  - With exacerbation, progression, or side effects of treatment – Acutely worsening, poorly controlled or progressing but that does not require hospitalization
  - With severe exacerbation, progression, or side effects of treatment. Significant risk of morbidity and may require hospital level of care
- Acute illness or injury
  - Uncomplicated- low risk of morbidity and little or no risk of mortality with treatment
  - With systemic symptoms - having a high risk of morbidity without treatment
  - Complicated – extensive injury or illness requiring
    - Evaluation of body systems that are not directly part of the injured organ,
    - Treatment options are multiple and/or associated with risk of morbidity
- Undiagnosed new problem with uncertain prognosis - likely to result in a high risk of morbidity without treatment
- Acute or chronic illness or injury that poses a threat to life or bodily function – acute or chronic illness or injury that poses a threat to life or bodily function in the near term without treatment

2021 Amount & Complexity of Data Reviewed & Analyzed

- Represented in Categories
- Tests, documents, orders, independent historians- *each unique test counted* to meet threshold number
- Count only independent interpretation of tests which are not reported separately
- Discussion of management or test interpretation with external physician, other qualified health professional or appropriate source
  - Not including separately reportable interpretation
  - Includes
    - Specialist or other provider
    - School nurse
    - Prison update

Risk of Morbidity or Mortality

- Examples provided to illustrate risk of options considered or acted upon
  - Straightforward (99202, 99212)
    - Minimal risk from treatment, including no treatment or testing
  - Low (99203, 99213)
    - Low risk of complication or morbidity
    - Minimal consent/discussion
  - Moderate (99204, 99214)
    - Typically expectation of review with patient or surrogate, obtain consent and monitor, or
    - Complex social factors in management decisions
  - High (99205, 99215)
    - Need to discuss concerns and/or options, monitoring is necessary

2021 Medical Decision Making

CPT	Level MDM	Number and complexity of problems addressed in the encounter, including relevant history and exam	Amount and complexity of data reviewed and analyzed - addressed analysis such as attached Xray	Risk of complications and/or morbidity or mortality of patient management considered or selected, considered social determinants of health such as poverty (can't afford medication)
99211	N/A	N/A	Straightforward, self-limited (maybe patient didn't really need a visit)	N/A
99202, 99212	**Straightforward**	**Minimal** • 1 Self Limited or Minor Problem	**Minimal or none**	**Minimal risk of morbidity** from additional diagnostic testing or treatment
99203, 99213	**Low**	**Low** • 2 or more self -limited or minor problems or, • 1 stable chronic illness, or • 1 acute uncomplicated injury	**Limited** (Must meet the requirements of at least **1 of the 2 categories**) **Category 1: Tests and documents** • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment**

2021 Medical Decision Making

CPT	Level MDM	Number and complexity of problems addressed in the encounter, including relevant history and exam	Amount and complexity of data reviewed and analyzed - addressed analysis such as attached Xray	Risk of complications and/or morbidity or mortality of patient management considered or selected, considered social determinants of health such as poverty (can't afford medication)
99204, 99214	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or, • 2 or more stable chronic illnesses; or, • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	**Moderate** (must meet requirements of at least **2 of the 3 categories)** **Category 1: Tests and Documents** • Any combination of 2 of the following: • Review prior external note(s) one from each unique source • Review results of each unique test • Ordering each unique test • Assessment requiring independent historian(s) Or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

2021 Medical Decision Making

CPT	Level MDM	Number and complexity of problems addressed in the encounter, including relevant history and exam	Amount and complexity of data reviewed and analyzed - addressed analysis such as attached Xray	Risk of complications and/or morbidity or mortality of patient management considered or selected, considered social determinants of health such as poverty (can't afford medication)
99205, 99215	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least **2 out of 3 categories)** **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) Or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); Or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

AMA 2021 Office Based E/M Changes - Time

- Time used to choose level of code – time spent in care of the patient on the date of service
- Preparing to see the patient
  - Reviewing tests,
  - Obtaining and or reviewing separate history or records
  - Performing medically necessary exam and evaluation
  - Counseling and education patient, family or caregiver
  - Communicating results
  - Ordering medications, tests or procedures
  - Referring and communicating with other healthcare professionals for services not reported separately
  - Documentation
  - Independent interpretation of results not reported separately
  - Care coordination not separately reported
- Does not include pre/post work not performed on the DOS, that may be spent in evaluation of the patient

AMA 2021 Office Based E/M Changes - Time

- If a physician and NPP spend time in care of a patient only one can be counted
- Time spent on activities normally performed by clinical staff cannot be counted
- Cannot count time spent performing separately billable services
- AMA does not specify how time should be documented
- Medicare, Medicaid and commercial payor requirements may vary
- Best practice is to document time for each activity until formal guidance per payor is available

AMA 2021 Office Based E/M Changes - Time

New Patient	2020 Time (Typical time)	2021 Total Time (Actual time)
99201	10 minutes	Deleted
99202	20 minutes	15-29 minutes
99203	30 minutes	30-44 minutes
99204	45 minutes	45-59 minutes
99205	60 minutes	60-74 minutes

Established Patient	2020 Time (Typical time)	2021 Total Time (Actual time)
99211	5 minutes	Time option deleted
99212	10 minutes	10-19 minutes
99213	15 minutes	20-29 minutes
99214	25 minutes	30-39 minutes
99215	40 minutes	40-54 minutes

2021 Office Based E/M Prolonged Services

- Existing prolonged service codes 99354-99356 revised to exclude office-based services
- New CPT 99417 - Each additional 15-minutes beyond level 5 outpatient office evaluation and management

AMA 2021 Office Based Prolonged Services

Total Duration Prolonged Service with New Patient	CPT
Less than 75 minutes	Add on code cannot be reported
75-89 minutes	99205, 1 unit 99417
90-104 minutes	99205, 2 units 99417
105 or greater minutes	99205, 3 units 99417

Total Duration Prolonged Service with Established Patient	CPT
Less than 55 minutes	Add on code cannot be reported
55-69 minutes	99215, 1 unit 99417
70-84 minutes	99215, 2 units 99417
85 or greater minutes	99215, 3 units 99417

