Compliance Matters

A Quarterly Healthcare Compliance Newsletter

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In this issue:

New Unspecified Diagnosis Codes Excluded by CMS for 2017

On May 26, Centers for Medicare & Medicaid Services (CMS) outlined additional unspecified diagnosis codes it is excluding from both ICD-9 and ICD-10 reporting beginning January 2, 2017.

The technical alert states the codes, "will not be accepted in the in the Alleged Cause of Injury, Incident or Illness (Field 15) or in any ICD Diagnosis Code field starting with Field 18. Updates to previously submitted records using these excluded codes, will also be rejected."

These additions and upcoming changes to the ICD-10 codeset underline the need for clinical documentation improvement and ICD-10 training, experts say, as code and rule freezes are lifted by the healthcare payment agency. ICD-10-CM will include 1900 new codes and several more changes and deletions. Attention to documentation quality will be paramount.

Impacts Workers' Comp and Auto

CMS writes that this change supersedes the applicable language in the MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No Fault Insurance, and Workers' Compensation User Guide (Version 4.9).

The following ICD-9-CM will be added to the list of excluded diagnosis codes:

- **999.9** (Other and unspecified complications of medical care, not elsewhere classified)

The following ICD-10-CM will be added to the list of excluded diagnosis codes:

- **T88.7XXA** (Unspecified adverse effect of drug or medicament, initial encounter)
- **T88.7XXD** (Unspecified adverse effect of drug or medicament, subsequent encounter)
- **T88.7XXS** (Unspecified adverse effect of drug or medicament, sequela)
- **T88.8XXA** (Other specified complications of surgical and medical care, not elsewhere classified, initial encounter)
- **T88.8XXD** (Other specified complications of surgical and medical care, not elsewhere classified, subsequent encounter)
- **T88.8XXS** (Other specified complications of surgical and medical care, not elsewhere classified, sequela)
- **T88.9XXA** (Complication of surgical and medical care, unspecified, initial encounter) ·
- **T88.9XXD** (Complication of surgical and medical care, unspecified, subsequent encounter)
- **T88.9XXS** (Complication of surgical and medical care, unspecified, sequela)

Click here to read the Technical Alert.

National Health Care Fraud Takedown Results in Charges against 301 Individuals for Approximately $900 Million in False Billing

Most Defendants Charged and Largest Alleged Loss Amount in Strike Force History

Attorney General Loretta E. Lynch and Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced today an unprecedented nationwide sweep led by the Medicare Fraud Strike Force in 36 federal districts, resulting in criminal and civil charges against 301 individuals, including 61 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $900 million in false billings.

Twenty-three state Medicaid Fraud Control Units also participated in today's arrests. In addition, the HHS Centers for Medicare & Medicaid Services (CMS) is suspending payment to a number of providers using its suspension authority provided in the Affordable Care Act. This coordinated takedown is the largest in history, both in terms of the number of defendants charged and loss amount.

Attorney General Lynch and Secretary Burwell were joined in the announcement by Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division, FBI Associate Deputy Director David Bowdich, Inspector General Daniel Levinson of the HHS Office of Inspector General (OIG), Acting Director Dermot O'Reilly of the Defense Criminal Investigative Service (DCIS), and Deputy Administrator and Director of CMS Center for Program Integrity Shantanu Agrawal M.D.

The defendants announced today are charged with various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes, money laundering and aggravated identity theft. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, including home health care, psychotherapy, physical and occupational therapy, durable medical equipment (DME) and prescription drugs. More than 60 of the defendants arrested are charged with fraud related to the Medicare prescription drug benefit program known as Part D, which is the fastest-growing component of the Medicare program overall.

> "As this takedown should make clear, health care fraud is not an abstract violation or benign offense – It is a serious crime," said Attorney General Lynch. "The wrongdoers that we pursue in these operations seek to use public funds for private enrichment. They target real people – many of them in need of significant medical care. They promise effective cures and therapies, but they provide none. Above all, they abuse basic bonds of trust – between doctor and patient; between pharmacist and doctor; between taxpayer and government – and pervert them to their own ends. The Department of Justice is determined to continue working to ensure that the American people know that their health care system works for them – and them alone."

