Compliance Matters

A Healthcare Compliance Newsletter

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ICD-10 Testing Opportunities for Medicare Providers

On July 31, HHS issued a rule (CMS-0043-F) finalizing October 1, 2015 as the new compliance date for health care providers and health plans to transition to ICD-10. ICD-10 represents a significant code set change that impacts the entire health care community.

CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS, as well as the Medicare Fee-For-Service (FFS) provider community, is ready:

- CMS internal testing of its claims processing systems
- CMS Beta testing tools available for download
- Acknowledgement testing
- End-to-end testing

For more information, see MLN Matters® Special Edition Article #SE1409, "Medicare FFS ICD-10 Testing Approach."

Acknowledgement Testing

This past March, CMS conducted a successful ICD-10 acknowledgement testing week. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015 implementation date.

In addition, special acknowledgement testing weeks in November, March, and June of 2015 will give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events. Contact your Medicare Administrative Contractor (MAC) for more information about acknowledgment testing.

End-to-End Testing Volunteers Being Sought January 26-30, 2015

During the week of January 26 through 30, 2015, a sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The goal of end-to-end testing is to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare Fee-For Service (FFS) claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate Remittance Advices are produced

Approximately 850 volunteer submitters will be selected to participate in the January end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers.

To volunteer as a testing submitter:

- Volunteer forms are available on your MAC website
- MACS will review applications and select the group of testing submitters

By October 24, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing

Additional opportunities for end-to-end testing will be available in 2015. Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

For more information:

MLN Matters® Special Edition Article #SE1409, "Medicare FFS ICD-10 Testing Approach"

Successful Results from CMS ICD-10 Acknowledgement Testing Week

This past March, the Centers for Medicare & Medicaid Services (CMS) conducted a successful ICD-10 testing week. Testers submitted more than 127,000 claims with ICD-10 codes to the Medicare Fee-for-service (FFS) claims systems and received electronic acknowledgements confirming that their claims were accepted.

Approximately 2,600 participating providers, suppliers, billing companies and clearinghouses participated in the testing week, representing about five percent of all submitters. Clearinghouses, which submit claims on behalf of providers, were the largest group of testers, submitting 50 percent of all test claims. Other testers included large and small physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers, and ambulance providers.

Nationally, CMS accepted 89 percent of the test claims, with some regions reporting acceptance rates as high as 99 percent. The normal FFS Medicare claims acceptance rates average 95-98 percent. Testing did not identify any issues with the Medicare FFS claims systems.

This testing week allowed an opportunity for testers and CMS alike to learn valuable lessons about ICD-10 claims processing. In many cases, testers intentionally included such errors in their claims to make sure that the claim would be rejected, a process often referred to as negative testing. To be processed correctly, all claims must have a valid diagnosis code that matches the date of service and a valid national provider identifier. Additionally, the claims using ICD-10 had to have an ICD-10 companion qualifier code and the claims using ICD-9 had to use the ICD-9 qualifier code. Claims that did not meet these requirements were rejected.

HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the anticipated October 1, 2015 implementation date. Submitters should contact their local Medicare Administrative Contractor (MAC) for more information about acknowledgment testing. However, those who submit claims may want to delay acknowledgement testing until after October 6, 2014, when Medicare updates its systems.

CMS will be conducting end-to-end testing in 2015. Details about this testing will be released soon.

Link: http://www.cms.gov/eHealth/ListServ_ICD10AckTestWeek.html

Ebola Virus: ICD-9-CM and ICD-10-CM

The rapid spread of the Ebola virus in west Africa has raised questions about how we track this disease so we reviewed the current and future coding and identification of this serious virus that has been dominating the headlines.

The Ebola virus causes an acute, serious illness which is often fatal if untreated. Ebola virus disease (EVD) first appeared in 1976 in 2 simultaneous outbreaks, one in Nzara, Sudan, and the other in Yambuku, Democratic Republic of Congo. The latter occurred in a village near the Ebola River, from which the disease takes its name.