CMS 2021 Changes

Adopted AMA MDM changes

Adopted AMA Time based services for the same date as the encounter

New prolonged service code 99417 accepted with office-based E/Ms

- *Sum of actual minutes*

Medicare Add-On HCPCS

- GPC1X (11 minutes) – "Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition"
- Recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience
- Capture work associated with ongoing care and/or potentially evolving illness
  - Clinical complexity of the care provided by a physician in the context of patient characteristics;
  - The nature of the physician-patient relationship developed and maintained, in many cases indefinitely
  - The responsibility assumed by physicians to continually update and maintain their knowledge-base required to deliver cognitively intense services
- Not "restricted" to specific specialties
- Assume certain specialties will furnish this more than others
- Still need additional clarification and CMS is seeking additional comments

Infectious Disease Example

- Infectious Disease Society provided an example to use GPC1X as a stand-alone code to report days of non-face to face care following a visit:
- A 67-year-old man with history of diabetes, atrial fibrillation and hypertension develops a foot ulcer- and is eventually diagnosed with osteomyelitis with MRSA and a multi-drug resistant Proteus. Patient is treated with a six-week course of intravenous antibiotics (vancomycin and ertapenem). The patient requires wound care, and a wound vacuum is placed. During the six-week antibiotic treatment course the patient requires close monitoring of his creatinine, vancomycin levels and INR, as the antibiotics cause a change in the steady dose of Coumadin he has been taking for his atrial fibrillation. The patient requires weekly wound vacuum changes and, while on the antibiotics, subsequently develops Clostridioides difficile infection.
- Infectious Disease specialist
  - Monitors the patient's weekly blood count, creatinine and vancomycin levels,
  - Coordinates care with the primary care and cardiologist to adjust the Coumadin dose
  - Coordinates care with the podiatrist regarding wound care and the use of the wound vacuum
  - On development of Clostridioides difficile infection, oral vancomycin is started, and the infectious diseases physician must now
    - Monitor the patient via phone calls every two days,
    - Check his potassium level and other electrolyte levels and arrange for supplementation via the IV route as needed
  - Spends approximately 20 minutes, three times per week for two weeks, and subsequently about 30 minutes weekly until the patient finishes the course of IV antibiotics

2021 Evaluation and Management Training

Begin notification early

Provide education for code selection

Update

- Templates
- Macros
- EMR

Audit frequently

2021 Pricing Transparency Changes

Pricing Transparency

- All facilities licensed as hospitals must display a comprehensive machine-readable file that makes public all standard charge information for all hospital items and services
  - Can have separate tabs
  - Facility can choose file format
  - Considered proposing requirement that hospitals use XML only
- Group Health Plans including Employer Group heath Plans provide internet-based service tool
  - Personalized out-of-pocket cost information
    - Negotiated rates, for all covered healthcare items and services,
    - Prescription drugs

Pricing Transparency Definitions

- Hospital: An institution in any State in which State or applicable local law provides for the licensing of hospitals, licensed as a hospital pursuant to such law; or approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing
- Items and services: All items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge
- Standard charge: gross charge, negotiated charge, discount rate, de-identified maximum rate, de-identified minimum rate

Pricing Transparency Definitions

- Hospital location: Any location operating under a consolidated or single State license including critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), sole community hospitals (SCHs), and inpatient rehabilitation facilities (IRFs)
- Service package: An aggregation of individual items and services into a single service with a single charge (base rate)
- Negotiated rate: In-network amount, allowed charge, negotiated discount or other identified agreed price between a payer and facility
- Discount rate: Amount agreed to as a self pay discount
- Shoppable Service: 300 Identified elective services (services which can be scheduled in advance) for which all reimbursement detail for all payors, all standard charges must be provided

Pricing Transparency

- Separate files must be created to report each hospital location operating under a single hospital license (or approval) that has a different set of standard charges
- Hospital's outpatient department located at an off-campus location (from the main hospital location) operating under the hospital's license, are subject to the requirements in this rule
- Does not include entities such as independent ASCs, physicians, community health centers independent labs or radiology practices

Pricing Transparency Standard Charge

- Charge and rate are used interchangeably by CMS
- Gross charge - charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts
- Payer-specific negotiated charge (rate) - Applies to each item or service for which a payer and the facility have a negotiated rate (reimbursement agreement)
  - Name of the third-party payer and plan must be clearly identified for each negotiated rate
  - Includes managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans
  - Requirement does not include non-negotiated payment rates (such as those payment rates for FFS Medicare or Medicaid)
    - Hospitals may choose to add government payers
- Discounted cash price as an alternative type of standard charge. If no discounted cash price exists for a service, enter the gross charge as discounted price
- De-identified minimum negotiated charge - lowest negotiated rate, by service, excluding payer identifier, with which agreement exists
- De-identified maximum negotiated charge – highest negotiated rate, by service, excluding payer identifier, with which agreement exists

Pricing Transparency – Comprehensive File

- Publish DRGs reported by the hospital
  - Crosswalk to MS-DRG as necessary, e.g. APR-DRG/MS-DRG comparison
    - Rates associated with DRGs can have multiple levels of payments based on the types of co-morbidities
    - May change based on change in a patient's condition or treatment plan
  - Publish the base rate negotiated by the hospital, not the adjusted or final payment received by the hospital for a packaged service
  - Include description
  - Per CMS the average of previous year pricing is not sufficient

Pricing Transparency Comprehensive File

- CMS example of gross charge file

HOSPITAL XYZ MEDICAL CENTER Prices posted and effective: (mm/dd/yy) Notes: (insert any clarifying notes)					
DESCRIPTION	CPT/HCPCS code	NDC	O/P Default/gross charge	IP/ER/ gross charge	erX Charge quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		1,000.13	1,394.45	
HB IV INFUS HYDRATION EA ADDL HR	96361		251.13	383.97	
HB IV INFUS THERAPY 1ST HR	96365		1,061.85	1,681.50	
HB ROOM CHARGE 1:5 SEMI PRIV				2,534.00	
HB ROOM CHARGE 1:5 OB PRIV DELX				2,534.00	
HB ROOM CHARGE 1:5 OB DELX 1 ROOM				2,534.00	
HB ROOM CHARGE 1:5 OB DELX 2 ROOMS				2,534.00	
SURG LEVEL 1ST HR 04	Z7506			3,497.16	
SURG LEVEL 1 ADDL 30 MIN 04	Z7508			1,325.20	
SURG LEVEL 2ND HR 04	Z7506			6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	713013212	251.13	383.97	12 Each
PHENYLEPHRINE HCL 10% OP DROP		17478020605	926.40	1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	0.00	0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		185.00		
GENETIC OUNSEL 15 MINS	S0265		94.00		
DIALYSIS TRAINING/COMPLETE	90989		988.00		
ANESTH, PROCEDURE ON MOUTH	170		87.00		

Invalid HCPCS

Units NDC or HCPCS? HCPCS is NOS unit of one NDC is per 50mg suppository. Is price for 12 suppositories?

