

# PC-ACE Pro32

Release Newsletter

Version 2.19

April 2010

## Institutional Change Summary

We are pleased to announce the release of PC-ACE Pro32 version 2.19. This upgrade contains several CMS Medicare Mandates and product enhancements effective 4/1/2010, including these highlighted changes:

### ENCLOSED MATERIALS

- ◆ Pre-built PC-ACE Pro32 2.19 upgrade file named PCACEUP.EXE and replacement SETUP.EXE file for any new providers
- ◆ This Newsletter

### CMS MEDICARE MANDATES

#### CR6557 - Coverage of Kidney Disease Patient Education Services

◆ Added a new institutional claim edit which requires that HCPCS codes G0420 and G0421 are billed with Revenue Code 0942 when Stage IV Diagnosis Code 585.4 is present on TOB 22x, 23x, 34x, 75x, 81x, 82x, or 85x claims.

◆ Updated Revenue Code Table to make the Revenue Code 0942 valid for Hospice Type of Bills, (i.e., 81x and 82x).

◆ Added an Institutional edit prohibiting any other revenue codes from being present on a Hospice claim if Revenue Code 0942 is present.

◆ Added an Institutional claim edit to ensure that if the TOB equals 81x or 82x and the HCPCS codes G0420 or G0421, then Value Code 61 or G8 is present.

◆ Modified an existing institutional claim edit and added a new edit to permit billing of Revenue Code 0942 on Hospice claims (TOB = 81x/82x).

◆ Modified an existing institutional claim edit and added a new edit to permit billing of Revenue Code 0942 on CORF claims (TOB = 75x).

#### CR 6715 – Pharmacogenomic Testing for Warfarin Response

◆ Added an Institutional claim edit to insure that Warfarin testing HCPCS code G9143 is always billed with Modifier 'Q0'.

◆ Added an Institutional claim edit to insure that Diagnosis Code V707 is present on claims which include Warfarin testing HCPCS code G9143 (billed with Modifier 'Q0').

#### CR 6840 – Healthcare Provider Taxonomy Codes (HPTC) Update April 2010

◆ Updated the Provider Taxonomy Code reference file with the latest WPC published code set. Codes Added: 1 ; Codes Deleted/Terminated: 0 ; Codes Modified: 1. The new code is: "344800000X - Transportation Services : Air Carrier". The modified code is: 2080P0201X.

#### CR 6676 – Implementation of the Updated HIPAA 00510 837 Institutional (837i) Edits and 005010 837 Professional (837p) Edits

◆ SDI will implement 005010 claim edits to insure implementation guide compliance, and will review and implement Medicare business edits where practical and beneficial to the provider community.

#### CR6589 – HIPAA Version 5010 for Transaction 835 - Health Care Claim Payment / Advice and Updated Standard Paper Remit

◆ SDI will implement changes to support 5010 requirements over a period of several quarters beginning in the Q2 2009.

### ADDITIONAL CMS MANDATED CHANGES

#### CR6723 - Claim Status Category Code and Claim Status Code Update

◆ Changes described in this mandate were included in a previous release.

#### CR6788 - Non-systems Internet Only Manual (IOM) Chapter 25 Changes

◆ Changed the description for Condition Code 69 to "IME/DGME/N&AH PAYMENT ONLY"

◆ Changed the description for Condition Code D4 to "CHANGES IN CLINICAL CODES (ICD) FOR DIAGNOSIS AND/OR PROCEDURE CODE"

◆ Changed the description for Occurrence Span Code 72 to "FIRST/LAST VISIT DATES"

◆ Changed the description for Occurrence Span Code 75 to "SNF LEVEL OF CARE DATES"

◆ Changed the description for Occurrence Span Code M2 to "INPATIENT RESPITE DATES"

#### CR6775 - Outpatient Intravenous Insulin Treatment (Therapy)

◆ Added a new HCPCS code effective 4/5/2010, G9147 – OIVIT

#### CR6778 - Medicare Systems Edit Refinements Related to Hospice Services

Added several institutional claim edits to enforce rules preventing hospice services from being billed in non-covered settings. These edits apply to TOB = 81x/82x on claims submitted on or after 7/6/2010. The specific edit additions are:

◆ Added an institutional claim edit, which prohibits billing of HCPCS codes Q5001, Q5002, and Q5003 with GIP revenue code 0656 on Hospice claims.

