

Compliance Matters

A Healthcare Compliance Newsletter

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Happy Ho Ho Holidays!



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October 1, 2015 ICD-10 Compliance Date Remains Firm

On July 31, the U.S. Department of Health & Human Services (HHS) issued a rule finalizing October 1, 2015 as the compliance date for healthcare providers, health plans, and healthcare clearinghouses to implement ICD-10-CM. Although previous deadlines were moved “to allow insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready,” HHS has dubbed further delay of ICD-10 a myth, and announced “no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2015.”

ICD-10-CM implementation is inevitable for several key reasons. Most significantly, the ICD-9-CM code set currently in use contains “outdated, obsolete terms that are inconsistent with current medical practice, new technology, and preventive services,” as stated in the July 2014 press release, and lacks the needed flexibility to keep up with changes. ICD-9-CM hasn’t received regular updates in several years. And because ICD-9 will receive no updates beyond 2015, even non-covered entities are best served by the transition to ICD-10

Skipping ICD-10 and holding out for ICD-11, as some have proposed, isn’t a viable solution. As reported in FierceHealthIT, ICD-11 isn’t expected to be ready for use for at least a decade, and perhaps much longer. The American Medical Association’s Board of Trustees estimates that ICD-11 won’t be available for use in the U.S. for 20 years, and expressed reservations about skipping ICD-10, stating that such a move “is fraught with its own pitfalls and therefore, based on current information available, is not recommended.”

“Just as an increase in the number of words in a dictionary doesn’t make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn’t necessarily make it more complex to use,” CMS argues. “In fact, the greater number of codes in ICD-10-CM/PCS make it easier for you to find the right code.” As well, “the improved structure

and specificity of ICD-10-CM/PCS will likely assist in developing increasingly sophisticated electronic coding tools that will help you more quickly select codes.”

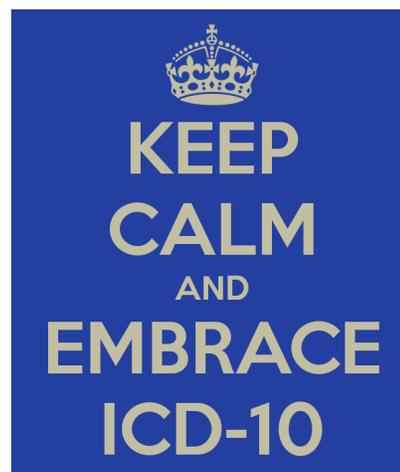
Some have argued that the proliferation of ICD-10 codes will spell the end of the superbill. But because most physician practices use a relatively small number of diagnoses related to their specialty, they can continue to use super bills containing the most common diagnosis codes reported in their practice, and supplement with additional tools.

Furthermore, the cost of ICD-10 implementation has been greatly exaggerated, causing widespread discouragement from starting training. Recent surveys have demonstrated costs could average only \$3,500 per provider.

Additionally, as we head into 2015, the methods promulgated by the [Coalition for ICD-10](#), and other implementation proponents should serve as a springboard for the industry to continue pushing Congress to refuse any new delays.

CMS July 31, 2014 Press Release: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-07-31.html>

ICD-10 Myths and Facts: <http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10MythsandFacts.pdf>



National Correct Coding Initiative Edits (NCCI)

Back in 1996, the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote correct coding and prevent inappropriate payment of Medicare Part B claims. As this is an automated prepayment review by CMS, the NCCI edits reduce payment error by identifying coding errors made by providers. In 2009, 7.8 % of Medicare dollars did not comply with one of more Medicare coverage, coding, billing or payment rules, translating into \$24.1 billion dollars in Medicare overpayments and underpayments annually.

The NCCI edits define when two HCPCS/CPT[®] procedure codes may not be reported together except under special circumstances. CMS based the NCCI coding policies on current coding conventions, coding guidelines, national and local Medicare policies (NCDs and LCDs), and standard medical and surgical practice. Coding polices and guidelines require that procedures are reported with the most comprehensive CPT[®] code that describes the services performed. For example, a coder should not report a Basic Metabolic Panel (BMP, CPT[®] 80047) with a Comprehensive Metabolic Panel CMP, CPT[®] code 80053) as all the analytes in CPT[®] 80047 BMP are a subset of the Comprehensive Metabolic Panel and would have been already performed as part of that procedure.