Used to dilate pupils - Was this price verified? Is this representative of a patient dose?

Pricing Transparency Comprehensive File

- Example single file
- As many columns as necessary

XYZ MEDICAL CENTER
PRICES POSTED AND EFFECTIVE: (DATE)
Notes: (Insert clarifying notes)

CPT/ HCPCS	DESCRIPTION	NDC	NDC UNIT	I/P GROSS CHG	OP GROSS CHARGE	CASH PRICE	MINIMUM NEGOTIATED RATE	MAXIMUM NEGOTIATED RATE	MEDICARE	AETNA HMO	AETNA PPO	AETNA POS
73525	HIP ARTHROGRAPHY				1,050.00	333.00	420.00	993.00	382.00	611.00	856.00	734.00
73551	XRAY, FEMUR; 1 VIEW				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73552	XRAY, FEMUR; MINIMUM 2 VIEWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73560	KNEE 1 2 VIEWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73562	KNEE 3 VIEWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73564	KNEE COMP MIN 4 VWS				309.00	98.00	124.00	292.00	113.00	180.00	252.00	216.00
73565	KNEE BOTH STANDING AP				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73580	KNEE ARTHROGRAPHY				1,050.00	333.00	420.00	993.00	382.00	611.00	856.00	734.00
73590	TIBIA FIBULA 2 VIEWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73592	LOWER EXTREMITY INFANT MIN 2 VWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73600	ANKLE 2 VWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73610	ANKLE COMP MIN 3 VWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73615	ANKLE ARTHROGRAPHY				1,050.00	333.00	420.00	993.00	382.00	611.00	856.00	734.00
73620	FT 2 VIEWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73630	FT COMP MIN 3 VWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73650	CALCANEUS MIN 2 VWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73660	TOES MIN 2 VIEWS				220.00	70.00	88.00	208.00	80.00	128.00	179.00	154.00
73700	CT LOWER EXTREMITY WO CON				309.00	98.00	124.00	292.00	113.00	180.00	252.00	216.00
73701	CT LOW XTR W CON				502.00	159.00	201.00	474.00	183.00	292.00	409.00	350.00

Pricing Transparency Comprehensive File

- Example multiple tabs
- Breakdown is facility decision

	A	B	C	D	E	F	G	H	I	J	K
5	CPT/ HCPCS	DESCRIPTION	NDC	NDC UNIT	CASH PRICE	MINIMUM NEGOTIATED RATE	MAXIMUM NEGOTIATED RATE	BCBS HMO	BCBS PPO	BCBS INDEMNITY	BCBS MCR MANAGED CARE
6	10005	FNA BIOPSY INC US GUID FIRST LESION			1,281.00	543.00	1,891.00	610.00	976.00	1,367.00	1,172.00
7	25370	REVISE RADIUS OR ULNA			5,749.00	2,437.00	8,486.00	2,738.00	4,380.00	6,132.00	5,256.00
8	25375	REVISE RADIUS & ULNA			5,749.00	2,437.00	8,486.00	2,738.00	4,380.00	6,132.00	5,256.00
9	25390	OSTEOPLSTY RADIUS OR ULNA SHORTENING			12,561.00	5,324.00	18,542.00	5,982.00	9,571.00	13,399.00	11,485.00
10	35226	REPR BLOOD VESSEL DIRECT LOWER EXTREM			1,281.00	543.00	1,891.00	610.00	976.00	1,367.00	1,172.00
11	35231	REPR BLOOD VESSEL W VEIN GRFT NECK			5,820.00	2,467.00	8,591.00	2,771.00	4,434.00	6,207.00	5,321.00
12	35236	RPR BLOOD VESSL W VEIN GRFT UPPR EXTREM			9,651.00	4,091.00	14,247.00	4,596.00	7,354.00	10,295.00	8,824.00
13	35256	RPR BLOOD VESSL W VEIN GRFT LWR EXTREM			9,651.00	4,091.00	14,247.00	4,596.00	7,354.00	10,295.00	8,824.00
14	35903	EXCIS OF INFECTED GRFT EXTRM			5,820.00	2,467.00	8,591.00	2,771.00	4,434.00	6,207.00	5,321.00
15	43754	GI INTUBATN AND ASPIR DX SNGL SPEC			532.00	226.00	785.00	254.00	405.00	567.00	486.00
16	43755	NG TUBE INSERTN, DX INC DRUG ADMIN			291.00	124.00	429.00	139.00	222.00	310.00	266.00
17	43756	DX DUOD INTUB W/ASP SPEC			1,651.00	700.00	2,437.00	786.00	1,258.00	1,761.00	1,509.00
18	43757	DX DUOD INTUB W/ASP SPECS			1,651.00	700.00	2,437.00	786.00	1,258.00	1,761.00	1,509.00
19	44378	SMALL BOWEL ENDOS W CONTR BLED			3,271.00	1,386.00	4,828.00	1,558.00	2,492.00	3,489.00	2,990.00
20	44380	ILEOSCOPY THRU STOMA DIAG			1,651.00	700.00	2,437.00	786.00	1,258.00	1,761.00	1,509.00

