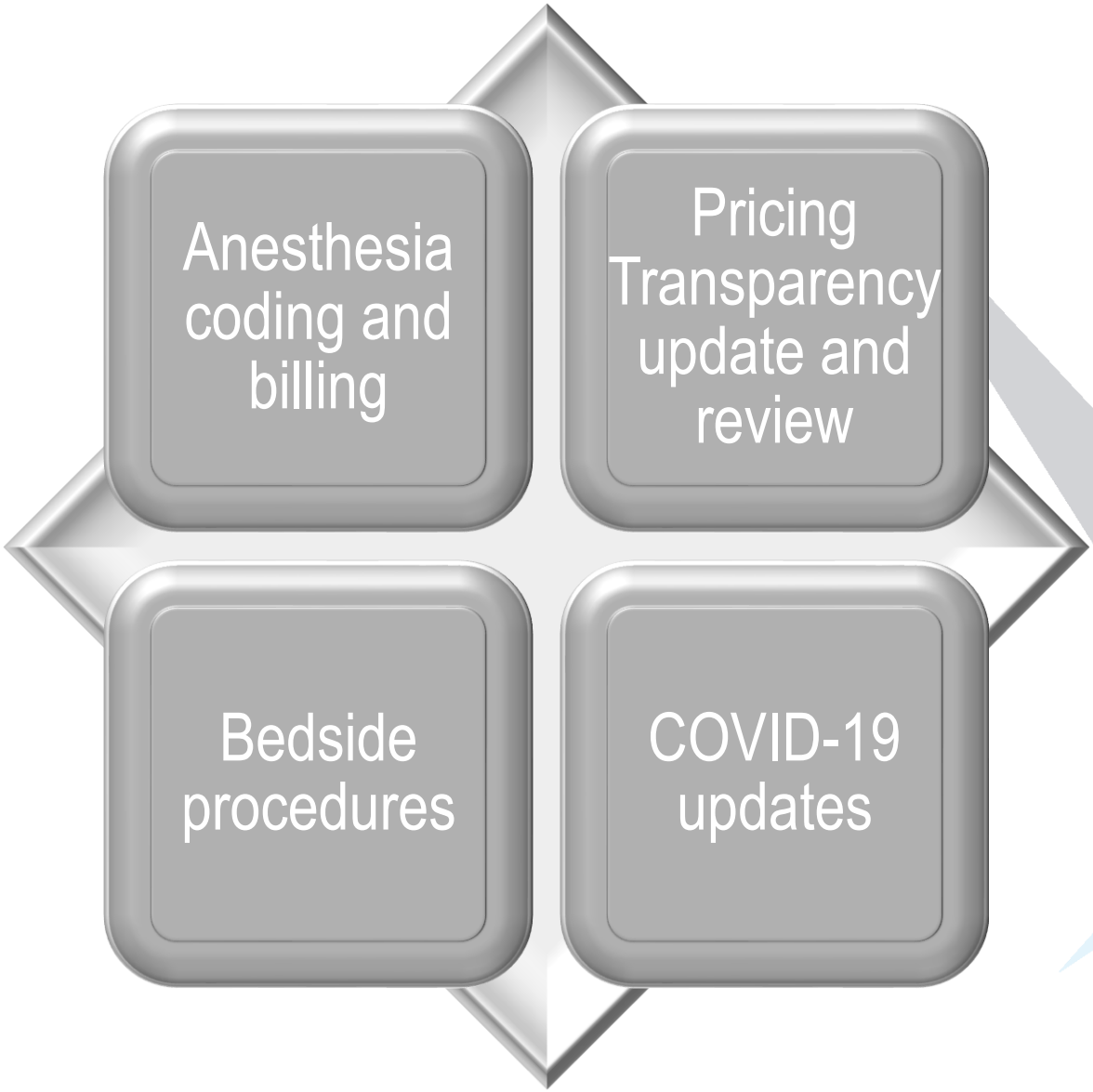
# Welcome to the
# WVCAH Quarterly Revenue Cycle Call

WARBIRD
CONSULTING PARTNERS

*Uniquely Qualified*

We will be starting momentarily

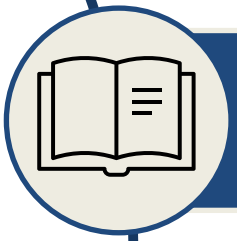
# Agenda


Anesthesia coding and billing
Pricing Transparency update and review
Bedside procedures
COVID-19 updates

# Anesthesia Coding and Billing

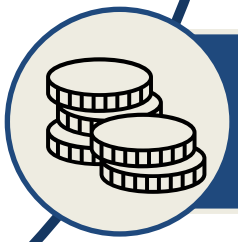
# Facility Anesthesia

Facilities do not use anesthesia CPTs to report the facility component of anesthesia



