



News Flash – A new MLN Matters article (MM6740) has been released on the subject of Revisions to Consultation Services Payment Policy. This article alerts physicians and non-physician practitioners that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, physicians and non-physician practitioners should code a patient evaluation and management visit with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. For more information, please view the article located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf> on the CMS website.

MLN Matters® Number: MM6761

Related Change Request (CR) #: 6761

Related CR Release Date: December 11, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1872

Implementation Date: January 4, 2010

January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0

Provider Types Affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the Home Health Prospective Payment System, or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider Action Needed

This article is based on Change Request (CR) 6761, which describes changes to the I/OCE and OPPS to be implemented in the January 2010 OPPS and I/OCE updates. Be sure billing staffs are aware of these changes.

Disclaimer

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Background

CR 6761 describes changes to billing instructions for various payment policies implemented in the January 2010 OPPS update. The January 2010 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR 6761. Attached to CR 6761 are lengthy specifications for the I/OCE. A summary of the changes for January 2010 is within Appendix M of Attachment A of CR 6761 and that summary is captured in the following key points:

- For CY 2010, Medicare is modifying edit 74 for TOB 85x to apply edit 74 to conditional or independently bilateral codes (indicator 1 or 3) with modifier 50 and more than one unit of service on the same or multiple lines on the same day, with the same revenue code. Medicare will exclude any bilateral lines with any other modifier present. This applies to bill type 85x with revenue code 96x, 97x or 98x.
- For CY 2010, Medicare will bypass diagnosis edits (1-5) for bill types 322 and 332 if the FROM date is on/after 9/26 and on/before 9/30.
- Effective August 3, 2009, Medicare will apply a mid-quarter National coverage Determination (NCD) date for code G9143.
- Effective September 1, 2009, Medicare will apply a mid-quarter approval date for codes G9141 and G9142.
- Effective September 28, 2009, Medicare will add new code 90470 retroactively.
- Effective September 28, 2009, Medicare will apply a mid-quarter NCD approval date for codes 75558, 75560, 75562, and 75564.
- For CY 2010, Medicare will:
 - Add code 92520 to the 'Sometimes Therapy' list and logic;
 - Update composite Ambulatory Payment Classification (APC) requirements (add/delete codes as specified in the Preliminary Summary of Data Changes document attached to CR6761);
 - Change the Status Indicator (SI) for 'blank' revenue code 657, from 'M' to 'A', when submitted on bill types 81x and 82x;
 - Make Healthcare Common Procedure Coding System (HCPCS) /APC/SI changes as specified by the Centers for Medicare & Medicaid Services (CMS) in the Preliminary Summary of Data Changes attached to CR 6751;

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- Implement version 15.3 of the National Correct Coding Initiative (as modified for hospitals/OPPS);
- Add new modifiers as specified In CR 6751;
- Update procedure/device and device/procedure edit requirements;
- Update FB/FC device reduction amounts and crosswalk;
- Make SI assignment changes for blank revenue codes as specified by CR 6751;
- Revise the description for Payment Method Flag #1 as follows -
From: “Based on OPSS coverage or billing rules, the service is not paid”
To: “Service not paid based on coverage or billing rules”;
- Change descriptive references for code G0379 from ‘Direct admission...’ to ‘Direct referral...’; and
- Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS website.

Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR6761) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1872CP.pdf> on the CMS website.

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