> "Millions of seniors depend on Medicare for essential health coverage, and our action shows that this administration remains committed to cracking down on individuals who try to defraud the program," said Secretary Burwell. "We are continuing to put new tools and additional resources to work, including $350 million from the Affordable Care Act, for health care fraud prevention and enforcement efforts. Thanks to the hard work of the Medicare Fraud Strike Force, we are making progress in addressing and deterring fraud and delivering results to help ensure Medicare remains strong for years to come."

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare and Medicaid for treatments that were medically unnecessary and often never provided. In many cases, patient recruiters, Medicare beneficiaries and other co-conspirators were allegedly paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could then submit fraudulent bills to Medicare for services that were medically unnecessary or never performed. Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others charged are accused of submitting a total of approximately $900 million in fraudulent billing.

> "The Medicare Fraud Strike Force is a model of 21st-Century data-driven law enforcement, and it has had a remarkable impact on health care fraud across the country," said Assistant Attorney General Caldwell. "As the cases announced today demonstrate, the Strike Force's strategic approach keeps us a step ahead of emerging fraud trends, including drug diversion, and fraud involving compounded medications and hospice care."

> "These criminals target the most vulnerable in our society by taking money away from the care of the

elderly, children and disabled," said Associate Deputy Director Bowdich. "The FBI is committed to working with our partners and the public to stop fraud and ensure that healthcare dollars are used to help the sick, and not line the pockets of criminals."

"While it is impossible to accurately pinpoint the true cost of fraud in federal health care programs, fraud is a significant threat to the programs' stability and endangers access to health care services for millions of Americans," said Inspector General Levinson. "As members of the joint Strike Force, OIG will continue to play a vital role in tracking down these criminals and seeing that justice is done."

"DCIS, in partnership with our fellow federal investigative agencies, will continue to uncompromisingly investigate and bring to justice the people who perpetrate these criminal acts," said Acting Director O'Reilly. "Their actions threaten to cripple our vital national health care industry, and place our citizenry at risk. We will remain vigilant."

"Taxpayers and Congress provided CMS with resources to adopt powerful monitoring systems that fight fraud, safeguard program dollars, and protect Medicare and Medicaid," said Deputy Administrator and Center for Program Integrity Director Agrawal. "The diligent use of innovative data analytic systems has contributed or led directly to many of the law enforcement cases presented here today. CMS is committed to its collaboration with these agencies to keep federally-funded health care programs safe and strong for all Americans."

The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. The Medicare Fraud Strike Force operates in nine locations and since its inception in March 2007 has charged over 2,900 defendants who collectively have falsely billed the Medicare program for over $8.9 billion.

Including today's enforcement actions, nearly 1,200 individuals have been charged in national takedown operations, which have involved more than $3.4 billion in fraudulent billings. Today's announcement marks the second time that districts outside of Strike Force locations participated in a national takedown, and they accounted for 82 defendants charged in this takedown.

Add-On Codes: CMS and Payment Policy

An add-on code is a HCPCS/CPT code that describes a service that, with one exception (see next paragraph), is always performed in conjunction with another primary service. An add-on code with one exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a practitioner.

The Internet Only Manual, Claims Processing Manual, Publication 100-04, Chapter 12, Section 0.6.12(I) requires a provider to report CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) without its primary code CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) if two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service.

For the same date of service only one physician of the same specialty in the group practice may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292.

Add-on codes may be identified in three ways per CMS Transmittal 2636

- The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III, add-on code.
- On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".
- In the CPT Manual an add-on code is designated by the symbol "+". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

CMS has divided the add-on codes into three Groups to distinguish the payment policy for each group.