There is not coding or CMS guidance to govern facility reporting of anesthesia

Reporting process determined internally



Fees set internally

# Professional Anesthesia Services

- Anesthesia provider
  - A physician who performs the anesthesia service alone
  - A CRNA who is furnishing services that do not meet the requirements for payment at the medically directed rate
  - A qualified nonphysician anesthetist who is furnishing services that meet the requirements for payment at the medically directed rate
    - Split billed
- Concurrent procedures – Procedures directed or supervised by an anesthesiologist, where the timing of procedures overlap
- Most payors allow
  - 50% for medically direction of 2-4 procedures
  - Five or more procedures is considered supervised, not medically directed
  - Medicare and some commercial payors will only reimburse up to 3 base units plus 1 unit of time for medically supervised procedures

# Anesthesia Medical Direction

## Physician (or physician from the same group) who is medically directing procedures must:

- Perform a pre-anesthetic examination and evaluation
- Prescribes the anesthesia plan
- Participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

## Must be present and available in the immediate area of the operating suite

# Anesthesia CRNA

- A CRNA is a registered nurse who:
  - Is licensed as a registered professional nurse by the State in which the nurse practices;
  - Meets any licensure requirements the State imposes with respect to nonphysician anesthetists
  - Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs
  - Meets the following criteria:
    - Has passed a certification examination of the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists; or
    - Is a graduate of a nurse anesthesia educational program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs, and within 24 months of graduation, has passed a certification examination of the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

# Types of Anesthesia

- Local – Anesthetic drug injected to block sensation to the small affected area only
  - Anesthesiologist typically not involved if this is the only anesthesia provided
  - No separately billable CPT
- Nerve block – Regional anesthesia
  - Blocks a specific nerve or bundle of nerves resulting in a numbing a larger region
  - Report CPT associated with the nerve block procedure
  - May or may not be in the anesthesia code range
- Moderate Sedation
  - Typically supervised or administered by surgeon
  - Provides patient comfort while allowing the patient to communicate
  - Report moderate sedation CPTs 99151-99153
- Monitored Anesthesia Care
  - Deeper level of sleep, while allowing the patient to follow simple instructions if necessary
  - Requires pre/peri assessment and understanding of the patient's medical conditions monitor the state and impact of anesthesia including, airway, cardiovascular, hemodynamic, physiological derangement
  - Anesthesiologist able to convert to general anesthesia if necessary
  - Report anesthesia CPTs
- General Anesthesia
  - Patient is completely asleep and intubated
  - Report Anesthesia CPTs

# Anesthesia Base Units

- Anesthesia CPTs in the code range 00100-01999 crosswalk to surgical CPTs and describe the surgical service performed
- Base units are assigned to each time-based anesthesia CPT code in the range 00100-01999
- Used to determine the relative value of skill and resources required for each anesthesia CPT code, against a standard
- Base units are used in the reimbursement calculation by payors
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/2018-Anesthesia-BaseUnits-CPT.zip

# Anesthesia Time

- Report all time, in minutes, on the same line as the highest base-unit CPT
  - Begins when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area
  - Ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient (the patient may be placed safely under postoperative care)
  - Do not count time during an interruption
  - Do not count time spent when pain block is placed before induction or after emergence,
  - Report time only for discontinued procedures, not discontinued modifiers
- Do not add base units (Payer will add base units)
- Payer will convert total time into units of 15-minute increments rounded to 1 decimal place

# Anesthesia Modifiers

| Required Anesthesia Modifier | Common Reimbursement Percentage |
|---|---|
| AA | 100% |
| QZ | 100% |
| AD | Additional base units |
| QK | 50% |
| QX | 50% |
| QY | 50% |

- First position modifiers
  - AA - Anesthesia Services performed personally by the anesthesiologist
    - May also be reported in rare circumstances where 2 anesthesiologists are medical necessary
  - QZ – CRNA service: Without medical direction by a physician
  - QX – Qualified nonphysician anesthetist service with medical direction by a physician
  - Corresponding MD claim
    - QY - Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
    - QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
    - AD - Medical supervision by a physician; more than 4 concurrent anesthesia procedures or performs other services while directing anesthesia care

# Physical Status Modifiers

- Second position modifiers
  - Medicare requires Physical Status modifiers as informational only, in the last position
- Additional information to identify patient condition that may complicate anesthesia
- Documentation must support physical status reported

| Physical Status Modifier | Description | Common points added to Commercial Calculations |
|---|---|---|
| P1 | A normal healthy patient | 0 |
| P2 | A patient with mild systemic disease | 0 |
| P3 | A patient with severe systemic disease | 1 |
| P4 | A patient with severe systemic disease that is a constant threat to life | 2 |
| P5 | A moribund patient who is not expected to survive without the operation | 3 |
| P6 | A declared brain-dead patient whose organs are being removed for donor purposes | 0 |