◆ Added an institutional claim edit, which prohibits billing of HCPCS codes Q5001 and Q5002 with respite revenue code 0655 on Hospice claims.

◆ Added an institutional claim edit, which prohibits billing of HCPCS codes Q5004, Q5005, Q5006, Q5007, and Q5008 with CHC revenue code 0652 on Hospice claims.

#### CR6776 - Billing and Processing for Health Control Group Volunteers in a Qualified Clinical Trial

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▲ Modified several institutional claim edits to support Healthy Control Group Volunteer participation in clinical trials. These participants, by definition, do not have any underlying conditions. Therefore, providers need to report Diagnosis Codes V70.5 (Health examination, group survey) or V70.7 (Examination of participant in clinical trial), as the primary diagnosis instead of the secondary diagnosis, as no primary diagnosis exists.

#### **CR6782 - Dialysis Adequacy, Infection and Vascular Access Reporting**

Added several institutional claim edits to enforce tighter Dialysis Adequacy, Infection and Vascular Access Reporting rules for ESRD claims. The new edits include:

- ▲ Added an institutional claim edit requiring that Value Code D5 be present on all TOB 72x claims (effective 7/1/2010).
- ▲ Added an institutional claim edit requiring that Occurrence Code 51 be present on all TOB 72x claims (effective 7/1/2010) except those reporting Value Code D5 with value equal 9.99.
- ▲ Added an institutional claim edit requiring that HCPCS Modifier V5, V6 or V7 be present on TOB = 72x claims billing Hemodialysis Revenue Code 0821 (effective 7/1/2010). This modifier should be reported on the latest line item date of service billing for Revenue Code 0821.
- ▲ Added an institutional claim edit requiring that HCPCS Modifier V8 or V9 be present on each dialysis Revenue Code line (0821, 0831, 0841, 0851) on all TOB = 72x claims (effective 7/1/2010).

#### **CR6774 - Correction to Processing of Non-Covered Revenue Codes**

▲ Modified an existing Institutional claim edit to allow billing of invalid Revenue Codes when charges are non-covered, modifiers GA, GL, GX, GS and TS are not present on the line, and Condition code 20 is not present on the claim.

#### **CR6857 - April 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

- ▲ Added the following HCPCS codes (eff 4/1/2010):
  - **C9258** - INJECTION, TELAVANCIN, 10 MG
  - **C9259** - INJECTION, PRALATREXATE, 1 MG
  - **C9260** - INJECTION, OFATUMUMAB, 10 MG
  - **C9261** - INJECTION, USTEKINUMAB, 1 MG
  - **C9262** - FLUDARABINE PHOSPHATE, OR, 1MG
  - **C9263** - INJECTION, ECALLANTIDE, 1 MG
  - **G0432** - INFECT ANTIGEN DETECT, EIA
  - **G0433** - INFECT ANTIGEN DETECT, ELISA
  - **G0435** - INFECT ANTIGEN DETECT, RAPID"

#### **CR6801 - Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List**

▲ Modified the description for Condition Code 47 to read "Transfer from Another Home Health Agency".

#### **CR6783 - Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 5010 Acknowledgements Instructions**

▲ SDI will implement changes to support 5010 requirements over a period of several quarters beginning in the Q2 2009.

#### **CR6757 - Coding Patient Transfers Under the HH PPS**

▲ Added an institutional claim edit which terminates Admission Source codes B and C effective 7/1/2010.