- **Type I** – This type of add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service
- **Type II** – A Type II add-on code does not have a specific list of primary procedure codes. The CR lists the Type II add-on codes without any primary procedure codes. Claims processing contractors are encouraged to develop their own lists of primary procedure codes for this type of add-on codes. Like the Type I add-on codes, a Type II add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.
- **Type III** – The third type of add-on code has some, but not all, specific primary procedure codes identified in the CPT® manual. CMS advises claims processing contractors that the primary procedure codes in the CPT® manual are not exclusive, and encourages contractors to develop their own lists of additional primary procedure codes.

Click here to reference the Type I, Type II or Type III lists of CMS add-on CPT ® codes. See the bottom pages of the transmittal.

DHHS' OIG Mid-Year Work Plan

The U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) recently released an updated Mid-Year Work Plan for fiscal year 2016.

The updated Work Plan summarizes new and ongoing reviews and activities that OIG plans to pursue in the current year and beyond. This edition of the Work Plan describes OIG audits and evaluations that are underway or planned, and certain ongoing legal and investigative initiatives.

Summaries of ***nine new review activities*** to be aware of follow:

CMS' Implementation of New Medicare Payment System for Clinical Diagnostic Laboratory Tests – Mandatory Review

We will assess CMS's ongoing activities and progress toward implementing CMS's new Medicare payment system for clinical diagnostic laboratory tests. CMS is required to replace its current system of determining payment rates for Medicare Part B clinical diagnostic laboratory tests with a new market-based approach that will use rates paid to laboratories by private payers (Protecting Access to Medicare Act of 2014, § 216). OIG is also required to conduct analyses of the implementation and effect of the new payment system.

Intensity-Modulated Radiation Therapy

We will review Medicare outpatient payments for intensity-modulated radiation therapy (IMRT) to determine whether the payments were made in accordance with Federal requirements. IMRT is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor.

Prior OIG reviews have identified hospitals that have incorrectly billed for IMRT services. In addition, IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan.

Medicare Home Health Fraud Indicators

We will describe the extent that potential indicators associated with home health fraud are present in home health billing for 2014 and 2015. We will analyze Medicare claims data to identify the prevalence of potential indicators of home health fraud. The Medicare home health benefit has long been recognized as a program area vulnerable to fraud, waste, and abuse. OIG has a wide portfolio of work involving home health fraud, waste, and abuse.

National Background Check Program for Long-Term-Care Employees

We will review the procedures implemented by participating States for long-term-care facilities or providers to conduct background checks on prospective employees and providers who would have direct access to patients and determine the costs of conducting background checks. We will determine the outcomes of the States' programs and determine whether the checks led to any unintended consequences. This mandated work will be issued at the program's conclusion as required, which is expected to be 2018 or later.

Outpatient Outlier Payments for Short-Stay Claims

We will determine the extent of potential Medicare savings if hospital outpatient stays were ineligible for an outlier payment. CMS makes an additional payment (an outlier payment) for hospital outpatient services when a hospital's charges, adjusted to cost, exceed a fixed multiple of the normal Medicare payment (Social Security Act (SSA) § 1833(t)(5)). The purpose of the outlier payment is to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. Prior OIG reports have concluded that a hospital's high charges, unrelated to cost, lead to excessive inpatient outlier payments.

Skilled Nursing Facility Prospective Payment System Requirements

We will review compliance with the skilled nursing facility (SNF) prospective payment system requirement related to a 3-day qualifying inpatient hospital stay. Medicare requires a beneficiary to be an inpatient of a hospital for at least 3 consecutive days before being discharged from the hospital, in order to be eligible for SNF services (SSA § 1861(i)). If the beneficiary is subsequently admitted to a SNF, the beneficiary is required to be admitted either within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment. Prior OIG reviews found that Medicare payments for SNF services were not compliant with the requirement of a 3-day inpatient hospital stay within 30 days of an SNF admission.