As a claim is processed by the Medicare contractor, the system tests every pair of procedure codes to determine if they comply with the NCCI edit policy. This means every code pair reported for the same date of service for the same beneficiary by the same provider is reviewed against the NCCI-edit tables. If a pair of codes on the claim matches (“hits”) a pair in the NCCI edit table, the “Column Two” code of the edit pair is denied for payment. Using the CMP/BMP example above, in the NCCI edit tables, CPT[®] 80047 is the “Column Two” code and would have payment denied.

NCCI-associated modifiers are used to indicate the special circumstances such as when the procedures are performed at different anatomic sites, a separate procedure or repeat clinical diagnostic laboratory test. If an edit allows use of NCCI-

associated modifiers, the two procedure codes may be reported together. NCCI-associated modifiers may not be used to bypass an edit unless the criteria for use of the modifier are met.

Each active NCCI edit has a modifier indicator of 0 or 1. A modifier indicator of “0” indicates that an edit can never be bypassed even if a modifier is used. In other words, the Column 2 code of the edit will be denied. A modifier indicator of “1” indicates that an edit may be bypassed with an appropriate modifier appended to the Column 1 and/or Column 2 code.

The NCCI-associated modifiers are: E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, LT, RC, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, 25, 27, 58, 59, 78, 79, and 91.

In January 1, 2013, additional modifiers were added to the list of NCCI-associated modifiers that will allow an edit to be bypassed when the modifier is used correctly (i.e., edits with modifier indicator of “1”). These were LM (left main coronary artery), RI (ramus intermedius), 24 (unrelated evaluation and management service by the same physician during a postoperative period), and 57 (decision for surgery).

SPECIAL REPORT: National Correct Coding Initiative

Effective Jan 15, 2015, new more specific modifiers become effective (see also Compliance Matters, Sept 2014) supplementing Modifier -59 (Distinct Procedural Service).

- **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.

Services denied based on NCCI edits may not be billed to Medicare beneficiaries, nor can a provider use an “Advanced Beneficiary Notice” (ABN) to seek payment from the patient since these denials are based on incorrect coding rather than medical necessity or a benefit exclusion.

Hospitals, like physicians and other providers, must follow national correct coding policies. Though the NCCI edits were initially developed for processing professional claims, the NCCI edits are incorporated into the Outpatient Code Editor (OCE) used for processing outpatient hospital service claims, outpatient physical therapy and speech-language pathology services, skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies (HHAs). These are commonly referred to as the NCCI “Hospital” Version of CCI edits.

Review the NCCI manual on CMS here: <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/>



CMS Finalizes New Safeguards to Reduce Medicare Fraud

On December 3rd, CMS Administrator Marilyn Tavenner announced new rules that strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers with unpaid debt from re-entering Medicare, remove providers with patterns or practices of abusive billing, and implement other provisions to help save more than \$327 million annually.

“The changes announced today are common-sense safeguards to preserve Medicare for generations to come, while making the rules more consistent for all providers that work with us,” Administrator Tavenner said. “The Administration is committed to using all appropriate tools as part of its comprehensive program integrity strategy shaped by the Affordable Care Act.”

Summary of the Provider Enrollment Provisions

Provider enrollment is the gateway that allows health care providers to bill for services provided to Medicare beneficiaries. CMS routinely evaluates its provider enrollment policies, and has implemented new safeguards as a result of provisions in the Affordable Care Act. In the February 2011 final screening rule (76 FR 5862), CMS revised its enrollment policy in order to increase the integrity of the Medicare program. CMS is now finalizing a number of additional provider enrollment provisions, including the following:

- Adding the ability to deny the enrollment of providers, suppliers, and owners affiliated with an entity that has unpaid Medicare debt. This will help prevent individuals and entities from being able to incur substantial debt to Medicare, leave the Medicare program and then re-enroll as a new business to avoid repayment of the outstanding Medicare debt. CMS will only enroll otherwise eligible individuals or entities if they repay the debt or enter into a repayment plan.
- Adding the ability to deny the enrollment or revoke the billing privileges of a provider or supplier if a managing employee has been convicted of certain felony offenses. This provision ensures that CMS can block or remove bad actors from the Medicare program to protect beneficiaries and safeguard the Medicare Trust Funds.
- Permitting CMS to revoke billing privileges of providers and suppliers that have a pattern or practice of billing for services that do not meet Medicare requirements. This is intended to address providers and suppliers that regularly submit improper claims in such a way that it poses a risk to the Medicare program.