# Altered Circumstances Modifiers

**Monitored Anesthesia Care**

QS – Monitored Anesthesia Care
G8 - Deep complex, complicated, or markedly invasive surgical procedures
G9 - Patient with a history of severe cardio- pulmonary condition

59 – Separate and distinct encounter

51 – Multiple procedure

76 - Repeat procedure or service by same physician on the same day

77 - Repeat procedure by a different physician on the same day

78- Unplanned return to the operating or procedure room, by the same physician, following an initial procedure for a related procedure

79 - Unrelated procedure that was performed by the same physician during a post-operative period

# Modifier 22

- Modifier 22 - Increased Procedural Services
- Append modifier 22 to report field avoidance and the increased work and complexity that follows when an anesthesiologist has limited access to the patient's airway
- Many payors only allow additional reimbursement for procedures with low base points
  - Typically, 5 base points or less
- Supporting documentation may be required

# Qualifying Circumstances CPTs

| Physical Status Modifier | Description | Ex: UH Units base units Added |
|---|---|---|
| 99100 | Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure) | 1 |
| 99116 | Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure) | 5 |
| 99135 | Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure) | 5 |
| 99140 | Anesthesia complicated by emergency conditions (List separately in addition to code for primary anesthesia procedure | 2 |

- Additional time units may be applied by payor
- Medicare does not reimburse PPS for qualifying circumstances

# Additional Services

- Separately reportable services, if performed the day before or the day of the surgical procedure include:
  - 93503 - INSERTION FLOW DIRECTED CATHETER FOR MONITORING ( e.g. Swan Ganz)
  - 99291-99292 – CRITICAL CARE
  - 36555-36571 – INSERT CENTRAL VENOUS ACCES DEVICE
  - 31500- EMERGENCY INTUBATION
  - 62273 - INJECTION EPIDURAL BLOOD/CLOT PATCH

# Anesthesia Billing

- Example: General anesthesia surgery represented by 2 possible anesthesia CPTs
- 72-year-old patient with severe COPD

| CPT | DESCRIPTION | BASE UNIT | Time |
|---|---|---|---|
| 00162 | ANES NOSE ACCESS SINUS RADICAL | 7 | 60 min |
| 00164 | ANES NOSE ACCSS SIN BX SOFT TISSUE | 4 | 120 min |

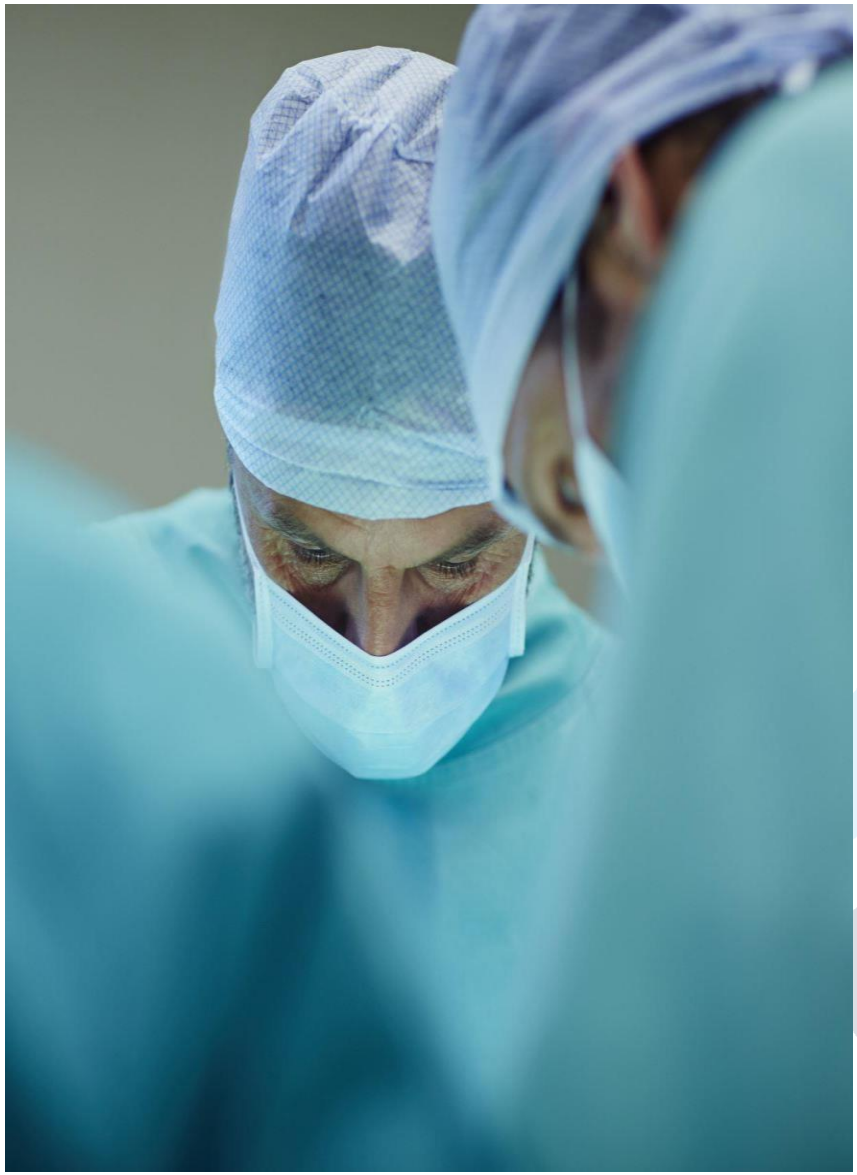
  - Bill 00162 x 180 minutes
  - Append modifiers for anesthesia service and /or direction or supervision as necessary
  - Append physical status modifier P3
  - Add Qualifying Circumstances CPT 99100
- Payer calculates (180/15) = 12
  - Payer assigns Base Units = 7
  - Payer assigns 1 unit for modifier P3, 1 unit for 99100
  - Allowed amount based on 21 units
    - 12-time units +7 Base units plus 2 units patient health factors
- If billed incorrectly with time calculation up front:
  - 180/15=12 – reported as 00162 X 12
  - 12-minute procedure
  - Payer calculates (12/15)=0.8
    - Allowed amount based on 9.8 units (0.8+7 + 2 )