Potentially Avoidable Hospitalizations of Medicare and Medicaid Eligible Nursing Home Residents for Urinary Tract Infections

We will review nursing home records for residents hospitalized for urinary tract infections (UTI) to determine if the nursing homes provided services to prevent or detect UTIs in accordance with their care plans before they were hospitalized. A CMS-sponsored study identified UTIs as being associated with potentially avoidable hospitalizations and found that UTIs are generally preventable and manageable in the nursing home setting. UTIs acquired during the course of health and medical care could indicate poor quality of care. In a hospital setting, there are payment implications for hospital-acquired catheter-associated urinary tract infections. Nursing homes must develop and follow comprehensive care plans addressing each resident's care needs, which includes urinary incontinence (42 CFR § 483.25(d)).

Physician-Administered Drugs for Dual Eligible Enrollees

We will determine whether Medicare requirements for processing physician-administered drug claims impact State Medicaid agencies' ability to correctly invoice Medicaid drug rebates for dual eligible enrollees. Dual eligible describes individuals who are enrolled in both Medicare and Medicaid. States are required to collect rebates on physician-

administered drugs. To collect these rebates, State agencies must submit to the manufacturers the National Drug Codes for all single-source drugs and for the top 20 multiple-source physician-administered drugs. For dual eligible enrollees, covered Medicare Part B prescription drugs received in a hospital outpatient setting (which include physician-administered drugs) require a copayment, which Medicaid is generally responsible for paying. If a State agency paid any portion of a drug claim to the provider, the State agency must then invoice the eligible drugs for rebate and the manufacturer would thus be liable for payment of the rebate.

State Medicaid Fraud Control Unit FY 2015 Annual Report

We will analyze the statistical information that was self-reported by the MFCUs for FY 2015, describing in the aggregate the outcomes of MFCU criminal and civil cases. We will identify common themes from onsite reviews of the 50 MFCUs that were published from FY 2011 through FY 2015. We will identify the potential costs and benefits of creating MFCUs in jurisdictions that currently do not have a Unit.

> "OIG's mission is to protect the integrity of HHS programs, as well as the health and welfare of program beneficiaries. In fulfillment of this mission, we promote provider compliance, recommend program safeguards, and follow up on those recommendations ..."

— Inspector General Daniel R. Levinson

Click here to review the OIG Mid-Year Work Plan.

Medlearn Matters Special Edition 1615 (SE1615): Zika Virus Testing

On February 1, 2016, the World Health Organization (WHO) declared the Zika virus a Public Health Emergency of International Concern (PHEIC). According to the Centers for Disease Control and Prevention (CDC), the Zika virus disease is a nationally notifiable condition that has caused outbreaks in many countries and territories.

The virus is primarily spread through the bite of an infected Aedes species mosquito, although other modes of transmission include mother-to-child transmission, blood transfusion and sexual transmission. Currently there are a few diagnostic tests that can determine the presence of the virus. These tests are available through the CDC and CDC-approved state health laboratories. A small number of tests have been issued an Emergency Use Authorization by the Food and Drug Administration (FDA) and may be available through commercial laboratories.

On June 27 2016, CMS released SE 1615 informing the public that Medicare covers Zika virus testing under Medicare Part B as long as the clinical diagnostic laboratory test is reasonable and necessary for the diagnosis or treatment of a person's illness or injury.

Presently there are no specific HCPCS codes for testing of the Zika virus; however, laboratories should contact their local MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

MM SE1615 can be read here in its entirety. Since Medicare's inception in 1966, private health care insurers have processed medical claims for Medicare beneficiaries. Originally these entities were known as Part A Fiscal Intermediaries (FI) and Part B carriers.

Review of Current Medicare Administrative Contractors

In 2003 the Centers for Medicare & Medicaid Services (CMS) was directed via Section 911 of the Medicare Prescription Drug Improvement, and Modernization Act (MMA) of 2003 to replace the Part A FIs and Part B carriers with A/B Medicare Administrative Contractors (MACs) in accordance with the Federal Acquisition Regulation (FAR).