- Making the effective date of billing privileges consistent across certain provider and supplier types. Most practitioners and practitioner groups may only submit bills as of the filing date of their enrollment application or the date of first furnishing services at a new practice location, whichever is later. CMS is now eliminating ambulance suppliers' previous ability to bill for up to a year prior to enrollment in the Medicare program. Also, CMS now requires that ambulance providers and other provider and supplier types submit any claims within 60 days of the revocation of their billing privileges, consistent with the requirements for practitioners and practitioner groups. This provision is estimated to save \$327 million annually.

Incentive Reward Program

At this time, CMS is not finalizing proposals on the Medicare Incentive Reward Program due to the complexity of the operational aspects of the proposed changes. CMS may finalize them in future rulemaking.

The final rule can be downloaded at: <https://www.federalregister.gov/public-inspection>.



Medicare Administrative Contractor (MAC) Updates: Jurisdiction JJ

On September 17, 2014 the Centers for Medicare & Medicaid Services (CMS) awarded Jurisdiction J (JJ) A/B MAC to Cahaba GBA – formerly Jurisdiction 10 (J10). This includes administration of Medicare Part A and Part B Fee-for-Service claims in Alabama, Georgia and Tennessee.

This jurisdiction comprises approximately 7.3% of the overall national Medicare Fee-for-Service Part A and Part B claims volume. The A/B MAC Jurisdiction J contract will provide Medicare services to more than 400 hospitals, 50,000 physicians, and 2.5 million Medicare beneficiaries.

Inclusive of all options, the awarded A/B MAC Jurisdiction J contract has a total estimated value of \$287.8 million.

As Cahaba is the incumbent contractor for this MAC jurisdiction, CMS anticipates that implementation of the new contract will go smoothly, with few (if any) disruptions in service for Medicare beneficiaries and providers.

The implementation date for the cutover to MAC Jurisdiction JJ is **February 18, 2015**.

For any new MAC contractor and its associated LCD content, Passport Health Communications retains all legacy edits and includes the new MAC LCD edits with the appropriate effective dates to any and all affected subscribers. The change in contractor is noted in the Information or Notification letter forwarded or included with every LCD subscription release.



“Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC)...” can be read here: <http://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/downloads/JA1017.pdf>



Preventive and Screening Services Update

Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy

On December 11th, CMS published updated Transmittal 3146, CR 8874 updating Medicare Claims processing for Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy.

The purpose of this change request (CR) is to ensure accurate program payment for three screening services for which the beneficiary should not be charged the coinsurance or deductible.

The coinsurance and deductible for these services are currently waived, but due to coding changes and additions to the Medicare Physician Fee Schedule Database, the payments for CY 2015 would not be accurate without this CR for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with colorectal cancer screening tests.

Intensive Behavioral Therapy for Obesity

Effective for claims with dates of service January 1, 2015 and after, the practitioner furnishing intensive behavioral therapy for obesity in a group setting shall report the relevant group code for each beneficiary participating in a group therapy session. The qualified practitioner furnishing these services shall report HCPCS code G0473 when furnishing these services to a maximum group of ten beneficiaries.

Coinsurance and Deductible

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with the following HCPCS code G0473: Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)

Screening Digital Breast Tomosynthesis

Effective January 1, 2015, HCPCS code 77063 (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2 D imaging only).

Coinsurance and Deductible

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with the following HCPCS codes:

- 77063: Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

Anesthesia furnished in conjunction with Colonoscopy

Effective January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

- Modifier 33 – Preventive Services: when the primary services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure.

For separately reported services specifically identified as purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services, the modifier should not be used.

Coinsurance and Deductible

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to the following anesthesia claim lines when furnished in conjunction with screening colonoscopy services and when billed with Modifier 33:

- 00810: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

NOTE: New codes will be effective January 1, 2015, and will appear in the January 2015 updates of the Medicare Physician Fee Schedule Database (MPFSDB) and the Integrated Outpatient Code Editor (IOCE).

Read the entire transmittal here: <http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3146CP.pdf>



ESRD Laboratory Services: Elimination of the 50/50 Rule April 2015

The Medicare End Stage Renal Disease (ESRD) benefit previously provided payment for dialysis and some dialysis related services under a per treatment composite rate. Separate payment for Automated Multi-Channel Chemistry (AMCC) laboratory tests was determined according to the 50/50 rule where separate payment for the laboratory services was subject to whether 50

percent or more of the tests performed were in excess of the composite rate.