The current outbreak in west Africa, (first cases notified in March 2014), is the largest and most complex Ebola outbreak since the Ebola virus was first discovered in 1976. There have been more cases and deaths in this outbreak than all others combined. It has also spread between countries starting in Guinea then spreading across land borders to Sierra Leone and Liberia, by air (1 traveler only) to Nigeria, and by land (1 traveler) to Senegal.

It is thought that fruit bats of the Pteropodidae family are natural Ebola virus hosts. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as

chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest.

First symptoms are the sudden onset of fever fatigue, muscle pain, headache and sore throat. This is followed by vomiting, diarrhea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (e.g. oozing from the gums, blood in the stools). Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes.

The Centers for Disease Control, (CDC) helps countries track the epidemic, including using real-time data to improve real-time response (e.g., identifying the epicenter and tracking the response).

Per the CDC, no cases have been reported in the United States.

In ICD-9-CM, using the Index to Diseases and Injuries, using Fever, hemorrhagic or Infection Virus leads to find 065.8 other specified arthropod-borne hemorrhagic fever This ICD-9-CM code is not specific for the Ebola virus.

With its increased specificity, the ICD-10-CM Index to Diseases and Injuries, a unique listing for Ebola virus disease is present, A98.4, Ebola virus disease

The new Compliance Date of 10/1/2015 allows each of us more time to review, investigate and practice ICD-10.

New Modifiers Effective January 1, 2015 for Distinct Procedural Services

The Centers for Medicare and Medicaid Services (CMS) is establishing four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service” effective January 1, 2015.

Currently, providers can use the -59 modifier to indicate that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled. Because it can be so broadly applied, some providers incorrectly consider it to be the “modifier to use to bypass National Correct Coding Initiative (NCCI)”, it is the most widely used modifier.

It is also associated with considerable abuse and high levels of manual audit activity, leading to reviews, appeals and even civil fraud and abuse cases. CMS is concerned by this pattern of abuse because such behavior siphons off funds that should be available to legitimate and compliant providers and additionally unnecessarily increases beneficiary costs.

The primary issue associated with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as a use to identify different encounters, different anatomic sites, and distinct services. Usage to identify a separate encounter is infrequent and usually correct; usage to define a separate anatomic site is less common and problematic; usage to define a distinct service is common and not infrequently overrides the edit in the exact circumstance for which CMS created the edit in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

These modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of the -59 modifier. CMS will not stop recognizing the -59

modifier but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. CMS will continue to recognize the -59 modifier in many instances but may selectively require a more specific -X{EPSU} modifier for billing certain codes at high risk for incorrect billing.

For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers. The -X{EPSU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line

As a default, at this time CMS will initially accept either a -59 modifier or a more selective - X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, these modifiers are valid modifiers even before national edits are in place, so contractors are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier when necessitated by local program integrity and compliance needs.

Read the entire Transmittal here: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

HHS Launches Challenge to Improve Hypertension through Health IT

ONC and Million Hearts challenge looks to develop new clinical decision support tools

In an effort to help clinical practices use health information technology (health IT) like electronic health records (EHRs) to reduce high blood pressure, the Department of Health and Human Services (HHS) today launched a new challenge asking health care professionals and other caregivers to submit the tools they use to improve patient care.

The EHR Innovations for Improving Hypertension Challenge, launched by the Office of the National Coordinator for Health IT (ONC), is part of Million Hearts®, a national initiative to prevent 1 million heart attacks and strokes by 2017. Co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services, Million Hearts brings together communities, health systems, nonprofit organizations, federal agencies including ONC, and private-sector partners from across the country to fight heart disease and stroke.

> "Heart disease and stroke are two of the leading causes of death in the U.S. and there are many health-care providers who employ clinical decision support tools, like standardized treatment approaches or protocols to control hypertension among their patients. This challenge helps us find the best examples of those efforts and scale them up," said **Karen DeSalvo**, MD, MPH, national coordinator for health information technology.

Evidence-based treatment protocols provide a playbook for providers to guide their selection of effective therapies for blood pressure control, contributing to better health, better health care and lower costs for patients. The deadline for submissions is October 6 and winners will be announced on October 28.