#### **January 2010 HCPCS Update (Source – CMS Website)**

- ▲ Added the following HCPCS codes (effective 1/1/2010):
  - **G0428** - INPT TELEHEALTH CONSULT 80M
  - **G0429** - INPT TELEHEALTH CONSULT 110M

▲ Modified the descriptions for the following HCPCS codes:

- **G0425** - INPT TELEHEALTH CONSULT 20M
- **G0426** - INPT TELEHEALTH CONSULT 40M
- **G0427** - INPT TELEHEALTH CONSULT 55M

#### **April 2010 HCPCS Update (Source – CMS Website)**

▲ Modified the description for the following HCPCS modifiers:

- **GA** - REQUIRED LIABILITY NOTICE
- **GX** - VOLUNTARY LIABILITY NOTICE
- **RA** - REPLACEMENT ITEM
- **RB** - REPLACEMENT PART OF ITEM

#### **Category III Codes Update (Source – CMS Website)**

▲ Added new HCPCS codes effective 7/1/2010:

- 0223T** - ACOUSTIC/ELECTR CARDGRPHY
- 0224T** - ACSTIC/ELEC CARDGRPHY AV/VV
- 0225T** - ACSTIC/ELEC CARDGRPHY AV+VV
- 0226T** - ANOSC HIGH RESOL DX+COLL
- 0227T** - ANOSC HIGH RESOL DX W/BX
- 0228T** - US TFRML EDRL INK CRV/T 1LVL
- 0229T** - US TFRML EDRL INJ CRV/T +LVL
- 0230T** - US TFRML EDRL INJ L/S 1LVL
- 0231T** - US FRMTL EDRL INJ L/S 1LVL
- 0232T** - INJ PLSM IMG GUID HRVSTG&PREP
- 0233T** - SKN AGE MEAS SPCTRSCPY

#### **Claim Adjustment Reason Code Reference File Update**

▲ Updated the Claim Adjustment Reason Codes reference file with the latest WPC published code set. Codes Added: 2 ; Codes Deleted/Terminated: 0 ; Codes Modified: 1. The new codes are: "233 - Services/charges related to the treatment of a hospital-acquired condition or preventable medical error." and "234 - This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)". The modified code is: 40.

#### **Claim Status Response Codes Reference File Update**

▲ Updated the Claim Status Response Codes reference file with the latest WPC published code set. Category Codes Added: 1 ; Status Codes Added: 31; Codes Deleted/Terminated: 0 ; Status Codes Modified: 107. The new category code is: "E3 - Correction required - relational fields in error.". The new status codes are: "703 - Advanced Billing Concepts (ABC) code", "704 - Claim Note Text", "705 - Repriced Allowed Amount", "706 - Repriced Approved Amount", "707 - Repriced Approved Ambulatory Patient Group Amount", "708 - Repriced Approved Revenue Code", "709 - Repriced Approved Service Unit Count", "710 - Line Adjudication Information. Note: At least one other status code is required to identify the data element in error.", "711 - Stretcher purpose", "712 - Obstetric Additional Units", "713 - Patient Condition Description", "714 - Care Plan Oversight Number", "715 - Acute Manifestation Date", "716 - Repriced Approved DRG Code", "717 - This claim has been split for processing.", "718 - Claim/service not submitted within the required timeframe (timely filing).", "719 - NUBC Occurrence Code(s)", "720 - NUBC Occurrence Code Date(s)", "721 - NUBC Occurrence Span Code(s)", "722 - NUBC Occurrence Span Code Date(s)", "723 - Drug days supply", "724 - Drug dosage", "725 - NUBC Value Code(s)", "726 - NUBC Value Code Amount(s)", "727 - Accident date", "728 - Accident state", "729 - Accident description", "730 - Accident cause", "731 - Measurement value/test result", "732 - Information submitted inconsistent with billing guidelines. **Note:** At least one other status code is required to identify the inconsistent

information.", and "733 - Prefix for entity's contract/member number.". The modified status codes are: 16, 17, 18, 19, 23, 24, 25, 26, 73, 85, 88, 89, 90, 91, 92, 93, 94, 96, 97, 106, 109, 114, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 153, 155, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 170, 173, 174, 175, 176, 182, 183, 387, 395, 466, 467, 470, 478, 487, 491, 496, 499, 500, 501, 502, 503, 504, 505, 506, 508, 514, 560, 561, 562, 563, 635, 663, 676, 677, 680, 689, and 695.