A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.

CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program.

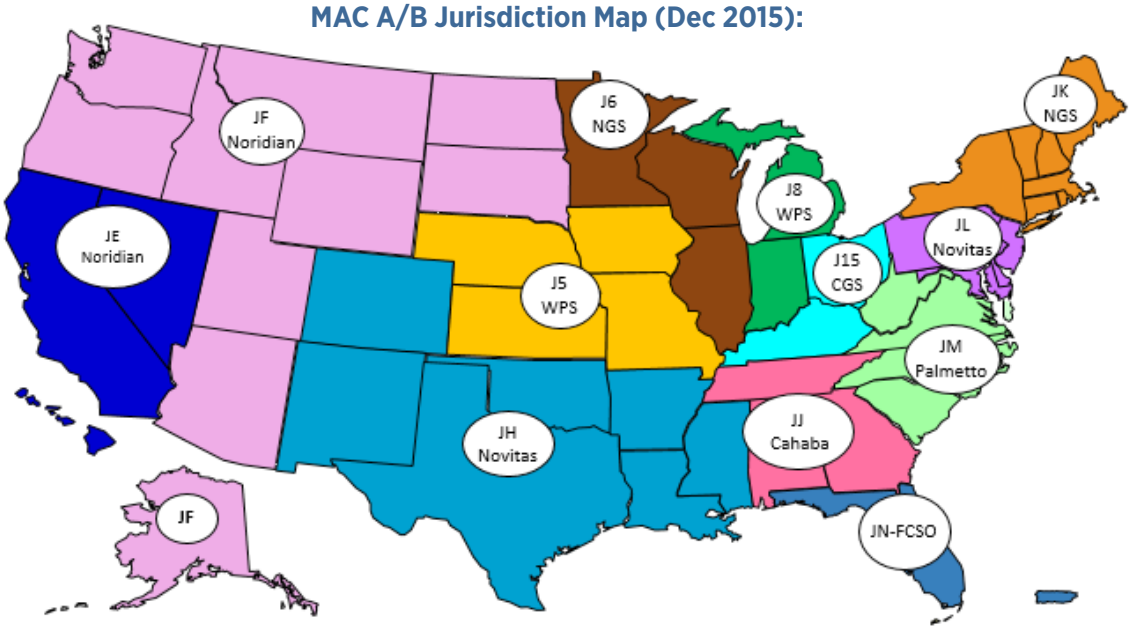
MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims. MACs perform many activities including:

- Process Medicare FFS claims
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCD's)
- Review medical records for selected claims
- Coordinate with CMS and other FFS contractors

Currently there are 12 A/B MACs and 4 DME MACs in the program that process Medicare FFS claims for nearly 70% of the total Medicare beneficiary population, or 37.5 million Medicare FFS beneficiaries. The MACs serve more than 1.5 million health care providers enrolled in the Medicare FFS program.

Collectively, the MACs process more than 1.2 billion Medicare FFS claims annually, 210 million Part A claims and more than 1 billion Part B claims, and paid $367 billion in Medicare benefits.

MAC A/B Jurisdiction Map (Dec 2015):



JW Modifier: Drug Amount Discarded/Not Administered to any Patient

Effective January 1, 2017, when processing claims for Part B drugs and biologicals (except those provided under Competitive Acquisition Program, CAP), the use of the JW modifier to identify unused drugs or biologicals that are appropriately discarded **is required**.

The current policy allows contractors the discretion to determine whether to require the JW modifier for any claims with discarded drugs or biologicals, and the specific details regarding how the discarded drug or biological information should be documented.

In order to more effectively identify and monitor billing and payment for discarded drugs and biologicals, CMS is revising this policy to require the uniform use of the JW modifier for all claims with discarded Part B drugs and biologicals.

Also, effective January 1, 2017, providers are required to document the discarded drug or biological in the patient's medical record.