ESRD facilities were required to report the following modifiers:

- **CD** to indicate if the laboratory test was included in the composite rate;
- **CE** to indicate the laboratory tests exceeded the frequency of the composite rate; or
- **CF** to indicate the laboratory test was not included in the composite rate.

In addition, ESRD facilities were required to itemize on the claim the individual laboratory Current Procedural Terminology (CPT) codes rather than reporting disease panel codes.

Effective 4/1/2015, ESRD laboratory services are no longer paid in accordance with the 50/50 rule. The ESRD PPS requires that all renal dialysis laboratory services be paid in the ESRD facility bundled payment and therefore may only be billed by the ESRD facility.

Also, for ESRD claims with dates of service on or after April 1, 2015, ESRD facilities will no longer be required to submit the 50/50 rule modifiers CD, CE, and CF. In addition, ESRD facilities should report organ or disease-oriented panel codes on Type of Bill 072X for codes listed in the following table when performed for an ESRD beneficiary if:

- These codes best describe the laboratory services provided to the beneficiary, which are paid under the ESRD PPS; or
- The test is not related to the treatment of ESRD, in which case the ESRD facility would append modifier “AY” and the service may be paid separately from the ESRD PPS.

HCPCS/CPT® Code and Description

80047	METABOLIC PANEL IONIZED CA
80048	METABOLIC PANEL TOTAL CA
80051	ELECTROLYTE PANEL
80053	COMPREHEN METABOLIC PANEL
80061	LIPID PANEL
80069	RENAL FUNCTION PANEL
80076	HEPATIC FUNCTION PANEL

The official guidance to your MAC can be read here: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3116CP.pdf>



CMS Creates New Chief Data Officer Post

CMS announced the formation of the Office of Enterprise Data and Analytics (OEDA) which will be led by **Niall Brennan**, the agency’s first **Chief Data Officer** (CDO), and tasked with overseeing improvements in data collection and dissemination as the agency strives to be more transparent.



Niall Brennan
Chief Data Officer

OEDA will help CMS better harness its vast data resources to guide decision-making and develop frameworks promoting appropriate external access to and use of data to drive higher quality, patient-centered care at a lower cost.

CMS collects a wealth of data that is critical to decision making for the agency and other stakeholders in the nation’s health care system. CMS generates data administering the Medicare, Medicaid and CHIP programs. In addition, new responsibilities, including stewardship of the EHR Incentive Programs, more expansive quality measurement programs, and the establishment of the Health Insurance Marketplaces, have expanded the scope of data that CMS collects.

As CMS works to shift the focus from volume of services to better health outcomes for patients, coordinating care, and spending dollars more wisely, the need for CMS to analyze data across its multiple programs and provide greater access to this data, whether in granular or aggregate form, will only intensify.

“It’s clear how much data transparency will help the country improve outcomes, control costs and aid consumer decision making,” said CMS Principal Deputy Administrator Andy Slavitt. “This appointment signals to the industry that there is no turning back from the health care data agenda. Niall Brennan will help make sure CMS leads the way.”

The creation of this new post and the data and analytics office builds on the steps CMS has taken in recent years to better harness its data resources both internally and externally. CMS is now routinely analyzing claims data in real time and applying predictive analytics to proactively identify fraud and abuse and track key metrics such as hospital readmissions.

Accountable Care Organizations and State Medicaid agencies receive monthly near real-time feeds of Medicare data to support care coordination. CMS has launched the Virtual Research Data Center to facilitate lower cost access to CMS data for researchers and federal grantees. CMS has also released numerous public use datasets; the most notable releases to date include the release of data on hospital charges and physician utilization in 2013 and 2014.

“Our commitment to transparency is matched by our commitment to keeping personal information safeguarded. We can’t expect to advance health outcomes unless we also ensure that our policies and practices around data privacy are leading the way,” said Slavitt. “We look forward to building on the success of recent releases, providing a clearer picture of the health care delivery system.”



Modified Requirements for Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)

Medicare Part B coverage of screening FOBTs and ultrasound screening for AAA is covered for certain beneficiaries that meet eligibility requirements as described in regulations. As part of the CY 2014 Physician Fee Schedule rule, CMS revised the Medicare Part B coverage requirements for Ultrasound Screening for AAA and Screening FOBT.