# Anesthesia Exceptions

- If the same anesthesia CPT code applies to two or more of the surgical procedures (bilateral procedure), enter the anesthesia code with the -51 modifier and the number of surgeries to which the modified CPT code applies
- EGD and colonoscopy on the same day
  - Report anesthesia for both if applicable, no modifier necessary for most payers
- Obstetrics - The base unit and the time units for the primary and the add-on obstetrical anesthesia code are billed on separate lines
  - Primary CPT 01967 – Anesthesia neuraxial labor, planned vaginal delivery
    - 01968 – Anesthesia cesarean following neuraxial labor
    - 01969 – Anesthesia cesarean hysterectomy following neuraxial labor
    - May be reported on multiple claims for different anesthesiologists
- Second-third degree burns
  - Primary CPT 01952 - Anesthesia for 2nd-3rd degree burn excision or debridement with or without skin grafting, any site, for total body surface area 4-9%
    - 01953 – ANES 2/3 DGR BRN EXC/DBRDMT W/WO GRF EA ADDL 9% TBS
      - Not time based, report units based on body surface
- 01996 – Daily management epidural or subarachnoid drug administration for postop pain relief
  - Per day code, not time based

# West Virginia Medicaid

- Limits the time paid for maternity anesthesia to 2 hours
- Anesthesiologists and CRNAs (within the scope of their license) may bill for the following additional services:
  - Swan-Ganz placement or any other central venous pressure line;
  - Critical care visits
  - Emergency intubations
  - Spinal puncture
  - Blood patch



# United Health Reimbursement Guidelines

- Anesthesia services with modifier 22, and base units less than 5 will be considered for additional reimbursement
  - Services with a Base Unit Value of 5 or greater already take positioning and field avoidance if any into account.
- Physical status modifiers and qualifying circumstance codes may be reported to distinguish various levels of complexity or to identify conditions that significantly affect the character of anesthesia services
- One unit will be added for modifier AD

| Procedure Code | Modifying Units Allowed | Guidance |
|---|---|---|
| 99100 | 1 | Not allowed with anesthesia codes 00326, 00561, 00834 and 00836 |
| 99116 | 5 | Not allowed with anesthesia codes 00561, 00562, 00563 and 00567 |
| 99135 | 5 | Not allowed with anesthesia codes 00561, 00562, 00563 and 00567 |
| 99140 | 2 | An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part |

# United Health Reimbursement Guidelines

- UnitedHealthcare will reimburse one additional anesthesia unit with modifier 59, 76, 77, 78, 79 or XE, in the event an anesthesia administration service is provided during a different operative session on the same day as a previous operative session
- Nerve block codes billed in conjunction with anesthesia services must be appended with the appropriate modifier 59, XE, or XU to be considered for additional reimbursement
- United Health follows NCCI guidelines when considering add on codes for reimbursement
- Reimbursement for CPT 01967 – Neuraxial labor, is capped at 435 minutes, regardless of time reported. Physical status units, qualifying circumstances units and base units will be added to minutes reported, or capped minutes
- Add on Obstetrics services are separately considered if reported

# Summary

- Crosswalk surgical CPTs to anesthesia CPTs
- Identify the anesthesia CPT with the highest base units
- Convert hours to minutes and enter the total minutes to the CPT with the highest base units unless exceptions apply
  - Report additional anesthesia CPTs if exceptions apply
- Add all applicable modifiers
  - Anesthesia
  - Physical status
  - MAC
  - Additional services
  - Increased procedural service
- Report CPTs representing qualifying circumstances if applicable
- Do not add base units
- Do not convert time to 15-minute blocks per unit