> "We are excited that with this challenge we will be able to share the best practices that many physicians and their teams are using to help patients improve their blood pressure and reduce their risk of heart attack and stroke," said **Janet Wright**, MD, executive director of Million Hearts. "Our goal of preventing a million heart attacks and strokes in five years can happen by helping at least 10 million more hypertensive patients achieve safe and swift control. The new challenge is designed to help patients and their care teams use health IT tools to protect and improve their cardiovascular health"

Million Hearts encourages clinicians across the country to improve the quality of care through the ABCS - Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation. ONC is at the forefront of Million Hearts by identifying how providers and practices can leverage health IT to prevent heart disease and stroke.

New CMS Rule Allows Flexibility in Certified EHR Technology for 2014

The Department of Health and Human Services (HHS) published a final rule 8/29/14 that allows health care providers more flexibility in how they use certified electronic health record (EHR) technology (CEHRT) to meet meaningful use for an EHR Incentive Program reporting period for 2014. By providing this flexibility, more providers will be able to participate and meet important meaningful use objectives like drug interaction and drug allergy checks, providing clinical summaries to patients, electronic prescribing, reporting on key public health data and reporting on quality measures.

> "We listened to stakeholder feedback and provided CEHRT flexibility for 2014 to help ensure providers can continue to participate in the EHR Incentive Programs forward," said **Marilyn Tavenner**, CMS administrator. "We were excited to see that there is overwhelming support for this change."

Based on public comments and feedback from stakeholders, the Centers for Medicare & Medicaid Services (CMS) identified ways to help eligible professionals, eligible hospitals, and critical access hospitals (CAHs) implement and meaningfully use Certified EHR Technology. Specifically, eligible providers can use the 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT for an EHR reporting period in 2014 for the Medicare and Medicaid EHR Incentive Programs; All eligible professionals, eligible hospitals, and CAHs are required to use the 2014 Edition CEHRT in 2015.

These updates to the EHR Incentive Programs support HHS' commitment to implementing an effective health information technology infrastructure that elevates patient-centered care, improves health outcomes, and supports the providers that care for patients.

The rule also finalizes the extension of Stage 2 through 2016 for certain providers and announces the Stage 3 timeline, which will begin in 2017 for providers who first became meaningful EHR users in 2011 or 2012.

For more information about the EHR Incentive Programs, please visit: http://www.cms.gov/EHRIncentivePrograms

Correct Billing of Aprepitant (J8501)

According to the Centers for Medicare & Medicaid Services' (CMS') national coverage determination (NCD) 110.18 (Aprepitant for chemotherapy-induced emesis), Medicare covers the use of the oral three-drug regimen of Aprepitant (Emend®), a 5-HT3 antagonist, and dexamethasone for patients receiving certain highly emetogenic chemotherapy agents in the treatment of reducing chemotherapy-induced emesis. On May 29, 2013, CMS revised the NCD to extend coverage for highly and moderately emetogenic chemotherapy.

Per the CMS, Internet-only manual (IOM), Medicare National Coverage Determination (NCD)Manual (Publication 100-03, Chapter 1, 110.18), CMS defines highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCNN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC).

The defined patient population for which the use of oral anti-emetic three drug combination was determined to be reasonable and necessary is for patients who received one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine (J9050)
- Cisplatin (J9060)
- Cyclophosphamide (J8530, J9070)
- Dacarbazine (J9130)
- Mechlorethamine (J9230)
- Streptozocin (J9320)
- Doxorubicin (J9000, Q2049)
- Epirubicin (J9178)
- Lomustine (J8999)

The following drugs are effective for dates of service on or after May 29, 2013:

- Alemtuzumab (J9010)
- Azacitidine (J9025)
- Bendamustine (J9033)
- Carboplatin (J9045)
- Clofarabine (J9027)
- Cytarabine (J9098, J9100)
- Daunorubicin (J9150, J9151)
- Idarubicin (J9211)
- Ifosfamide (J9208)
- Irinotecan (J9206)
- Oxaliplatin (J9263)
- Dactinomycin (J9120) (added; identified by at least two of the three guidelines as a highly emetogenic chemotherapy agent).

Billing Requirements

Services must be bill using Healthcare Common Procedure Coding System (HCPCS) code J8501 (Aprepitant , oral, 5 mg) with the appropriate cancer diagnosis. Providers submitting claims to Medicare fiscal intermediaries (FIs) must bill HCPCS J8501 with revenue code 0636 (drugs requiring detailed coding).