CMS encourages physicians, hospitals and other providers and suppliers to care for and administer drugs and biologicals to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

Read the entire MedLearn Matter Article 9963 here.

HHS: Phase 2 of HIPAA Audit Program Begins

As a part of its continued efforts to assess compliance with the HIPAA Privacy, Security and Breach Notification Rules, the HHS Office for Civil Rights (OCR) has begun its next phase of audits of covered entities and their business associates. Audits are an important compliance tool for OCR that supplements OCR's other enforcement tools, such as complaint investigations and compliance reviews. These tools enable OCR to identify best practices and proactively uncover and address risks and vulnerabilities to protected health information (PHI).

In its 2016 Phase 2 HIPAA Audit Program, OCR will review the policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the Privacy, Security, and Breach Notification Rules. These audits will primarily be desk audits, although some on-site audits will be conducted.

The 2016 audit process begins with verification of an entity's address and contact information. An email is being sent to covered entities and business associates requesting that contact information be provided to OCR in a timely manner. OCR will then transmit a pre-audit questionnaire to gather data about the size, type, and operations of potential auditees; this data will be used with other information to create potential audit subject pools.

If an entity does not respond to OCR's request to verify its contact information or pre-audit questionnaire, OCR will use publically available information about the entity to create its audit subject pool. Therefore an entity that does not respond to OCR may still be selected for an audit or subject to a compliance review. Communications from OCR will be sent via email and may be incorrectly classified as spam. If your entity's spam filtering and virus protection are automatically enabled, we expect entities to check their junk or spam email folder for emails from OCR.

The audit program is developing on pace and OCR is committed to transparency about the process. OCR will post updated audit protocols on its website closer to conducting the 2016 audits. The audit protocol will be updated to reflect the HIPAA Omnibus Rulemaking and can be used as a tool by organizations to conduct their own internal self-audits as part of their HIPAA compliance activities.

OCR's audits will enhance industry awareness of compliance obligations and enable OCR to better target technical assistance regarding problems identified through the audits.

If you are selected for an audit, submit the requested documentation and any written comments demonstrating your compliance with the following HIPAA requirements:

- Privacy rule: Notice of Privacy Practices and Content Requirements, Privacy—Specific Requirements for Electronic Notice and Privacy—Right to Access.
- Breach notification rule: Breach Notification—Timeliness and Breach Notification—Content.
- Security rule: Security Risk Analysis and Security Risk Management.

Through the information gleaned from the audits, OCR will develop tools and guidance to assist the industry in compliance self-evaluation and in preventing breaches. We will evaluate the results and procedures used in our phase 2 audits to develop our permanent audit program.

For more information on phase 2 of the OCR's HIPAA compliance audit program, check out the audit phase 2 program objectives and frequently asked questions.

Revised Medicare Vision Fact Sheet – Newly Revised

To see coverage guidelines and coding requirements, click here to see the new Fact Sheet.

Search for Excluded Persons:

To avoid Civil Monetary Penalty (CMP) liability, health care entities need to routinely check the LEIE to ensure that new hires and current employees are not on Office of the Inspector General's (OIG) excluded list.

Mandatory exclusions: OIG is required by law to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances

The effects of an exclusion are outlined in the Updated Special Advisory Bulletin on the Effect of Exclusions From Participation in Federal Health Programs, but the primary effect is that no payment will be provided for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This includes Medicare, Medicaid, and all other Federal plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan), but the primary effect is that no payment will be provided for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This includes Medicare, Medicaid, and all other Federal plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

Search individuals in the Exclusions Database

Review the Updated Special Advisory Bulletin

2017 New ICD-10-CM Revisions Effective 10/1/16

A final list of new and revised ICD-10-CM and ICD-10-PCS codes have been released. These are effective October 1, 2016 (FY 2017).

The diagnosis changes reflect 1,943 new ICD-10-CM codes and 311 deletions.

Experian Health Exclusive

For your convenience we are hosting the above lists on our healthcare blog. Click the links below to download these spreadsheets.