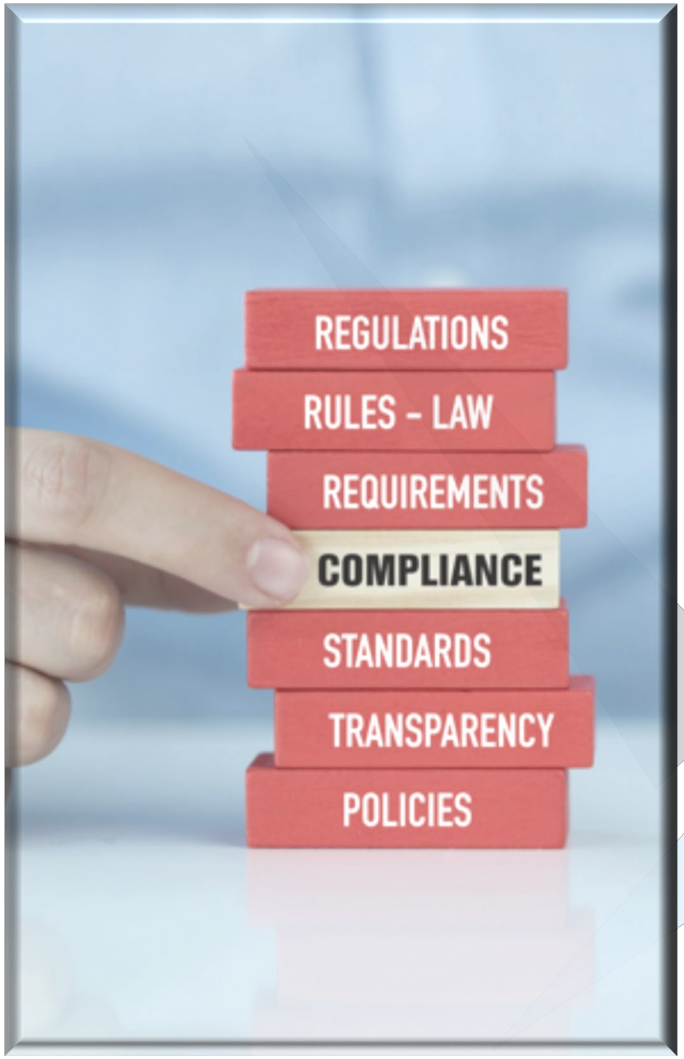
Sheet1 | MANDATORY SHOPPABLE SERVICES | AETNA | comprehensive | COMP ROUNDED | Non Negotiated | BC | UH | DRG | Shoppable

Pricing Transparency Shoppable Services

- CMS requires a second, consumer friendly file of 300 elective shoppable services
- Include all components of services where applicable
- Plain language description
- CPT, HCPCS, DRG identifier as necessary
- Revenue code as applicable
- Charge quantity
  - All 5 standard charges for 300 shoppable services
- Locations within hospital system where service is provided
- 70 identified by CMS
- 230 optional by facility
- If facility does not perform any of the 70 CMS identified services, choose as many additional services as necessary to either achieve 300 shoppable services, up to all services performed

CMS Mandated Shoppable Services

- Psychotherapy visits
- Office visits
- Commonly performed labs
- Commonly performed radiology services
- 5 MS-DRGs
- 21 surgical procedures
- 4 medicine procedures



CMS Mandated Shoppable Services

EVALUATION AND MANAGEMENT SERVICES	PRIMARY CPT / HCPCS
PSYCHOTHERAPY 30 MIN	90832
PSYCHOTHERAPY 45 MIN	90834
PSYCHOTHERAPY 60 MIN	90837
FAMILY PSYCHOTHERAPY NOT INCLUDING PT 50 MIN	90846
FAMILY PSYCHOTHERAPY INCLUDING PT 50 MIN	90847
GROUP PSYCHOTHERAPY	90853
OFFICE OUTPATIENT NEW STRTFWD 15-29 MIN TOTAL	99202
OFFICE OUTPATIENT NEW LOW 30-44 MINUTES TOTAL	99203
OFFICE OUTPATIENT NEW COMPRHNSIV 45-59 MIN TOTAL	99204
OFFICE OUTPATIENT NEW HIGH 60-74 MINUTES TOTAL	99205
OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	99243
OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	99244
INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	99385
INITIAL PREVENTIVE MEDICINE NEW PT AGE 40-64YRS	99386

CMS Mandated Shoppable Services

LAB AND PATHOLOGY SERVICES	PRIMARY CPT / HCPCS
METABOLIC PANEL TOTAL CA	80048
COMP METAB PANEL	80053
OBSTETRIC PANEL	80055
LIPID PANEL	80061
HEPATIC FUNCTN PANEL	80076
URINALYSIS MANUA USING MICROSCOPE	81000
URINALYSIS WO MICRO MANUAL	81002
PROSTATE SPECIF ANTIGEN TOTAL	84153
PROSTATE SPECIF ANTIGEN FREE	84154
THYROID STIMULATING HORMONE (TSH)	84443
COMPLETE CBC W/AUTO DIFF WBC	85025
COMPLETE CBC AUTOMATED	85027
PROTHROMBIN TIME	85610
PTT	85730

CMS Mandated Shoppable Services

RADIOLOGY SERVICES	PRIMARY CPT / HCPCS
CT HEAD BRAIN WO CON	70450
MRI BRAIN INC STEM WO W CON FS	70553
SPINE LUMBOSACRAL MIN 4 VWS	72110
MRI SPINAL CANAL LUMB WO CON	72148
CT PELVIS W CON	72193
MRI ANY JNT LOW XT WO CON	73721
CT ABD AND PELVIS W CON	74177
ULTRASOUND ABDOM B SCAN	76700
US OB>14 WKS TRANS ABD INI GSTN	76805
ULTRASOUND TRANSVAGINAL	76830
DX MAMMO INCL CAD UNI	77065
DX MAMMO INCL CAD BI	77066
SCR MAMMO BI INCL CAD	77067

CMS Mandated Shoppable Services

MEDICINE AND DRG	DRG/CPT/HCPCPS
CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	216
SPINAL FUSION EXCEPT CERVICAL W/O MCC	460
MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	470
CERVICAL SPINAL FUSION W/O CC/MCC	473
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	743
ECG MIN 12 LEAD W INTERP AND RPT	93000
L HRT CATH W/NJX L VENTRICULOGRAPHY IMG S&I	93452
POLYSOMNOGR W 4PL PARA	95810
THERAPEUTIC EX EA 15 MIN	97110