Effective for claims with dates of service on or after May 29, 2013, Medicare administrative contractors (MACs) will deny lines for oral Aprepitant if an encounter for antineoplastic chemotherapy (ICD-9 V58.11 or ICD-10 Z51.11) is not present.

If Aprepitant denies on a claim, the 5HT3 and dexamethasone will also deny. Effective July 7, 2014, an audit was implemented to suspend claims for medical review when Aprepitant (J8501) is billed without a 5HT3 antagonist (HCPCS codes Q0162, Q0166, or Q0180); and dexamethasone (HCPCS J8540) on the same claim.

In the case where a patient already has the oral agents at home, the provider must include a supporting statement to that fact.

MUE Program Modification Effective January 1, 2015

The Centers for Medicare & Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim.

On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. At that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is newly assigning a MAI to each HCPCS code. Contractors shall apply MUEs to either claim lines or date of service, based on the MUE adjudication indicator (MAI) for that particular code, on or after the beginning effective date of an edit and before or on the ending effective date.

For HCPCS codes with confidential MUEs (i.e., Publication Indicator = 0), the MAI levels may not be published or shared with anyone outside of your organization. All other MAIs for non-confidential MUEs can be published or shared.

The CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

MUEs for HCPCS codes with a MAI of “1”

- MUEs for HCPCS codes with a MAI of “1” will continue to be adjudicated as a claim line edit.

Providers can use modifiers to override this edit by moving excess units to another line. They can also appeal excess units if there is no applicable modifier or if they are providing more than the modifier lines will allow.

MUEs for HCPCS codes with a MAI of “2”

- MUEs for HCPCS codes with a MAI of “2” are absolute date of service edit. These are “per day edits based on policy”. UOS on the same date of service (DOS) in excess of the MUE

value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance.

The MAI of "2" edit sums not only all units on the claim, but also all units in other claims processed for that date of service to prevent providers from overriding the edit by simply submitting multiple claims. The date of service edits with an MAI of 2 may not be overridden by the contractor in initial determinations. Higher level contractors can override this "sub-regulatory" guidance and approve higher units in limited cases and the processing contractor can override the edit if directed to do so by these contractors..

MUEs for HCPCS codes with a MAI of "3"

- MUEs for HCPCS codes with a MAI of "3" are date of service edits. These are "per day edits based on clinical benchmarks".

If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal

Therefore, contractors can override date of service MAIs of 3 if presented with documentation showing the units were provided and reasonable and necessary

Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, contractors are not expected to identify claims but should reopen impacted claims that are brought to their attention. Since MUEs are auto-deny edits, denials may be appealed

A denial of services due to an MUE is a coding denial, not a medical necessity denial.

The presence of an ABN shall not shift liability to the beneficiary for UOS (units of services) denied based on an MUE.

Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.

Read the One-Time Notification effective 1/1/2015 here: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.pdf

New Waived Tests

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. Change Request (CR) 8805, from which this article is taken, informs carriers and MACs about the latest new CPT codes that are subject to CLIA edits.

Make sure that your billing staffs are aware of these CLIA-related changes for 2014 and that you remain current with certification requirements.

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR8301 (i.e., CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are as follows:

- G0434QW, September 6, 2013, BTNX Inc. Rapid Response Multi-Drug Urine Test Cup;
- G0434QW, September 6, 2013, BTNX Inc. Rapid Response Multi-Drug Urine Test Panel;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. CR2 Multi-Drug Urine Test Cup;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. CR3 Multi-Drug Urine Test Cup;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. SMARTOX U3 Multi-Drug Urine Test Cup;
- G0434QW, October 24, 2013, American Institute of Toxicology, Inc., AIT Laboratories Drug of Abuse Cup;
- 80061QW, 82962, 82465QW, 83718QW, 84478QW, November 12, 2013, Jant Pharmacal LipidPlus Lipid Profile and Glucose Measuring System (LipidPlus Lipid Profile test strips);
- G0434QW, December 4, 2013, Nobel Medical Inc. INSTA-SCREEN Multi-Drug Urine Test Cup;
- G0434QW, December 5, 2013, Micro Distributing II, LTD One Step Multi-Drug Urine Test Panel;
- G0434QW, February 11, 2014, Alfa Scientific Designs, Inc. Confidential Drug Test – Multi Drugs of Abuse Urine Test (OTC);
- 87880QW, February 18, 2014, BD Veritor System for Rapid Detection of Group A Strep (direct from throat swab);
- 85018QW, February 18, 2014, Clarity HbCheck Hemoglobin Testing System;
- 87077QW, February 18, 2014, Jant Accutest Rapid Urease test (H. pylori detection);
- G0434QW, March 13, 2014, UCP Biosciences, Inc. UCP Multi-Drug Test Key Cups;
- 83986QW, March 18, 2014, RightBio Metrics, RightSpot Infant pH Indicator;
- 83986QW, March 18, 2014, RightBio Metrics, RightSpot pH Detector;
- 83986QW, March 18, 2014, RightBio Metrics, RightSpot pH Indicator;
- 85018QW, March 21,2014, AimStrip Hb Hemoglobin (Hb) Testing System;
- G0434QW, April 11, 2014, PTox Drug Screen Cup {Cassette Dip Card format};
- 86308QW, April 22, 2014, Polymedco Polystat Mono {whole blood};
- 82274QW, G0328QW, April 22, 2014, Rapid Response(TM) FIT-Fecal Immunochemical Test;
- 84443QW, May 16, 2014, Germaine Laboratories, Inc. AimStep Thyroid Screen {whole blood};
- 82055QW, May 21, 2014, Express Diagnostics International, Incorporated Saliva Alcohol Test;
- 83037QW, May 22, 2014, BIO-RAD in2it (II) System Analyzer Prescription Home Use; and
- 87880QW, May 23, 2014, Accustrip Strep A {Specimen type (Throat Swab)}.

You should be aware that your MAC will not search their files, to either retract payment or retroactively pay claims; however, they should adjust such claims that you bring to their attention.

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare Carrier or A/B MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

The official instruction, CR8805 issued to your Medicare Contractor regarding this change may be viewed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2988CP.pdf

Screening for Hepatitis C Virus (HCV) in Adults

Change Request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for hepatitis C virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B.

1. Adults at high risk for HCV infection. "High risk" is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

General Claims Processing Requirements for Claims with Dates of Service on and After June 2, 2014:

New G code G0472, short descriptor - Hep screen high risk/other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used.

1. Beneficiary coinsurance and deductibles do not apply to code G0472.
2. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:

HCPCS G0472

3. For those determined to be high-risk initially, claims must be submitted with:
   - HCPCS G0472
   - ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)
4. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
   - HCPCS G0472,
   - ICD diagnosis code V69.8, and ICD diagnosis code 304.91, unspecified drug dependence, continuous

CMS Publishes Final Regulation/National Coverage Determination for Cardiac Rehabilitation for Heart Failure

On July 18, 2014, CMS published a National Coverage Determination (NCD) and accompanying instructions regarding cardiac rehabilitation (CR) for heart failure (HF) patients.

As the final Medicare policy states, coverage of cardiac rehabilitation for beneficiaries with stable, chronic heart failure was effective for dates of service on and after February 18, 2014.

The implementation date was August 18, 2014. This means that all Medicare contractors (known as MACs or Medicare Administrative Contractors)

must have completed changes to their claims processing software so that appropriate heart failure diagnoses (ICD-9 codes) are not denied. For CR programs that received denials for CR services provided to heart failure patients as of February 18th or later, re-submission after August 18th will most likely be necessary for reimbursement. Please work with your billing departments to be sure inappropriate denials are tracked and corrected.

Medicare now covers CR services to patients with stable, chronic heart failure defined as:

1. Patients with left ventricular ejection fraction of 35% or less, and
2. NYHA class II-IV symptoms despite being on optimal heart failure therapy for at least 6 weeks.