Per Transmittal 3096, CR 8881, the following policy changes are effective for dates of service on and after January 27, 2014, implemented November 18, 2014:

- Ultrasound Screening for AAA: Coverage of AAA screening is modified by eliminating the one year time limit with respect to the referral for this service. This modification allows coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the Initial Preventive Physical Examination (IPPE, also commonly known as the “Welcome to Medicare Preventive Visit”). The beneficiary need only obtain a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist. All other coverage requirements for this service remain unchanged.
- Screening FOBTs : In addition to the beneficiary’s attending physician, the beneficiary’s attending physician assistant, nurse practitioner, or clinical nurse specialist may furnish written orders for screening FOBTs, per section 42 CFR 410.37(b). All other coverage requirements for this service remains unchanged.

Read the MLN Matters® Article here: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8881.pdf>



Testing with CMS FAQs: International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing

CMS has published FAQ's for Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing. Please review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to know prior to testing if you were selected to participate by CMS

1. How is ICD-10 end-to-end testing different from acknowledgement testing?

The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected. End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. What constitutes a testing slot for this testing?

A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. What data must I provide to the MAC before testing?

For each testing slot, you must provide the MAC: up to 2 submitter identifiers (IDs), up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and up to 10 Health Insurance Claim Numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

4. What should I consider when choosing HICNs for testing?

The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?

No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?

Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to know during the testing with CMS

1. Is it safe to submit test claims with Protected Health Information (PHI)?

The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. What Dates of Service can be used on test claims?

Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015. Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015. Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015. For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. Can both ICD-9 and ICD-10 codes be submitted?

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, (and later).

4. Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?

Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare Administrative Contractor (MAC) for further information.

Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. If a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?

If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015) you must submit a revised CMN/DIF to extend the end date for that CMN/DIF. If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?

Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

7. For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?

You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

8. For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?

Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required. You do not need to submit the supporting data sheets.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work?



Payment for G0101 and Q0091 in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that Bill Under the All-Inclusive Rate (AIR) System

HCPCS Level II codes G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination and Q0091 Screening Papanicolaou smear have been added to the list of preventive services paid by CMS, based on the All-Inclusive Rate (AIR) system for rural health clinics (RHCs) and federally qualified health centers (FQHCs). G0101 and Q0091 are billable visits when furnished by a RHC or FQHC practitioner.

CR8927 instructs:

These services will be paid the AIR on RHC and FQHC claims for 71X and 77X Types of Bills (TOBs), effective for dates of service on or after January 1, 2014. Please note that deductible and coinsurance are NOT to be applied to G0101 or Q0091. If other billable visits are furnished on the same day as G0101 or Q0091, only one visit will be paid.

G0101 or Q0091 are payable annually for:

- Women at high risk for developing cervical or vaginal cancer
- Women of childbearing age who have had an abnormal Papanicolaou test within the past three years

G0101 or Q0091 are payable every two years for women at normal risk.

“FQHCs billing under the PPS, G0101, and Q0091 are qualifying visits when billed with FQHC payment HCPCS codes G0466 or G0467,” according to CR 8927.

Medicare will adjust any denied claims with codes G0101 or Q0091 that you bring to their attention prior to implementation on April 6, 2015.

See MLN Matters® [MM8927](#) for more information.

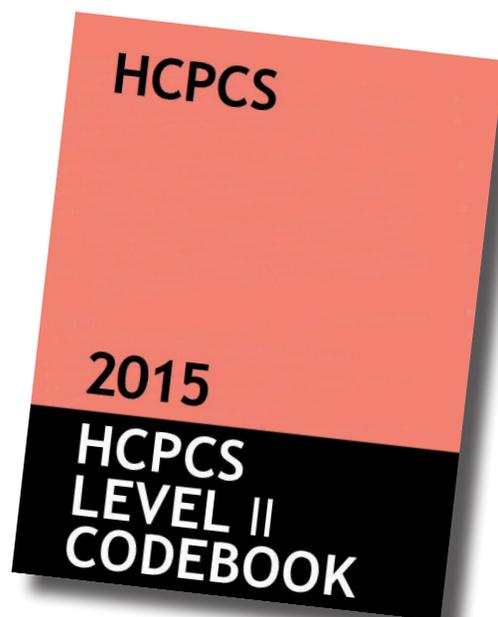


CMS 2015 Changes to HCPCS Level II Codes

The annual release of the CMS HCPCS Level II procedure codes has 462 changes, and while they affect the whole code set, most take place in the frequently used G codes. Effective January 1st 2015, all Passport Health clients will be updated to include these important changes.