CMS Mandated Shoppable Services

SURGERY	PRIMARY CPT / HCPCS
EXCIS OF CYST FIBROADENOMA 1+ LES	19120
SHLDR ARTHRSCPY DECMPRSN SUBACRMIAL SPC	29826
ARTHRSCPY MENISCTMY MED OR LAT	29881
TONSILLECTOMY & ADENOIDECTOMY <12YR	42820
EGD DIAG BRUSH WASH	43235
EGD FLEXIBLE TRANSORAL W BX SNGL, MULTI	43239
COLNSCPY FLEX SPLEN DIAG	45378
COLNSCPY FLEX SPLEN BX	45380
COLONOSCOPY LESN REMOV SNARE	45385
COLNSCPY W ENDO US FS	45391
LAPAROSCOPIC CHOLECYSTECTOMY	47562
REPR INIT ING HERNIA >5YRS	49505
BIOPSY PROSTATE NEEDLE PUNCH	55700
LAPS PROSTECT RETROPUBIC RAD W/NRV SPARING ROBOT	55866
ROUTINE OBSTETRIC CARE	59400
RTINE C SECTN W ANTE/PST PRTM	59510
ROUTINE OBSTETRC & ANTEPRTM VBAC	59610
NJX INTERLAMINAR LMBR/SAC WO (W) GUID	62322-62323
INJ ANSTH TRANS EPI LUM SGL LV	64483
DISCISS SEC MEM CATARACT LASER	66821
CATARACT REMOVAL W INSERTN IC	66984

Pricing Transparency Shoppable Services

- Clearly identify all associated services which may result in additional costs

HOSPITAL XYZ MEDICAL CENTER
Prices posted and effective: (mm/dd/yy)
Notes: (insert any clarifying notes)

Shoppable Service	Primary Service and Ancillary Services	CPT/HCPCS	Standard Charge BCBS HMO
Diagnostic Colonoscopy	Facility primary diagnostic procedure	45378	$640.00
	Physician/Surgeon		$319.00
	Anesthesia physician services		Not provided by hospital may be separately billed
	Pathology interpretation		Not provided by hospital may be separately billed

Pricing Transparency Shoppable Services

- CMS provides for optional creation of price look up tool
- Patient friendly
- Requires patient to enter PHI, must be secure
- Similar to eligibility software
- Must maintain current patient insurance information, eligibility
- Map to appropriate procedure based on patient identified service
- Expensive to set up and maintain

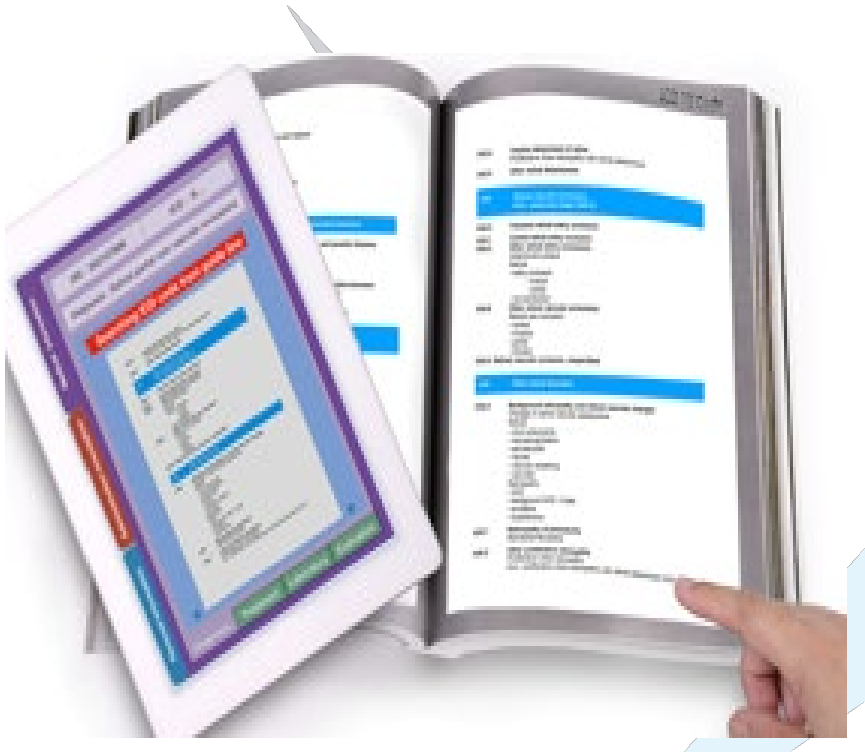
Action Items to Optimize Results

- Scrub Chargemaster (again)
- Identify all charge lines with alternate CPT/HCPCS to crosswalk to payor expectations
- Identify and catalog all 3rd party payor contracts
  - Evergreen arrangements
  - Per Diem
  - Percent of charge
- Identify 300 Shoppable Services
  - Identify all components of each service for which charges and rates apply
  - Create user friendly file to include all services associated with each shoppable service
- Review and determine file content and display options
- Prepare and train financial counselors to create optimal customer service experiences
- Schedule annual review

2021 CPT HCPCS Changes

2021 CPT Description Changes

- 60 CPT descriptions were updated
  - 40 code changes clarify the current description and do not change the use of the code
  - May change short and medium description but do not require education
- 46 CPT Codes were deleted by AMA
  - 22 temporary, new technology codes
  - 41 codes with no suggested replacements
- 90 New CPT codes
- 12 Emergency Covid-19 codes effective August-November 2020



2021 CPT Description Changes

2021 CPT	2021 MEDIUM DESCRIPTION CHANGES	CHANGES TO CODE DESCRIPTION
29822	ARTHROSCOPY SHOULDER DEBRIDEMENT LTD 1-2 STRUCTR	Add 1 or 2 discrete structures
29823	ARTHROSCOPY SHOULDER DEBRIDEMENT EXT 3+ STRUCTR	Add 3 or more discrete structures
33990	INSJ PERQ VAD W/IMAG LT HEART ARTERY ACCESS ONLY	Add left heart
33991	INSJ PRQ VAD TRNSPTAL W/IMAG LT HRT ART&VEN	Add left heart
76513	OPH US DX ANT SGM US IMMERSION B-SCAN/HR BIOM	Add unilateral or bilateral
99202	OFFICE OUTPATIENT NEW ~~20~~ 15-29 MINUTES TOTAL	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace Typically 20 minutes with 15-29 minutes total time spent
99203	OFFICE OUTPATIENT NEW 30-44 MINUTES TOTAL	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace typically 30 minutes with 30-44 minutes total time spent
99204	OFFICE OUTPATIENT NEW 45-59 MINUTES TOTAL	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace typically 45 minutes with 45-95 minutes total time spent.
99205	OFFICE OUTPATIENT NEW 60-74 MINUTES TOTAL	Replace key components of History and Physical with Medically appropriate history and physical for professional charges, replace typically 60 minutes with 60-74 minutes total time spent

