



News Flash - The April 2009 version of the *Medicare Disproportionate Share Hospital Fact Sheet* is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/2009_mdsh.pdf on the CMS website. This fact sheet provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005; number of beds in hospital determination; and Medicare DSH payment adjustment formulas.

MLN Matters Number: MM6080 **Revised**

Related Change Request (CR) #: 6080

Related CR Release Date: July 18, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1560CP

Implementation Date: July 7, 2008

July 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.2

Note: This article was revised on July 21, 2008, to reflect changes made to CR6080 on July 18, 2008. CR6080 was revised to reflect a legislative change that continues the cost-to-charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This required some adjustments to the table on pages 3-4 of this article. Also, the CR release date, transmittal number, and the Web address for accessing CR6080 were revised. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for outpatient services provided to Medicare beneficiaries.

Provider Action Needed

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

This article is based on Change Request (CR) 6080 which provides the Integrated OCE instructions and specifications for the July, 2008, I/OCE that will be used for processing Outpatient Prospective Payment System (OPPS) and Non-OPPS claims from hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

Background

Change Request (CR) 6080 informs providers and the Fiscal Intermediaries (FIs) and A/B MACs that the I/OCE is updated for July 1, 2008. The I/OCE routes all institutional outpatient claims (which includes non-OPPS through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

Claims with dates of service prior to July 1, 2007 are routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

CR 6080 provides the I/OCE instructions and specifications that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE instructions are attached to CR 6080 and will also be posted at <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the Centers for Medicare & Medicaid Services (CMS) website.

CR 6080 also includes as an attachment with detailed lists of the ambulatory payment classifications (APC), health care common procedure coding systems (HCPCS), and Current Procedural Terminology (CPT) code changes, additions, and deletions. We will not repeat all of those changes in this article. However, the key modifications of the OCE for the July 2008 release (V9.2) are summarized in the table below. In the table note that:

- Highlighted sections indicate change from the prior release of the software; and
- Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

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Effective Date	Edit	Summary of Change
7/1/08	24	Modify the software to maintain/retain 28 prior quarters (7 years) of programs & codes in each release. Remove older versions with each release. (The earliest version date included in the July 2008 release will be 4/1/01).
7/1/08	50	Change disposition for edit 50 to RTP (Return to Provider). Note: The IOCE change to RTP this claim will no longer trigger an initial determination. The provider should bill statutorily excluded services as noncovered and affix liability with the GY modifier (beneficiary liable).
4/1/01		Exclude denied or rejected lines from PHP (Partial Hospitalization Program) processing and from Daily Mental Health assignment criteria
		Make HCPCS/APC/SI changes as specified by CMS
	19, 20, 39, 40	Implement version 14.1 of the NCCI (National Correct Coding Initiative) file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
1/1/08	17	Remove codes 92621 and 92627 from the Inherently bilateral list – change bilateral indicator to '0'.
7/1/08	15	Change all max units to zero for all codes that currently have max unit values other than zero.
1/1/08	78	Update nuclear medicine/radiopharmaceutical edit requirements
7/1/08	71/77	Update procedure/device edit requirements
7/1/08	22	Add new modified CG (“Policy criteria applied”) to the valid modifier list.
		Documented some ‘general programming notes’ that were in effect but not previously documented
		Documented the exclusion of denied or reject lines from composite criteria
1/1/08	68	Implement mid-quarter NCD activation date for specified G codes and apply to G0398, G0399, and G0400 if Date of Service is before 3/13/08.
		Create a 508 Compliant version of the document (modify as necessary) – for publication on CMS website

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Additional Information

The official instruction, CR 6080, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1560CP.pdf> on the CMS website.

If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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