- ICD-10-CM New codes for 2017
- ICD-10-CM Deleted codes

New CLIA Waived Tests

On June 24, CMS released a change request informing contractors of new CLIA waived tests approved by the Food and Drug Administration. Since these tests are marketed immediately after approval, CMS must notify its contractors of the new tests so that the contractors can accurately process claims. There are 30 newly added waived complexity tests. This recurring update notification applies to Chapter 16, Medicare Claims Processing Manual, section 70.8 of the IOM.

Your Medicare Administrative contractor (MAC) will not search their files to either retract payment or retroactively pay claims; however, they should adjust such claims brought to their attention.

The following tests are approved by the FDA as waived tests under CLIA (QW Modifier required):

CPT Code	Effective Date	Description
G0434QW	From August 21, 2015 to December 31, 2015	Healgen Scientific LLC, Healgen Multi-Drug Urine Test Dip Card
G0477QW	On and after January 1, 2016	Healgen Scientific LLC, Healgen Multi-Drug Urine Test Dip Card
G0477QW	March 8, 2016	Tanner Scientific Multi-Panel Drug Test Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Easy Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Split Key Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Test Cassette
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Test Dip Card
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Easy Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Split Key Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Test Cassette
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Test Dip Card
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Easy Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Split Key Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Test Cassette
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Test Dip Card
87338QW	March 22, 2016	Meridian Bioscience Immunocard STAT! HpSA (Stool)
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Dip Card
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Quick Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Strip
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Turn-Key Split Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Dip Card
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Quick Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Strip
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Turn-Key Split Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Dip Card
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Quick Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Strip
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Turn-Key Split Cup
G0477QW	April 21, 2016	Chemtron Biotech, Inc. Chemtrue Multi-Panel Drug Screen Cup Tests
G0477QW	April 21, 2016	Chemtron Biotech, Inc. Chemtrue Multi-Panel Drug Screen Cup

Effective date: October 1, 2016
Implementation date: October 3, 2016
Click here to view the Transmittal.

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.

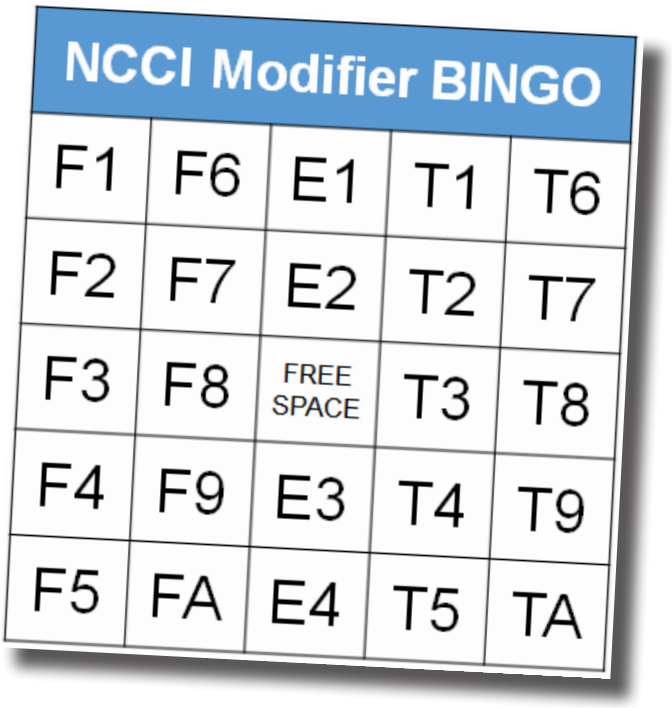
The NCCI edits define when two HCPCS/CPT ® procedure codes may not be reported together except under special circumstances. The Centers for Medicare & Medicaid Services (CMS) based the NCCI coding policies on current coding conventions, coding guidelines, national and local Medicare policies (NCDs and 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, RC, LT, 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).

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.

Click here to review the NCCI manual on CMS.

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