2021 CPT Description Changes

2021 CPT	2021 MEDIUM DESCRIPTION CHANGES	CHANGES TO CODE DESCRIPTION
99211	OFFICE OUTPATIENT VISIT ~~5 MINUTES~~ MINIMAL	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Remove Typically 5 minutes total time spent
99212	OFFICE OUTPATIENT VISIT 10-19 MINUTES	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace Typically 10 minutes with 10-19 minutes total time spent
99213	OFFICE OUTPATIENT VISIT ~~15~~ 20-29 MINUTES	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace Typically 15 minutes with 20-29 minutes total time spent
99214	OFFICE OUTPATIENT VISIT ~~25~~ 30-39 MINUTES	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace typically 25 minutes with 30-39 minutes total time spent
99215	OFFICE OUTPATIENT VISIT 40-54 MINUTES	Replace key components of History and Physical with Medically appropriate history and physical for professional charges. Replace typically 40 minutes with 40-54 minutes total time spent
99354	PROLNG ~~E&M/~~PSYCTX SVC OFFICE O/P DIR CON 1ST HR	Add except with outpatient services 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 for professional charges
99355	PROLNG ~~E&M/~~PSYCTX SVC OFFICE O/P DIR CON ADDL 30	Remove evaluation and management
99356	PROLNG SERVICE I/P OBS REQ UNIT/FLOOR 1ST HR	Add observation
99415	PROLNG CLINCL STAFF SVC DURING O/P E/M 1ST HR	typical service time was removed, and highest time in the range of total time of the service was added
99416	PROLNG CLINCL STAFF SVC DURING O/P E/M EA 30 MIN	typical service time was removed, and highest time in the range of total time of the service was added
99490	CHRON CARE MANAGEMENT SRVC 1ST 20 MIN PER MONTH	at least 20 minutes of clinical staff time was replaced with first 20 minutes of clinical staff time

2021 46 Deleted Codes

2021 Deleted CPT Code	Long Description	Replacement Codes
19324	MAMMAPLASTY AUGMENTATION W/O PROSTHETIC IMPLANT	15771, 15772
19366	BREAST RECONSTRUCTION OTHER TECHNIQUE	No Replacement code identified
32405	BIOPSY LUNG/MEDIASTINUM PERCUTANEOUS NEEDLE	32408
49220	STAGING LAPAROTOMY HODGKINS DISEASE/LYMPHOMA	No Replacement code identified
57112	VAGNC COMPL RMVL VAG WALL TOT PEL LMPHADEC BX	No Replacement code identified
58293	VAG HYST >250 GM COLPOURTCSTOPEXY W/WO NDSC CTR	No Replacement code identified
61870	CRNEC IMPLTJ NSTIM ELTRD CEREBELLAR CORTICAL	No Replacement code identified
62163	NEUROENDOSCOPY ICRA W/RETRIEVAL FOREIGN BODY	No Replacement code identified
63180	LAM&SCTJ DENTATE LIG W/WO DURAL GRF CRV 1/2 SEG	No Replacement code identified
63182	LAM&SCTJ DENTATE LIG W/WO DURAL GRF CRV >2 SEG	No Replacement code identified
69605	REVJ MASTOIDECTOMY W/APICECTOMY	No Replacement code identified
76970	ULTRASOUND EXAM FOLLOW-UP	No Replacement code identified
78135	RBC SURVIVAL STUDY DIFFERNTL ORGAN/TISS KINETICS	No Replacement code identified

2021 Deleted Codes

2021 CPT	Long Description	Replacement Codes
81545	ONCOLOGY THYROID GENE EXPRESSION 142 GENES	No Replacement code identified
92585	AUDITORY EVOKED POTENTIALS COMPREHENSIVE	92652, 92653
92586	AUDITORY EVOKED POTENTIALS LIMITED	92650, 92651
92992	ATRIAL SEPTECT/SEPTOST TRANSVENOUS BALLOON	No Replacement code identified
92993	ATRIAL SEPTECT/SEPTOSTOMY BLADE METHOD	No Replacement code identified
94250	EXPIRED GAS COLLECTION QUANT 1 PROCEDURE SPX	No Replacement code identified
94400	CO2 BREATHING RESPONSE CURVE	No Replacement code identified
94750	PULMONARY COMPLIANCE STUDY	No Replacement code identified
94770	CARBON DIOXIDE EXP GAS DETER INFRARED ANALYZER	No Replacement code identified
95071	INHLJ BRNCL CHALLENGE TSTG W/AGS/GASES	No Replacement code identified
99201	OFFICE OUTPATIENT NEW 10 MINUTES	99202

2021 New Surgical Codes

CPT Code	Long Description
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)
32408	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed
33741	Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (e.g., Rashkind, Sang-Park, balloon, cutting balloon, blade)
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (e.g., atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt
33746	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (e.g., atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance
57465	Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); bilateral

New Continuous Cardiac Monitoring

- 8 CPTs replace new technology Codes

2021 CPT Code	Long Description
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation

2021 New CPT Codes

CPT	CDM DESCRIPTION	Revenue Code
30468	RPR NSL VLV COLLAPSE W/IMPLT	360
32408	CORE NDL BX LNG/MED PERQ	360
33741	TAS CONGENITAL CAR ANOMAL	360
33745	TIS CGEN CAR ANOMAL 1ST SHNT	360
33746	TIS CGEN CAR ANOMAL EA ADDL	360
33995	INSJ PERQ VAD R HRT VENOUS	360
33997	RMVL PERQ RIGHT HEART VAD	360
55880	ABLTJ MAL PRST8 TISS HIFU	360
57465	CAM CERVIX UTERI DRG COLP	360
69705	NPS SURG DILAT EUST TUBE UNI	360
69706	NPS SURG DILAT EUST TUBE BI	360
71271	CT THORAX LUNG CANCER SCR C-	352
76145	MED PHYSIC DOS EVAL RAD EXPS	330
80143	DRUG ASSAY ACETAMINOPHEN	301