Some CR programs have been enrolling HF patients in CR since the effective date with successful Medicare reimbursement using diagnosis (ICD-9) code 428.22 (chronic systolic heartfailure). Each MAC has the authority to and may (or may not) identify acceptable ICD-9 codes. Again, you are advised to work with your billing dept. to find the most descriptive and appropriate ICD-9 code for each patient, given that patient's clinical diagnosis. It would be best practice to utilize the patient's medical record/Plan of Care to clearly document all the elements/conditions that qualify this patient for CR.

For more information, please read below:

CMS NCD for Cardiac Rehabilitation Programs (20.10.1): http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=359&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

Transmittal 2989, CR8758, July 18,2014 Cardiac Rehabilitaion for Chronic Heart Failure: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2989CP.pdf

Medlearn Matters ® 8758, Revised, Cardiac Rehabilitation for Chronic Heart Failure: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8758.pdf

What is an HPID (Health Plan IDentifier)?

Currently, health plans and other entities that perform health plan functions, such as third-party administrators (TPAs) and clearinghouses, are identified in transactions using multiple identifiers. The identifiers differ in length and format— some are alphanumeric and five characters while others are only numeric and nine digits. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) introduced the health plan identifier (HPID). The HPID creates a standard data element for health plans. The intent of the HPID is to simplify the routing, review and payment of electronic transactions and reduce errors and manual intervention.

The final rule, published Sept. 5, 2012, adopted a 10-digit HPID for health plans to use in electronic HIPAA transactions. HIPAA transactions include: medical and dental claims and encounters, payment and remittance advice, claims status request and response, eligibility and benefit inquiry and response, benefit enrollment and disenrollment, referrals and authorizations, and premium payment.

Certain health plans are required to have an HPID by Nov. 5, 2014. Health plans apply for an HPID through the Centers for Medicare and Medicaid Services (CMS).

Who needs to obtain an HPID?

Under the final rule, a self-funded customer needs to obtain its own HPID if it meetsthe definition of a controlling health plan (CHP). A controlling health plan is a health plan that:

1. Controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan and
2. If it has a sub-health plan(s) (SHP), exercises sufficient control over the sub-health plan(s) to direct its/their business activities, actions, or policies.

The proposed format of the HPID is a 10-digit, all-numeric identifier with a Luhn check-digit as the tenth digit.

Health plans, including self-funded plans, will either be a controlling health plan (CHP) or a sub-health plan. A controlling health plan is required to obtain an HPID, regardless of whether or not it is identified in covered transactions. A sub-health plan is not required to obtain an HPID, unless it is identified in covered transactions. Self-funded customers should consult their legal counsel if they have questions about whether or not they might be a controlling health plan or sub-health plan.

Under the final rule, only controlling health plans or sub-health plans can obtain their HPID. TPAs cannot obtain an HPID for self-funded health plans.

Fully insured customers are not required to obtain health plan for their standalone fully insured medical plans.

Health plans must have an HPID by Nov. 5, 2014. Small health plans, with annual receipts of $5 million or less, have until Nov. 5, 2015, to obtain their HPID.

All covered entities are required to use HPIDs in HIPAA-covered transactions when identifying a health plan in the transaction by Nov 7, 2016.

Number and Type of Entities That May Obtain an HPID or OEID	
Type of Entity	**Number of Entities**
Self insured group health plans	* 12,000
Health insurance issuers, individuals and group health markets, HMOs, including companies offering Medicaid managed care	** 1,827
Medicare, Veterans Health Administration (VHA), Indian Health Service (IHS), TRICARE, and State Medicaid programs	60
Clearinghouses and Transaction Vendors	*** 162
Third Party Administrators	**** 750
Total	~15,000
* "Report to Congress: Annual Report on Self-Insured Group Health Plans," by Hilda L. Solis, Secretary of Labor, March 2011.	
** "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 2011 Federal Register (Vol. 76), July, 2011," referencing data from www.healthcare.gov.	
*** Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf, based on a study by Gartner.	
**** Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf.	

Read the CMS Final Rule here: http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf

The HPID User Manual can be reviewed here: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HIOSHPOESUserManual0401012014.pdf

Fingerprint Based Background Checks

The Centers for Medicare & Medicaid Services (CMS) awarded the Fingerprint-based Background Check contract to Accurate Biometrics located in Chicago, Illinois on July 8, 2014. Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the "high" screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare.