# Pricing Transparency

# Pricing Transparency

- Effective January 1, 2021 CMS required all hospitals to publish a machine-readable file identifying all goods and services, including service packages
- Machine readable file using the proper naming convention
- Employer Identification Number_Facility-Name_standardcharges.file format (xml,json,csv)
- Underscore between EIN, facility name, and standard charges
- Dash can be used in facility name to separate words
- Standard charges should be all lower case, no spaces
- Example: 123456789_general-hospital_standardcharges.csv
- Multiple hospitals under the same EIN, with separate chargemasters or negotiated rates must have different files
  - Add NPI _ between EIN and hospital name
  - 123456789_987654321_facility-name_standardcharges.csv

# Standard Charges Comprehensive File

- Prominently displayed on the website
- Price estimator tools do not satisfy the requirement for the comprehensive file
- Include all goods and services, including packages
  - Per Diem, DRG, or other package rates not in the CDM must be included even if the packages are not included in the CDM
- Units required if applicable
  - Drug HCPCS associated with a vial must also populate a column with the conversion factor/multiplier for the vial
  - If NDC is used, include a column with the NDC units
- All standard charges
  - Gross charge
  - Discounted cash price
  - Each payer-specific negotiated charge
    - If the contract rate is percent of charge, calculate and publish the charge by percent of gross charge
    - Confirm contract is percent of charge or percent of allowed amount
  - De-identified minimum negotiated charge
  - De-identified maximum negotiated charge

# Negotiated Charges Definition

- Include negotiated charges for any entity that meets the definition of "*an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service. "*
- Includes local companies with contracts to perform labs, drug screening, etc.

# Sample Standard Charge File

| CPT/ HCPCS | DESCRIPTION | HCPCS UNIT | GROSS CHARGE | CASH PRICE | MINIMUM NEGOTIATED RATE | MAXIMUM NEGOTIATED RATE | BCBS HMO | BCBS PPO | BCBS INDEMNITY | BCBS MCR MANAGED CARE |
|---|---|---|---|---|---|---|---|---|---|---|
| 10005 | FNA BIOPSY INC US GUID FIRST LESION | | 1,400.00 | 1,281.00 | 543.00 | 1,891.00 | 610.00 | 976.00 | 1,367.00 | 1,172.00 |
| 25370 | REVISE RADIUS OR ULNA | | 8,500.00 | 5,749.00 | 2,437.00 | 8,486.00 | 2,738.00 | 4,380.00 | 6,132.00 | 5,256.00 |
| 25375 | REVISE RADIUS & ULNA | | 8,500.00 | 5,749.00 | 2,437.00 | 8,486.00 | 2,738.00 | 4,380.00 | 6,132.00 | 5,256.00 |
| 25390 | OSTEOPLSTY RADIUS OR ULNA SHORTENING | | 20,000.00 | 12,561.00 | 5,324.00 | 18,542.00 | 5,982.00 | 9,571.00 | 13,399.00 | 11,485.00 |
| 35226 | REPR BLOOD VESSEL DIRECT LOWER EXTREM | | 1,400.00 | 1,281.00 | 543.00 | 1,891.00 | 610.00 | 976.00 | 1,367.00 | 1,172.00 |
| 35231 | REPR BLOOD VESSEL W VEIN GRFT NECK | | 8,500.00 | 5,820.00 | 2,467.00 | 8,591.00 | 2,771.00 | 4,434.00 | 6,207.00 | 5,321.00 |
| 35236 | RPR BLOOD VESSL W VEIN GRFT UPPR EXTREM | | 15,000.00 | 9,651.00 | 4,091.00 | 14,247.00 | 4,596.00 | 7,354.00 | 10,295.00 | 8,824.00 |
| 35256 | RPR BLOOD VESSL W VEIN GRFT LWR EXTREM | | 15,000.00 | 9,651.00 | 4,091.00 | 14,247.00 | 4,596.00 | 7,354.00 | 10,295.00 | 8,824.00 |
| 35903 | EXCIS OF INFECTED GRFT EXTRM | | 9,000.00 | 5,820.00 | 2,467.00 | 8,591.00 | 2,771.00 | 4,434.00 | 6,207.00 | 5,321.00 |
| 43754 | GI INTUBATN AND ASPIR DX SNGL SPEC | | 900.00 | 532.00 | 226.00 | 785.00 | 254.00 | 405.00 | 567.00 | 486.00 |
| 43755 | NG TUBE INSERTN, DX INC DRUG ADMIN | | 500.00 | 291.00 | 124.00 | 429.00 | 139.00 | 222.00 | 310.00 | 266.00 |
| 43756 | DX DUOD INTUB W/ASP SPEC | | 2650.00 | 1,651.00 | 700.00 | 2,437.00 | 786.00 | 1,258.00 | 1,761.00 | 1,509.00 |
| 43757 | DX DUOD INTUB W/ASP SPECS | | 2650.00 | 1,651.00 | 700.00 | 2,437.00 | 786.00 | 1,258.00 | 1,761.00 | 1,509.00 |