Created by CMS in 1983 to report supplies, materials, injections, and certain services, the HCPCS Level II codes are one of the sets mandated by the Health Information Portability and Accountability Act (HIPAA). The alphanumeric codes are updated quarterly. An annual major revision is effective January 1 of each year. Changes this year included the following:

- 237 New codes
- 56 Changes
- 159 Discontinued codes
- 10 Coverage changes



CPT® Changes for 2015

The New Year brings with it a large number of new and revised CPT® changes for 2015. Effective January 1st, 2015, all Passport clients will be updated to include 541 CPT® code changes (264 new, 134 revised and 143 are deleted). Additionally, procedure codes that are no longer active will not be represented for the current dates of service. Some of these changes are outlined below:

Evaluation and Management

- 99481 and 99482 are deleted; replaced with a new combination code

Anesthesia

- 00452, 0062 and 00634 are deleted

Muskuloskeletal

- 20600, 20605 and 20610 revised: without ultrasound guidance; use with fluoroscopic, CT or MRI is used

New codes: Report these if ultrasound guidance is used

- 20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); **with ultrasound guidance**, with permanent recording and reporting
- 20606 Arthrocentesis, aspiration and/or injection, intermediate joint or burs (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); **with ultrasound guidance**, with permanent recording an reporting
- 20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); **with ultrasound guidance**, with permanent recording and reporting

Ablation of Bone Tumors

- 20982 is revised to include the adjacent soft tissue involved with the bone tumor:
Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency
- 20983 Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation

Open Rib Fractures

- 21800, 21810, 00245T, 00246T, 00247T, 00248T are deleted
- Newly select 21811, 21812 or 21813 based on the number of ribs treated

Percutanous Vertebroplasty

- 22520, 22521 and 22522 are deleted
- Newly select 22510, 22511 or 22512
- 22510: Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
- 22511: Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
- 22512: Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body

Percutaneous Vertebral Augmentation (Kyphoplasty)

- 22523, 22524 and 22525 are deleted
- Newly select 22513, 22514 or 22515
- 22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance, thoracic
- 22514, lumbar
- 22515, each additional lumbar or thoracic body
- Do not report imaging guidance or bone biopsy on the same body separately

Total Disc Arthroplasty

- 22856 revised to become parent code for 22858
- 22858 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
- See 0375T when more than two levels are performed: Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), cervical, three or more levels

Arthrodesis of Sacroiliac Joint

- 27280 revised to indicate an open procedure
- New code 27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
- Review carefully approach, open or percutaneous or minimally invasive when selecting code

Musculoskeletal

- 27370 is revised to indicate that the injection is performed for contrast
- 29020, 29025, 29715 are deleted

Pacemaker/Implantable Defibrillator

- Category III codes for subcutaneous implantable defibrillators (0319T, 0320T, 0321T, 0322T, 0323T, 0326T and 0327T) are deleted and replaced with Category I codes
- Revisions are made to all the existing cardioverter-defibrillator codes
- Table on page 187 (CPT® Professional Edition) is revised to include all the new codes

Cardiovascular: Heart and Great Vessels

- CPT® 33332 is deleted
- New code 33418, Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis
- 33419 Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)
- New code 0345T Transcatheter mitral valve repair percutaneous approach via the coronary sinus
- New code 0346T Ultrasound, elastography (List separately in addition to code for primary procedure)

Extracorporeal Membrane Oxygenation (ECMO) or Extracorporeal Life Support Services (ECLS)

- CPT® codes 33960, 33961 and 36822 are deleted
- Many new codes for initiation, management, cannulation, additional cannulation and repositioning and removing cannulae for adult and pediatric patients
- New codes:
 - 33946 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous
 - 33947 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial
 - 33948 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous
 - 33949 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial

Cardiovascular System

- CPT® 36469 is deleted
- New code: 34839 Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time

Transcatheter Procedures

- Descriptions have been revised on CPT® codes 37215, 37216 and 37217
- New code 37218: Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation

Endovascular Revascularization

- Descriptions have been revised for 37326 (include occlusive disease) and add-on code 37327

Esophagoscopy

- CPT® 43350 is deleted
- New code 43180, Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed
- Descriptions have been updated for the following codes:
 - 43194 Esophagoscopy, rigid, transoral; with removal of foreign body(s)
 - 43197 Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
 - 43215 Esophagoscopy, flexible, transoral; with removal of foreign body(s)
 - 43216 Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
 - 43247 Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)
 - 43250 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