Source: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1427.pdf

Two-Midnight Rule Review (CMS-1599-F)

On April 1, 2014, The President signed the Protecting Access to Medicare Act of 2014. Section 111 of this law, prohibiting CMS from allowing the Recovery Auditors to conduct inpatient hospital status reviews for "two-midnight" rule criteria on claims with dates of admission beginning October 1, 2013 through March 31, 2015. The introduction of Senate bill 2082 (Two-Midnight Coordination and Improvement Act of 2014) also suggests that more changes may be in store for this rule.

At present, CMS will conduct prepayment patient status probe reviews for dates of admission on or after October 1, 2013 but before March 31, 2015. In these reviews the MACs will select 10-25 claims, investigating the supporting documentation for the two-midnight rule. Based on the results of these initial reviews, MACs will conduct educational outreach efforts and repeat the process where necessary

In general, CMS will not conduct post-payment patient status reviews for claims with dates of admission October 1, 2013 through March 31, 2015.

Determining Patient Status Upon Admission: Overview

1. Reasonable 2 Midnight stay required for hospital care = Inpatient
2. Anticipate less than 2 midnight stay for hospital care = Observation (unless inpatient only procedure, which is appropriate for inpatient admission)

3. Unknown if will be at least 2 midnight stay =Observation (Change to inpatient if later determined to require a 2nd midnight)

Time Clock for 2 Midnight Rule

Includes	Does Not Include
Care in ED during the same encounter	Time in a waiting room or in triage
Observation time in the hospital	Time in ambulance
Time spent at a transferring facility	Delays in provision of care for convenience or other non-medically reasonable factor
Time spent in the OR	Care rendered for social reasons

Remember that while the total time in the hospital may be taken into consideration when the physician is making an admission decision, the inpatient admission does not begin until the inpatient order and formal admission occur.

For Observation Services, the Benefit Policy Manual states "Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services exceed 48 hours."

For more information and examples from CMS, refer to the Medicare Learning Network examples and presentation about the "Two-Midnight Rule" at the link below: http://www.cms.gov/outreach-and-education/outreach/NPC/National-Provider-Calls-and-events-Items/2014-01-14-midnight.html

Medicare Fee-For Service Claims Processing Guidelines for Implementing ICD-10

On October 1, 2015, all Medicare claims submissions of diagnosis and hospital inpatient procedure coding will change from the International Classification of Diseases, 9th Edition (ICD-9) to the 10th Edition (ICD-10). All entities covered by HIPAA must make the transition including systems changes throughout the entire health care industry.

For dates of service on and after October 1, 2015, entities covered under HIPAA are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after the compliance date. The following provides information on reporting guidelines, claims submissions and date span requirements for ICD-10.

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to CMS ICD10 WebSite for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCS) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

Claims Submissions

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service or dates of discharge/THROUGH dates on institutional claims and on professional and supplier claims on or after October 1, 2015. A claim cannot contain both ICD-9 codes and ICD-10 codes. Institutional claims will be returned to provider (RTP). Professional and Supplier claims will be returned as unprocessable.

Claims that Span the ICD-10 Implementation Date

CMS has identified potential claims processing issues for institutional, professional and supplier claims that could span the implementation date; that is where ICD-9 codes are effective for services on September 30, 2015 and earlier and ICD-10 codes effective for services October 1, 2015 and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 codes set must be used effective October 1, 2015.

Table A – Institutional Providers Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Table A – Institutional Providers Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Table A – Institutional Providers Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Table A – Institutional Providers Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
82X	Hospice – Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances / Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH
Table C – Professional Claims / Type of Claim	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
All anesthesia claims	Anesthesia procedures that begin on 9/30/15 but end on 10/1/15 are to be billed with ICD-9 diagnosis codes and use 9/30/15 as both the FROM and THROUGH date.	FROM
Table D –Supplier Claims / Supplier Type	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/15 (i.e., the FROM date of service occurs prior to 10/1/15 and the TO date of service occurs after 10/1/15).	FROM

The Compliance Matters Team

Theresa Marshall
Managing Editor
theresa.marshall@passporthealth.com

Fred Faller
Production Manager
fred.faller@passporthealth.com