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Information for Medicare Fee-For-Service Health Care Professionals

News Flash - - A new MLN Matters provider education article is now available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0837.pdf* on the CMS website. This Special Edition article assists all providers who will be affected by Medicare Administrative Contractor (MAC) implementations. It provides information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. This article alerts providers as to what to expect and how to prepare for the MAC implementations and will help to minimize any disruption in your Medicare business.

MLN Matters Number: MM6315 | Related Change Request (CR) #: 6315
Related CR Release Date: January 9, 2009 | Effective Date: January 1, 2009
Related CR Transmittal #: R1664CP | Implementation Date: January 5, 2009

Note: This article was updated on December 17, 2012, to reflect current Web addresses. All other information remains unchanged.

January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) that are subject to the edits of the I/OCE.

Provider Action Needed

This article is based on Change Request (CR) 6315, which describes changes to the January 2009 update of the I/OCE. CR6315 provides the I/OCE instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, and for all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Be sure billing staffs are aware of these changes.

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Background

CR 6315 describes changes to billing instructions for various payment policies implemented the January 2009 update of the Integrated Outpatient Code Editor (I/OCE). Attached to CR 6315 are lengthy specifications for the I/OCE. The full CR6315 can be accessed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1664CP.pdf*, but a summary of the changes for January 2009 is within Appendix M of Attachment A of CR 6315 and that summary is captured in the following key points.

Key Points of CR 6315 Based on Appendix M of the I/OCE Specifications

Part 1 of Appendix M

1. Item 1 of Appendix M has no impact on providers. This is an I/OCE logic change that supports the policy covered in #6 below.
2. For CY 2009, Medicare replaced current status indicator "Q" with three new separate status indicators: "Q1," "Q2," and "Q3." Status indicator "Q1" is assigned to all "STVX-packaged codes;" status indicator "Q2" is assigned to all "T-packaged codes;" and status indicator "Q3"is assigned to all codes that may be paid through a composite Ambulatory Payment Classification (APC) based on composite-specific criteria or separately through single code APCs when the criteria are not met. The change to establish new status indicators "Q1," "Q2," and "Q3 facilitates the use of status indicator-driven logic in Medicare ratesetting calculations, and in hospital billing and accounting systems. For CY 2009, Medicare is using new payment status indicator "R" for all blood and blood product APCs. This new status indicator was created in order to facilitate implementation of the reduced market basket conversion factor that applies to payments to hospitals that are required to report quality data but fail to meet the established quality reporting standards. This reduced conversion factor applies to CY 2009 payment for blood and blood products. For CY 2009, Medicare created a new status indicator "U" to designate brachytherapy source APCs for which separate payment is made in CY 2009.
3. For CY 2009, Medicare is implementing a new edit for mental health HCPCS codes that are not payable outside the partial hospital program submitted on Hospital Outpatient TOBs without Condition Code 41. Claims that meet these criteria will be returned to the provider.
4. For CY 2009, Medicare is implementing a new OPPS edit for claims when code C9898 is billed with charges greater than $1.01. Claims that meet these criteria will be returned to the provider.

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5. For CY 2009, Medicare is implementing a new edit that results in a line item denial for services provided on or after the effective date of NCD non-coverage.

6. For CY2009, Medicare will pay for multiple imaging procedures performed during a single session using the same imaging modality by applying a composite APC payment methodology. The services will be paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The composite APC payment methodology for multiple imaging services utilizes three imaging families (Ultrasound, CT and CTA, and MRI and MRA) and results in the creation of five new composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) will be assigned.

7. For CY 2009, Medicare is creating two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which is being deleted for CY 2009. When a community mental health center (CMHC) or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital will be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital will be paid through APC 0173.

8. For CY 2009, Medicare will reduce payment only for procedure codes that map to the APCs on the list of APCs subject to the adjustment for devices furnished without cost or with a full or partial credit from the manufacturer that are reported with modifier –FB or –FC, and that are present on claims with specified device HCPCS codes.

9. For CY 2009, Medicare will include HCPCS code G0384 (Level 5 Hospital Type B ED Visit) in the criteria that determine eligibility for payment of composite APC 8003 (Level II Extended Assessment and Management). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. There is no limitation on

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diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (status indicator T) or the hours of observation care reported are less than 8.

10. For CY 2009, Medicare has updated the list of codes approved for the partial hospitalization program.
11. No impact on providers.
12. With the APC split for PHP, the payment rate for the Daily Mental Health cap (APC 34) will be set to equal the payment rate for the Level II PHP APC (APC 173).
13. To solve the issue of processing differences between date of discharge (inpatient) and "from" date of service (outpatient), TOB 12x was added to the bypass for diagnosis edits (1-5) if claim From date is <10/1/xx and Through date is >= 10/1/xx.
14. NCCI edits are updated quarterly and the institutional version is one calendar quarter behind the physician version. In the past, the Outpatient Code Editor (OCE) had not applied the NCCI edits for the following categories of services: anesthesiology, evaluation and management, and mental health services. For CY 2009, Medicare has determined that these categorical exclusions will no longer apply. As a result, a large number of new institutional NCCI edits will be applied to claims effective January 1, 2009 to take into account the edits that were previously excluded. Providers are encouraged to begin to educate their staff about the application of the additional categories of NCCI edits to their claims.
15. For CY 2009, Medicare has determined that deductible is not applicable to HCPCS codes G0402 and Q0091.
16. No impact on providers.
17. For CY 2009, Medicare has determined that current procedural terminology (CPT) code 0183T, Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day, is newly designated as a "sometimes therapy" wound care service. In CY 2009, hospitals will receive separate payment under the OPPS when they bill for wound care services described by CPT code 0183T that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, "GP" for physical therapy, "GO" for occupational therapy, and "GN" for speech language pathology) or report their charges under a therapy revenue code

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(that is, revenue codes in the 042x, 043x, or 044x series), or both, to receive payment under the Medicare Physician Fee Schedule (MPFS).

18. No impact on providers.
19. For OPPS CY 2009, Medicare will package code G0177 into the Mental Health composite (APC 34), if present, but it will not contribute to the Mental Health cap.

Part 2 of Appendix M

1. HCPCS/APC/SI changes were made to various codes per legislation and review as specified by CMS.
2. See 14 above.
3. In July 2007, the CPT Editorial Panel released two vaccine codes on the American Medical Association Web site, specifically CPT codes 90681 and 90696 that were implemented in January 2008. Although the vaccines associated with these codes were not approved by the Food and Drug Administration (FDA) until April 3, 2008 (for CPT code 90681) and June 24, 2008 (for CPT code 90696), and Medicare did not assign the codes to separate APCs under the OPPS until the January 2009 update, their payments are retroactive to the FDA approval dates.. Items that are reported using these HCPCS codes with dates of service prior to the date of the FDA approval will be rejected.
4. See preceding item.
5. Medicare will implement a mid-quarter non-coverage date for codes 0062T, 0063T, 2526, and 22527.
6. Medicare has removed code J1051 from the list of procedures for “Females Only."

7-21. These items are documentation changes for the I/OCE and are N/A.

Additional Information

If you have questions, please contact your Medicare MAC, RHHI, or FI at their toll-free number which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

The official instruction (CR6315) issued to your Medicare MAC, RHHI, or FI is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1664CP.pdf on the CMS website.

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