# Shoppable Service File

**Publish a separate more comprehensive file including 300 shoppable services**

- 70 Medicare defined
- Each facility can choose the balance
- Must choose additional services to reach 300 shoppable services if all Medicare defined services are not performed
- Includes DRGs

**All goods and services associated with shoppable service, for which a patient responsibility may be assessed**

- Facility
- Professional
- Anesthesia
- Pathology
- Any carve-out or pass-through services

**Report all 5 standard charges for each shoppable service**

**Price estimator tools may satisfy shoppable service file where at least 300 shoppable services including Medicare defined DRGs, or replacement DRGs are included**

- Must provide the amount an individual patient utilizing the tool can expect to pay OOP
- Estimated range is not acceptable

# Sample Shoppable Service File

| 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 |

# Penalties for Non-Compliance

- $300.00 per day
- Penalties published on a CMS website
- CMS published steps include:
  - Provide a written warning notice to the hospital of the specific violation(s).
  - Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements, according to § 180.80.
  - Impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website according
- Hospital may submit a corrective action plan in response to a Notice of Violation
- Include:
  - The corrective actions or processes the hospital will take to address the deficiency or deficiencies identified by CMS
  - The timeframe by which the hospital will complete the corrective action
- Subject to CMS approval
- Once monetary penalty is imposed, facility has 30 days to submit written request for a hearing
  - Additional penalties may be imposed pursuant to continuing violations
- Penalty must be paid within 60 days of binding decision

# Action Steps Standard Charge File

- Identify all goods and services
- Review Chargemaster and correct any errors
- Review all commercial contracts
  - Create a column for each payor, each agreed upon rate
    - Identify all packages
    - If drugs and supplies are packaged, create a separate row for packaged rates
    - Units per negotiated rate
    - Confirm whether percent of charge contracts reimburse percent of charge or percent allowed amount
      - Confirm goods and services “allowed”
- Review agreements with local businesses
  - Drug testing
  - DOT
  - Worker Compensation incidents
  - Assign columns for each agreement
- Review cash payment or prompt payment policy and create a column for cash payment
- Identify, for each row, CPT or HCPCs, the highest and lowest contracted rate
- Create de-identified minimum and maximum column
- Name the file following CMS guidelines
- Publish file in machine readable format
- Schedule annual review and update

# Pricing Transparency Shoppable Services

- Review all 70 Medicare assigned shoppable services and create rows for each service performed
- DRGs will not be in CDM but must be included
- Choose enough shoppable services beyond Medicare-defined services to reach 300 shoppable services
- Identify each component within each shoppable service for which a separate bill may be incurred *even if the facility does not bill for the service*
- Create as many rows within each shoppable service as necessary to identify all components, all standard charges
- Create a column for each payer rate and each standard charge
- Publish file in machine readable format or as a look-up tool
- Schedule annual review and update

# Bedside Procedures

# Bedside Procedures

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

Updated September 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R475PR1.pdf

Inpatient ***routine*** services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge.

"…composed of two board components; (I) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made"

# Bedside Procedures

- Services expected to be provided for a routine patient
  - Convenience items
  - “Basic” medical supplies – Supplies usually kept in bulk
    - Gloves
    - Alcohol prep pads
    - Betadine swabs
    - Basic bandages/bandaging supplies
  - Basic Nursing services
- Other services may or may not be included in the Room and Board rate, depending on facility guidelines

# Bedside Procedures

- Create a policy defining non-specific and specific nursing teams
  - Non-specific hospital nursing teams
    - Admission and discharge
    - Insertion, removal of IVs, NG tubes,
    - Transfusion, infusion, hydration, injections
    - Isolation care and universal precautions
    - Respiratory care performed by nurses
- Most major payer policies specifically exclude services requiring specialty nursing
  - Wound care
  - Advanced IV access
  - Ostomy care
  - Surgical nurses assisting in bedside procedures

# COVID-19

# Medically Necessary Private Room

Need for Isolation

Medically necessary where isolation of a beneficiary is required to avoid jeopardizing their health or recovery, or that of other patients who are likely to be alarmed or disturbed by the beneficiary's symptoms or treatment or subjected to infection by the beneficiary's communicable disease. “

Must include written order for isolation

*https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf*

# Inpatient originating Telehealth Services

- Hospitals and critical access hospitals should bill their A/B/MAC for the originating site facility fee on a 12x TOB
  - Q3014 - TELEHEALTH FACILITY FEE
  - Use the Discharge date as the DOS
  - Outpatient MUE of 2 should not apply