CPT	CDM DESCRIPTION	Revenue Code
80151	DRUG ASSAY AMIODARONE	301
80161	ASY CARBAMAZEPIN 10,11-EPXID	301
80167	DRUG ASSAY FELBAMATE	301
80179	DRUG ASSAY SALICYLATE	301
80181	DRUG ASSAY FLECAINIDE	301
80189	DRUG ASSAY ITRACONZAOLE	301
80193	DRUG ASSAY LEFLUNOMIDE	301
80204	DRUG ASSAY METHOTREXATE	301
80210	DRUG ASSAY RUFINAMIDE	301
81168	CCND1/IGH TRANSLOCATION ALYS	301
81191	NTRK1 TRANSLOCATION ANALYSIS	310
81192	NTRK2 TRANSLOCATION ANALYSIS	310
81193	NTRK3 TRANSLOCATION ANALYSIS	310
81194	NTRK TRANSLOCATION ANALYSIS	310

2021 New CPT Codes

CPT	CDM DESCRIPTION	REVENUE CODE
81278	IGH@/BCL2 TRANSLOCATION ALYS	310
81279	JAK2 GENE TRGT SEQUENCE ALYS	310
81338	MPL GENE COMMON VARIANTS	310
81339	MPL GENE SEQ ALYS EXON 10	310
81347	SF3B1 GENE COMMON VARIANTS	310
81348	SRSF2 GENE COMMON VARIANTS	310
81351	TP53 GENE FULL GENE SEQUENCE	310
81352	TP53 GENE TRGT SEQUENCE ALYS	310
81353	TP53 GENE KNOWN FAMIL VRNT	310
81357	U2AF1 GENE COMMON VARIANTS	310
81360	ZRSR2 GENE COMMON VARIANTS	310
81419	EPILEPSY GEN SEQ ALYS PANEL	310
81513	NFCT DS BV RNA VAG FLU ALG	310
81514	NFCT DS BV&VAGINITIS DNA ALG	310

CPT	CDM DESCRIPTION	Revenue CODE
81529	ONC CUTAN MLNMA MRNA 31 GENE	310
81546	ONC THYR MRNA 10,196 GEN ALG	310
81554	PULM DS IPF MRNA 190 GEN ALG	310
82077	ASSAY SPEC XCP UR&BREATH IA	301
82681	ASSAY DIR MEAS FR ESTRADIOL	301
90377	RABIES IG HT&SOL HUMAN IM/SC	636
92229	IMG RTA DETC/MNTR DS POC ALY	920
92517	VEMP TEST I&R CERVICAL	920
92518	VEMP TEST I&R OCULAR	920
92519	VEMP TST I&R CERVICAL&OCULAR	920
92650	AEP SCR AUDITORY POTENTIAL	440
92651	AEP HEARING STATUS DETER I&R	440
92652	AEP THRSHLD EST MLT FREQ I&R	440
92653	AEP NEURODIAGNOSTIC I&R	440

2021 New CPT Codes

CPT	CDM DESCRIPTION	REVENUE CODE
93241	EXT ECG>48HR<7D REC SCAN A/R	730/985
93242	EXT ECG>48HR<7D RECORDING	730/985
93243	EXT ECG>48HR<7D SCAN A/R	730/985
93244	EXT ECG>48HR<7D REV&INTERPJ	730/985
93245	EXT ECG>7D<15D REC SCAN A/R	730/985
93246	EXT ECG>7D<15D RECORDING	730/985
93247	EXT ECG>7D<15D SCAN A/R	730/985
93248	EXT ECG>7D<15D REV&INTERPJ	730/985
94619	EXERCISE TST BRNCSPSM WO ECG	410
99417	PROLNG OFF/OP E/M EA 15 MIN	51X, 52X/960-983
99439	CHRNC CARE MGMT SVC EA ADDL 20	51X, 52X

Emergency Covid-19 Codes

CPT Code	Medium Descriptor	Effective Date
0202U	NFCT DS BCT/VIR RESPIR DNA/RNA 22 TRGT SARSCOV2	May 20, 2020
0223U	NFCT DS BCT/VIR RESPIR DNA/RNA 22 TRGT SARSCOV2	June 25, 2020
0224U	ANTB SEV AQT RESPIR SYND CORONAVIRUS 2 TITER(S)	June 25, 2020
0225U	NFCT DS DNA&RNA 21 TARGETS SARS-COV-2 AMP PROBE	August 10, 2020
0226U	SUROGAT VIR NEUTRLZJ TST SARSCOV2 ELISA PLSM SRM	August 10, 2020
0240U	NFCT DS RNA 3 TARGETS UPPER RESPIRATORY SPECIMEN	October 6, 2020
0241U	NFCT DS RNA 4 TARGETS UPPER RESPIRATORY SPECIMEN	October 6, 2020
99072	ADDL SUPL MATRL&STAF TM DRG PHE RES-TR NFCT DS	September 8, 2020

Emergency Covid-19 Vaccine Codes

CPT	MEDIUM DESCRIPTION	PRODUCER
0001A	IMM ADMN SARSCOV2 30MCG/0.3ML DIL RECON 1ST DOSE	Pfizer
0002A	IMM ADMN SARSCOV2 30MCG/0.3ML DIL RECON 2ND DOSE	Pfizer
0011A	IMM ADMN SARSCOV2 100 MCG/0.5 ML 1ST DOSE	Moderna
0012A	IMM ADMN SARSCOV2 100 MCG/0.5 ML 2ND DOSE	Moderna
91300	SARSCOV2 VACCINE DIL RECON 30 MCG/0.3 ML IM USE	Pfizer
91301	SARSCOV2 VACCINE 100 MCG/0.5 ML IM USE	Moderna

