



News Flash – The Centers for Medicare & Medicaid Services (CMS) has launched the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) and is waiting to hear from you. This survey offers Medicare Fee-For-Service (FFS) providers and suppliers an opportunity to provide feedback on interactions with their Medicare contractors. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate will be notified starting in January. If selected to participate, please complete this important survey. To learn more about the MCPSS, please visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCPSS/index.html> on the CMS website.

MLN Matters® Number: MM7252

Related Change Request (CR) #: 7252

Related CR Release Date: December 17, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2114CP

Implementation Date: January 3, 2011

January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0

Note: This article was updated on September 4, 2012, to reflect current Web addresses. All other content remains the same.

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), outpatient claims from any non-OPPS provider not paid under the OPPS, 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.

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Provider Action Needed

This article is based on Change Request (CR) 7252, which describes changes to the I/OCE and OPSS to be implemented in the January 2011 OPSS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR7252 describes changes to billing instructions for various payment policies implemented in the January 2011 OPSS update. The January 2011 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR7252.

Note: The full list of I/OCE specifications can now be found at <http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.

A summary of the changes for January 2011 is within Appendix M of Attachment A of CR7252 and that summary is captured in the following key points:

- Effective April 20, 2010, Medicare will add a new Gulf oil spill-related modifier 'CS' to the valid modifier list. Edit 22 is affected.
- Effective August 25, 2010, Medicare will change the mid-quarter National Coverage Determination approval date for codes C9801 and C9802 from August 26, 2010, to August 25, 2010. Edit 68 is affected.
- Effective January 1, 2011, Medicare will:
 - Modify the Partial Hospitalization Program (PHP) logic to assign separate/different PHP Ambulatory Payment Classification (APC), Level I and Level II, for hospital-based (bill type 13x with cc 41) and Community Mental Health Center (CMHC) (bill type 76x) PHPs (Appendix C of CR7252);
 - Modify the mental health logic to cap the payment rate for APC 34 at the rate for new APC 176;
 - For a specified group of ancillary services codes, change the Q[#] Status Indicator (SI) to 'N' if present on the same date of service as 99291 (critical care); otherwise, change the Q[#] SI to the standard SI and APC for the specified code. Exception: If modifier 59 is present on any line with the same date of service as 99291, Medicare will not package the specified ancillary codes, and will assign the standard SI and APC instead;
 - Extend the use of modifier FB to nuclear medicine procedures when the associated diagnostic radiopharmaceutical is obtained at no cost

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- to the provider – Assign Payment Adjustment Flag #7 to any Nuclear Medicine procedure code from a specified list if submitted with modifier 'FB' appended;
- Make HCPCS/APC/SI changes (data change files) as defined in the appendixes to CR7252;
 - Add new modifiers AY, AZ, DA, GU, NB, and PT to the valid modifier list;
 - Update composite APC requirements (add/delete codes as specified in the appendixes to CR7252);
 - Update procedure/device and device/procedure edit requirements;
 - Implement version 16.3 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers). Edits 19, 20, 39, and 40 are affected; and
 - Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS website.

Additional Information

The official instruction, CR7252 issued to your Medicare MAC, RHHI or FI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2114CP.pdf> on the CMS website.

If you have any 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 CMS website.

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