# COVID-19 Lab Tests

- Most labs priced by MAC in 2021
- https://www.palmettogba.com/Palmetto/Providers.nsf/docsR/JM%20Part%20A~Articles~Emergency%20and%20Disaster%20Instructions~COVID-19%20Laboratory%20Test%20Pricing?open&Expand=1
- U0005 – Add on to U0003 and U0004 if
  - COVID-19 CDLT results finalized in 2 calendar days or less from the date of specimen collection, *and*
  - The majority of COVID-19 CDLTs performed using high throughput technology in the previous calendar month were finalized in 2 calendar days or less for all patients
- CAHs not eligible for IPPS New COVID-19 Treatments Add-on Payment (NCTAP) add-on payment

| Lab Test | Description | 2021 Palmetto | CDLFS |
|---|---|---|---|
| C9803 | HOPD COVID-19 SPEC COLLECT | 24.67 | |
| 99211 | PROFESSIONAL COVID-19 SPEC COLLECT | 24.67 | |
| 86328 | IA NFCT AB SARSCOV2 COVID19 | $45.23 | |
| 86408 | NEUTRLZG ANTB SARSCOV2 SCR | $42.13 | |
| 86409 | NEUTRLZG ANTB SARSCOV2 TITER | $79.61 | |
| 86413 | SARS-COV-2 ANTB QUANTITATIVE | $51.43 | |
| 86769 | SARS-COV-2 COVID-19 ANTIBODY | $42.13 | |
| 87426 | SARSCOV CORONAVIRUS AG IA | $35.33 | |
| 87428 | SARSCOV & INF VIR A&B AG IA | $63.59 | |
| 87635 | INFECT AGNT DETECTION COVID-19 PCR | $51.31 | |
| 87636 | SARSCOV2 & INF A&B AMP PRB | $142.63 | |
| 87637 | SARSCOV2&INF A&B&RSV AMP PRB | $142.63 | |
| 87811 | SARS-COV-2 COVID19 W/OPTIC | $41.38 | |
| 0202U | NFCT DS BCT/VIR RSP DNA/RNA 22 TRGT COV2 BIOFIRE | $298.60 | |
| 0223U | NFCT DS BCT/VIR RESP DNA/RNA 22 TRGT COV2 QIAGEN | $298.60 | |
| 0224U | ANTIBODY SARS-COV-2 TITER(S) | $42.13 | |
| 0225U | NFCT DS DNA&RNA 21 SARSCOV2 | $298.60 | |
| 0226U | SVNT SARSCOV2 ELISA PLSM SRM | $42.38 | |
| 0240U | NFCT DS VIR RESP RNA 3 TRGT | $142.63 | |
| 0241U | NFCT DS RNA 4 TRGT UPPER RESPIR SPEC SAR FLU RSV | $142.63 | |
| U0001 | 2019-NCOV DIAGNOSTIC P | $35.91 | |
| U0002 | COVID-19 NON-CDC | $51.31 | |
| U0003 | COV-19 AMP PRB HGH THRUPUT | | $75.00 |
| U0004 | COV-19 TEST NON-CDC HGH THRU | | $75.00 |
| U0005 | INFEC AGEN DETEC AMPLI PROBE (ADD-ON) | | $25.00 |

# CLIAA Waiver for COVID-19 Antibody Testing

- Implementation date: April 5, 2021
- 87811QW effective DOS 10/6/20
  - SARS-COV-2 COVID19 W/OPTIC
  - Medium Description: IAADIADOO SEVERE AQT RESPIR SYND CORONAVIRUS
- 87428QW – effective DOS as of 10/20/20
  - SARSCOV & INF VIR A&B AG IA
  - Medium Description: IAAD IA SARSCOV & INFLUENZA VIRUS TYPES A&B

# COVID-19 Monoclonal Antibody Infusion

- Infusion administration codes include 1 hour infusion and pre/post monitoring

| HCPCS | CDM DESCRIPTION | RC | Medicare APC Payment |
|---|---|---|---|
| M0239 | BAMLANIVIMAB INFUSION | 330 | $310.75 |
| M0243 | CASIRIVI AND IMDEVI INFUSION | 330 | $310.75 |

- CMS will set rates for medications when free doses are no longer available

| HCPCS | CDM DESCRIPTION | RC | Medicare Payment |
|---|---|---|---|
| Q0239 | BAMLANIVIMAB 700 MG | 636 | Average cost if purchased |
| Q0243 | CASIRIVIMAB AND IMDEVIMAB 2400 MG | 636 | Average cost if purchased |

- Not eligible for NCTAP increases

# COVID-19 Vaccines

| CPT | DESCRIPTION | VENDOR | RC | APC |
|---|---|---|---|---|
| 91300 | SARSCOV2 VAC 30MCG/0.3ML IM | Pfizer | 636 | |
| 0001A | ADM SARSCOV2 30MCG/0.3ML 1ST | Pfizer | 771 | $15.50 |
| 0002A | ADM SARSCOV2 30MCG/0.3ML 2ND | Pfizer | 771 | $25.50 |
| 91301 | SARSCOV2 VAC 100MCG/0.5ML IM | Moderna | 636 | |
| 0011A | ADM SARSCOV2 100MCG/0.5ML1ST | Moderna | 771 | $15.50 |
| 0012A | ADM SARSCOV2 100MCG/0.5ML2ND | Moderna | 771 | $25.50 |