2021 CPT Errata

- AMA publishes Errata throughout the year when mistakes are identified in published CPT books.
- The initial release identified minor errors
  - Spelling errors in the short and medium description files
- Correct 99489 (Additional 30 min Complex Chronic Care Management):
  - (Do not report 99487, 99489 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, ~~98969~~, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607)
- Revise medium descriptor
  - 87426 - Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative , ~~multiple-step method~~ ; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])
  - Medium description - IAAD IA SEVERE AQTRESPIRSYND CORONAVIRUS

https://www.ama-assn.org/practice-management/cpt/errata-technical-corrections

2021 Deleted HCPCS

HCPCS	REPLACEMENT HCPCS	CDM DESCRIPTION	REVENUE CODE
C9055	J1632	RX BREXANOLONE 1 MG	636
C9059	J1738	RX MELOXICAM 1 MG	636
C9061	J3241	RX TEPROTUMUMAB-TRBW 10 MG	636
C9063	J3032	RX EPTINEZUMAB-JJMR 1 MG	636

2021 HCPCS Changes

HCPCS	CDM DESCRIPTION	CHANGE
E0880	TRAC STAND FREE STAND EXTREM	Remove e.g. bucks. No change to medium description
G2011	ALCOHOL/SUB ~~ABUSE~~ MISUSE ASSESS 5-14 MIN	Change abuse to misuse
G0396	ALCOHOL/SUB ~~ABUSE~~ MISUSE ASSESS/INTERV 15-30 MIN	Change abuse to misuse
G0397	ALCOHOL/SUB ~~ABUSE~~ MISUSE ASSESS/ INTERV 30+ MIN	Change abuse to misuse
J9305	RX PEMETREXED NOS 10MG	Add NOS to distinguish between new HCPCS J9304 PEMETREXED, PEMFEXY
L8701	EWH S/D UPRT MICRO SENSOR ~~CUSTOM FAB~~ ANY TYPE(S)	Remove custom fabricated and add any type
L8702	EWHF S/D UPRT MICRO SENSOR ~~CUSTOM FAB~~ ANY TYPE(S)	Remove custom fabricated and add any type

2021 New HCPCS

- Full 2021 File not published
- New codes published October 2021

HCPCS	CDM DESCRIPTION	REVENUE CODE
C9060	FLUOROESTRADIOL F18	343
C9062	RX DARATUMUMAB 10MG HYALURONIDASE	636
C9064	RX MITOMYCIN PYELOCALYCEAL INST 1MG	636
C9065	RX ROMIDEPSIN NON-LYOPHILIZED 1MG	636
C9066	RX SACITUZUMAB GOVITECAN-HZIY 10 MG	636
C9067	GALLIUM GA-68 DOTATOC 0.1 MCI	636
C9761	CYSTO, LITHO, VACUUM KIDNEY	360
C9768	ENDO US-GUIDE HEP PORTO GRAD	360
C9769	CYSTO W/TEMP PROS IMPLANT	960
G1020	CDSM CURBSIDE	960
G1021	CDSM EHEALTHLINE	960
G1022	CDSM INTERMOUNTAIN	960

2021 New HCPCS

HCPCS	CDM DESCRIPTION	REVENUE CODE
J1632	RX BREXANOLONE, 1 MG	636
J1738	RX MELOXICAM 1 MG	636
J3032	RX EPTINEZUMAB-JJMR 1 MG	636
J3241	RX TEPROTUMUMAB-TRBW 10 MG	636
J7351	RX BIMATOPROST ITC IMP1MCG	636
J9227	RX ISATUXIMAB-IRFC 10 MG	636
J9304	RX PEMETREXED, PEMFEXY 10 MG	636
K1006	SUCT PUM EXT URINE MGMT SYS	290
K1007	BIL HKAF PC S/D MICRO SENSOR	290
K1009	SPEECH VOLUME MODULATION SYS	290
K1010	INTRAURETHRAL DRAINAG DEVICE	290
K1011	ACTI INTRAURETHRAL DRAINAGE	290
K1012	CHARGER BASE STATION INTRAUR	290
Q4249	AMNIPLY, PER SQ CM	278
Q4250	AMNIOAMP-MP PER SQ CM	278
Q4254	NOVAFIX DL PER SQ CM	278

2021 New HCPCS

HCPCS	CDM DESCRIPTION	REVENUE CODE
Q4255	REGUARD, TOPICAL USE PER SQ	278
Q9001	VA CHAPLAIN ASSESSMENT	960
Q9002	VA CHAPLAIN COUNSEL INDIVIDU	960
Q9003	VA CHAPLAIN COUNSEL GROUP	960
T2047	HAB PREVO WAIVER PER 15	960
V2524	CNTCT LENS HYDROPHIL PHOTOCH	271
G1023	CDSM PERSIVIA	960
J1437	RX FE DERISOMALTOSE 10 MG	636

OPPS Changes

OPPS Proposed Rule Highlights

- Eliminate the Inpatient Only list over three calendar years
  - Starting with 300 musculoskeletal-related services in 2021
  - Seeking comments whether three years is an appropriate timeframe for the elimination
  - Continue the two-year exemption from site-of-service claims denials and recovery audit contractor referrals for services removed from the IPO
- Identify all performed Musculoskeletal inpatient only services on 2020 Addendum B file (Status Indicator C)
- Compare to final 2021 Addendum B File
- Identify appropriate APC and fee for charge set-up if fees are based on percent of Medicare

•2021 NPRM OPPS Addenda

Inpatient Only Procedure APC Migration

APC	Title	Number of Proposed Codes Assigned	Proposed 2021 APC Geometric Mean Cost	Proposed APC Fee
5113	Level 1 Musculoskeletal Procedures	411	$2777.09	$2,833.00
5114	Level 3 Musculoskeletal Procedures	445	$6136.58	$6,260.00
5115	Level 4 Musculoskeletal Procedures	120	$12104.07	$12,347.00
5116	Level 5 Musculoskeletal Procedures	50	$15711.96	$16,027.00

OPPS Proposed Rule Highlights

- Reimburse 340B drugs at ASP minus 34.7 percent, plus additional 6 percent reduction of the ASP, or ASP -28.7%
  - Decreased reimbursement from previously proposed reduction of ASP -22.5%
  - Biosimilar's reimbursement based individual biosimilar ASP, not reference product's ASP
  - Wholesale Acquisition Cost (WAC) will be used for products without an ASP

OPPS Proposed Rule Highlights

- Expand prior authorization requirements
  - 2021 additions - Cervical fusion with disc removal and implanted spinal neurostimulators
  - Likely to expand prior authorizations in future rulemakings

Questions