#### Remittance Advice Remark Codes Reference File Update

♣ Updated the Remittance Remarks Codes reference file with the latest WPC published code set. Codes Added: 10 ; Codes Deleted/Terminated: 0 ; Codes Modified: 2. The new codes are: "523 - The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.", "524 - Based on policy this payment constitutes payment in full.", "525 - These services are not covered when performed within the global period of another service.", "526 - Not qualified for recovery based on employer size.", "527 - We processed this claim as the primary payer prior to receiving the recovery demand.", "528 - Patient is entitled to benefits for Institutional Services.", "529 - Patient is entitled to benefits for Professional Services.", "530 - Our records indicate a mismatch in enrollment information for this patient.", "531 - Not qualified for recovery based on direct payment of premium.", and "532 - Not qualified for recovery based on disability and working status.". The modified codes are: N216 and N522.

#### NUBC Conference Call Minutes (August 2009)

Per a review of the NUBC conference call minutes (August 2009), made the following change:

♣ Added new Magnetoencephalography (MEG) Revenue Codes "0860 - General Classification" and "0861 - MEG" (eff 4/1/2010).

#### NUBC Conference Call Minutes (October 2009)

Per a review of the NUBC conference call minutes (October 2009), made the following changes:

♣ Added a non-fatal institutional claim edit which terminates Admission Source codes "7" (Emergency Room), "B" (Transfer from Another Home Health Agency) and "C" (Readmission to Same Home Health Agency) effective 7/1/2010.

♣ Added a new Occurrence Code "50 - Assessment Date" (eff 1/1/2011). Added a non-fatal institutional claim edit to enforce the effective date.

♣ Added a new Occurrence Code "51 - DATE OF LAST KT/V READING" (eff 7/1/2010). Added a non-fatal institutional claim edit to enforce the effective date.

♣ Added a new Value Code "D5 - LAST KT/V READING" (eff 7/1/2010). Added a non-fatal institutional claim edit to enforce the effective date.

#### NUBC Conference Call Minutes (November 2009)

Per a review of the NUBC conference call minutes (November 2009), made the following change:

♣ Added a new Condition Code "P7 - DIRECT INPATIENT ADMISSION FROM EMERGENCY ROOM" (eff 7/1/2010). Added a non-fatal institutional claim edit to enforce the effective date.

## MODIFICATIONS IN SUPPORT OF ANSI (HIPAA) IG COMPLIANCE

### ANSI-276/277 Health Care Claim Status Request and Response Enhancement (if applicable)

♣ Enhanced PC-ACE Pro32 to support changes mandated by the new ANSI-276/277 Health Care Claim Status Request and Response Implementation Guide (ASC X12N/005010X212) and ANSI-277CA Health Care Claim Acknowledgment Implementation Guide (ASC X12N/005010X214). This new functionality is limited to in-house distributor and selected provider testing during the transition from the 4010A1 release to the 5010 release. Providers will continue to use PC-ACE Pro32 normally to produce 4010A1 output files. The design changes for 5010 were made with the goal of minimizing the impact on users during the transition period.

### INSTALLING THE UPGRADE

Perform a full PC-ACE Pro32 database backup before installing the upgrade. To install the upgrade, run the attached PCACEUP.EXE file using Windows Explorer or equivalent, and follow the simple upgrade wizard steps. When prompted, enter the upgrade password provided by your software supplier. For networked instructions, it is recommended (but not required) that the update be run from the server's console.

**IMPORTANT:** The recommended database backup is for safety purposes only, and should NOT be restored after successfully installing the update. The update program preserves all existing claims and reference file settings.