# Vaccines in the Pipeline

- Astra Zeneca – 2 Dose series. Likely to seek FDA approval late spring
  - 91302 - Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage
    - SARSCOV2 VACCINE CHADOX1 5X1010 VP/0.5ML IM USE
  - 0021A - ADM SARSCOV2 5X10^10VP/.5ML 1
  - 0022A - ADM SARSCOV2 5X10^10VP/.5ML 2
- Janssen – Running trials for both single dose administration and 2-dose administration. EAU application submitted to February 4
  - 91903 - 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
    - SARSCOV2 VACCINE AD26 5X1010 VP/0.5ML IM USE
  - 0031A - 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
    - IMM ADMN SARSCOV2 AD26 5X1010 VP/0.5 ML 1 DOSE

# COVID-19 Inpatient Treatment

| HCPCS | Short Description | FDA Status |
|---|---|---|
| XW0DXM6 | Introduction of baricitinib into mouth and pharynx, external approach, new technology group 6 | Emergency Use Authorization only |
| XW0G7M6 | Introduction of baricitinib into upper GI, via natural or artificial opening, new technology group 6 | Emergency Use Authorization only |
| XW0H7M6 | Introduction of baricitinib into lower GI, via natural or artificial opening, new technology group 6 | Emergency Use Authorization only |
| XW033E5 | Introduction of remdesivir anti-infective into peripheral vein, percutaneous approach, new technology group 5 | FDA Approved - Report C9399 for purchased drug |
| XW043E5 | Introduction of remdesivir anti-infective into central vein, percutaneous approach, new technology group 5 | FDA Approved - Report C9399 for purchased drug |
| XW13325 | Transfusion of convalescent plasma (nonautologous) into peripheral vein, percutaneous approach, new technology group 5 | Emergency Use Authorization only |
| XW14325 | Transfusion of convalescent plasma (nonautologous) into central vein, percutaneous approach, new technology group 5 | Emergency Use Authorization only |

# Telephone Codes for Therapy Services

- Approved as sometimes therapy codes
- For the Duration of the PHE
- Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment;
- 98966 - 5-10 minutes of medical discussion
- 98967 - 11-20 minutes of medical discussion
- 98968 - 21-30 minutes of medical discussion

# Ambulance Transport

- During the COVID-19 PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished.
- The interim list of destinations that may include but are not limited to
  - Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital
  - (CAH), or Skilled Nursing Facility (SNF)
  - Community mental health centers
  - Federally Qualified Health Centers (FQHCs)
  - Rural health clinics (RHCs)
  - Physicians' offices
  - Urgent care facilities
  - Ambulatory Surgery Centers (ASCs)
  - Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when
  - an ESRD facility is not available
  - Beneficiary's home
- CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:
  - D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
  - E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
  - H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
  - N - Alternative care site for SNF
  - P - Physician's office
  - R - Beneficiary's home

# Palmetto Issues Log

# Palmetto Claim Issues Log

| Issue | Status | Last Update |
|---|---|---|
| The SNF PDPM Pricing Is Still an Ongoing Issue *The PRICER is not counting days correctly causing the per diem to be off and claims to incorrectly pay.* | Open | 01/07/2021 |
| 2020 Vaccine Payment Rates Incorrect G0008, G0009 and G0010 | Resolved - Providers may bring to our attention any claims still in need of adjustment. | 01/06/2021 |
| Outpatient claims incorrectly RTP for 32402 (Revenue/HCPCS mismatch), 32403 (Invalid DOS), and 32404 (HCPCS code is missing from the claim or is not on file). | Resolved and released | 12/28/2020 |
| Inpatient claims with dates of service on or after October 1, 2020, RTPd in error - Reason Code 37001 | Resolved and released | 12/28/2020 |

# References

- Anesthesia

https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Anesthesia-Policy.pdf

- Pricing Transparency FAQ

https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf

- Pricing Transparency Final Rule

https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf

https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and

# References

- COVID-19
  - https://www.ama-assn.org/system/files/2020-11/cpt-assistant-guide-coronavirus-november-2020.pdf
  - https://www.ama-assn.org/system/files/2020-10/cpt-assistant-guide-coronavirus-october-2020.pdf
  - https://www.ama-assn.org/system/files/2020-09/cpt-assistant-guide-coronavirus-september-2020.pdf
  - https://www.ama-assn.org/system/files/2020-03/cpt-reporting-covid-19-testing.pdf
  - https://www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf
  - https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf?inf_contact_key=79530e2a4eea4f25d95665fd4500e31d680f8914173f9191b1c0223e68310bb1

# Questions