Intestine: Endoscopy Stoma

- CPT® codes 44383, 44393 and 44397 are deleted
- 44380 is revised: Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- New codes:
 - 44381 Ileoscopy, through stoma; with transendoscopic balloon dilation
 - 44384 Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
- Other New Colonoscopy through Stoma codes:
 - 44401 Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
 - 44402 Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
 - 44403 Colonoscopy through stoma; with endoscopic mucosal resection
 - 44404 Colonoscopy through stoma; with directed submucosal injection(s), any substance
 - 44405 Colonoscopy through stoma; with transendoscopic balloon dilation
 - 44406 Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
 - 44407 Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and a
 - 44408 Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed

Endoscopy

- CPT® codes 45339, 45345, 45355, 45383,45387 are deleted
- New codes: 45346, 45347, 45349,45350,45388,45389,45390,45393,45398

Digestive: Other

- New CPT®code 45399 Unlisted procedure, colon

Urinary

- New codes:
 - 52441 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
 - 52442 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

Myelography

- New codes
 - 62302 Myelography via lumbar injection, including radiological supervision an interpretation; cervical
 - 62303 Myelography via lumbar injection, including radiological supervision an interpretation; thoracic
 - 62304 Myelography via lumbar injection, including radiological supervision an interpretation; lumbosacral

- 62305 Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)

Transversus Abdominis Plane Block (TAP)

- New codes:
- 64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)
- 84487 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)
- 64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
- 64489 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)

Eye and Ocular Adnexa

- New codes:
- 66179 Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
- 66184 Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft

Radiology

- CPT® 76645 is deleted
- New codes:
- Note: These are reported once per breast per session
- 76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
- 76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
- Other new codes:
- 77061 Digital breast tomosynthesis; unilateral
- 77062 Digital breast tomosynthesis; bilateral
- 77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
- Note: Report 77063 with 77057 for screening mammogram

Bone Studies

- CPT® 77082 is deleted

Radiation Oncology

- New combination codes report teletherapy isodose with basic dosimetry calculation and brachytherapy isodose planning with brachytherapy calculation(s).
- CPT® codes 77305, 77310, 77315, 77326, 77327, 77328 are deleted

Radiation Treatment Delivery

- Major revisions
- CPT® codes 77303, 77304, 77306, 77308, 77309, 77311, 77313, 77314, 77316, 77318, 77321 are deleted

Pathology/Laboratory

- Presumptive Drug Class screening
- New codes:
- 80300 Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed
- 80301 Drug screen, any number of drug classes from Drug Class List A; single drug class method, by instrumented test systems (eg, discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay) per date of service
- 80302 Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELISA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure
- 80303 Drug screen, any number of drug classes, presumptive, single or multipl drug class method; thin layer chromatography procedure(s) (TLC) (eg, acid, neutral, alkaloid plate), per date of service
- 80304 Drug screen, any number of drug classes, presumptive, single or multipl drug class method; not otherwise specified presumptive procedure (eg, TOF, MALDI, LDTD, DESI, DART), each procedure

Definitive Drug Testing

- Many new code for quantitating analgesics, anabolic steroids, antidepressants, cannabinoids, opiates would be examples

Microbiology

- New codes for molecular identification of pathogens include CPT® codes 87505, 87506 87507, 87623, 87624 and 87625

Reproductive Medicine

- New code 89337 Cryopreservation of mature oocytes

Vaccines

- New codes:
- 90651 Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use
- 90630 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use

Gastroenterology

- New code 91200 Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report

Ophthalmology

- New code 92145 Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report

Implantable and Wearable Cardiac Device Evaluations

- New codes for subcutaneous implanted defibrillators
- 93260 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health

Compliance Matters

- 93261 interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator

Echocardiography

- New code 93355 Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair)

Noninvasive Physiologic Studies and Procedures

- New code 93702 Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)

Cerebrovascular Arterial Studies

- New code 93895 Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral

Central Nervous System Assessments

- New code 96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Active Wound Care Management

- New codes 97607 and 97608

Other Services and Procedures

- New code 99188 Application of topical fluoride varnish by a physician or other qualified health care professional

Complex Chronic Care Management

- CPT® 99488 is deleted
- 99489 revised to include the requirements for the code

Advanced Care Planning

- New CPT® codes
- 99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face
- 99498 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes



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