

PC-ACE Pro32

Release Newsletter

Version 2.26

January 2011

Institutional Change Summary

We are pleased to announce the release of PC-ACE Pro32 version 2.26. This upgrade contains several CMS Medicare Mandates and product enhancements effective 1/1/2011, including these highlighted changes:

- ◆ **2011 HCPCS Annual Update Reminder** – Updated HCPCS file: 363 added; 236 deleted, and 565 modified.
- ◆ **Update to Medicare Deductible, Coinsurance and Premium Rates for CY 2011** – Updated Institutional claim edits to support the new 2011 rates
- ◆ **Support of the Version 5010 Errata (June 2010) of the ANSI Transactions: 837, 835 and 999 for In-House and Selected Provider Testing** - PC-ACE Pro32 has been enhanced to support in-house distributor and selected provider testing of the upcoming version 005010 errata (June 2010) transactions. A complete list of product changes will be made available to distributors in a separate document to facilitate Version 5010 errata testing activities.
- ◆ **Support of the Version 5010 (April 2008) and Version 5010 Errata (June 2010) of the ANSI-270/271 Eligibility Benefit Inquiry and Response Transactions for In-House and Selected Provider Testing** - PC-ACE Pro32 has been enhanced to support in-house distributor and selected provider testing of the upcoming Versions 005010 and 005010A1 of the ANSI-270/271 Eligibility Benefit Inquiry and Response transactions. A complete list of product changes will be made available to distributors in a separate document to facilitate Version 5010 testing activities.

ENCLOSED MATERIALS

- Pre-built PC-ACE Pro32 2.26 upgrade file named PCACEUP.EXE and replacement SETUP.EXE file for any new providers
- This Newsletter

CMS MEDICARE MANDATES

CR7224 – Update to Medicare Deductible, Coinsurance and Premium Rates for CY 2011

◆ Added three new Institutional claim edits to enforce the Medicare Deductible and Coinsurance amounts for Calendar Year 2011.

CR7227 – 2011 HCPCS Annual Update Reminder

◆ Replaced the HCPCS file with the annual 2011 update for claims processed on or after January 1, 2011. HCPCS Changes: 236 deleted; 363 added; 565 modified. Modifier Changes: 0 deleted; 8 added; 2 modified.

CR7024 - 5010 Implementation Changes to Present on Admission Indicator (POA) "1" and the "K3" Segment

◆ Added a "POA Exempt" field to the ICD-9 reference file's diagnosis code screen. This new indicator will be used to enforce POA reporting requirements for specific diagnosis codes. Populated this field in the standard ICD-9 reference file using the table data provided in this change request. Added and/or modified institutional claim edits to enforce POA reporting exemptions based on this reference file indicator.

◆ Added and/or modified institutional claim edits to prohibit POA reporting for exempt ICD-9 diagnosis codes.

◆ Confirmed that the institutional claim prepare module already suppresses POA indicator "1" on claims prepared in 5010 format

◆ Confirmed that the institutional claim print module already suppresses POA indicator "1" on paper UB-04 printed claims

◆ Confirmed that the institutional claim prepare module already suppresses POA reporting in the K3 segment for claims prepared in 5010 format.

CR7064 - ESRD PPS and Consolidated Billing for Limited Part B Services

◆ Added an Institutional claim edit, which prohibits reporting of Revenue Code 0880 on Medicare claims (TOB = 72x; eff 1/1/2011)

CR7079 - Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

◆ Added a new Institutional edit prohibiting the use of HCPCS codes G0438 and G0439 on any other TOBS other than 12x, 13x, 22, 23x, 71x, 77x, and 85x

ADDITIONAL CMS MANDATED CHANGES

CR7158 - Claim Status Category and Claim Status Codes Update

◆ Updated the Claim Status Response Codes reference file with the latest WPC published code set. Category Codes Added: 0 ; Status Codes Added: 10; Codes Deleted/Terminated: 0 ; Status Codes Modified: 121. The new status codes are: "743 - Entity's credential/enrollment information. **Note:** This code requires use of an Entity Code.", "744 - Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.", "745 - Identifier Qualifier Note: At least one other status code is required to identify the specific identifier qualifier in error.", "746 - Duplicate Submission Note: use only at the information receiver level in the Health Care Claim Acknowledgement transaction.", "747 - Hospice Employee Indicator", "748 - Corrected Data Note: Requires a second status code to identify the corrected data.", "749 - Date of Injury/Illness", "750 - Invalid Auto Accident State or Province Code", "751 - Invalid Ambulance Pick-up State or Province Code" and "752 - Invalid Ambulance Drop-off State or Province Code". The modified status codes are: 16 - 19, 23 - 26, 59, 60, 73, 85, 88 - 94, 96, 97, 106, 109, 114, 123 - 150, 153, 155, 157 - 168, 170 , 173 - 176, 182, 183, 220, 279, 288, 294, 318, 321,

322, 358 - 360, 363, 380, 383, 386, 387, 395, 414, 431, 466, 467, 470, 478, 480, 487, 491, 496, 499 - 506, 514, 560 - 563, 589, 633, 635, 663, 676, 677, 680, 689 and 695.

CR7159 - 2011 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) CB Update

▲ Implemented HCPCS code changes per the SNF/CB annual HCPCS code update (when available)

CR7133- Counseling to Prevent Tobacco Use

▲ Added new HCPCS codes effective 1/1/2011:

- **G0436** - TOBACCO-USE COUNSEL 3-10 MIN
- **G0437** - TOBACCO-USE COUNSEL >10 MIN

▲ Modified the existing temporary HCPCS codes C9801 and C9802 to add a 12/31/2010 termination date

▲ Added an Institutional edit to ensure that the TOB = 12x, 13x, 22x, 23x, 34x, 71x, 77x, or 85x if HCPCS codes G0436 or G0437 is present on the claim

CR7100 – Revenue Code Updates

▲ Added an Institutional claim edit prohibiting the use of Revenue Codes 0860 or 0861 on any type of bills other than 11x, 13x, or 85x

CR7185 – Annual Type of Service (TOS) Update

▲ New Codes added with the annual HCPCS update (January 2011 QR)

CR7142 - Clarification of Payment Window for Outpatient Services Treated as Inpatient Services

▲ Added a new Condition Code, 51, effective 6.25.2010

- **51** - ATTESTATION OF UNRELATED OUTPATIENT NONDIAGNOSTIC SERVICES

▲ Added a non-fatal Institutional claim edit, which prohibits reporting of the new Condition Code 51 on claims with service dates prior to 6/25/2010

▲ Added a non-fatal Institutional claim edit, which prohibits use of Condition Code 51 prior to 4/1/2011 (transmit date)

CR7144 - National Uniform Billing Committee (NUBC) Point of Origin Code Updates

▲ Modified an existing institutional claim edit which requires the Point of Origin (Admit Source) to be reported on outpatient claims such that TOB = 14x is no longer included in this requirement effective 4/1/2011

▲ Modified an existing institutional claim edit which prohibits reporting of Point of Origin (Admit Source) value '9 - Information Not Available' on outpatient claims such that it is no longer enforced for claim service dates on or after 4/1/2011
NUBC Conference Call Minutes (Source: August 2010)

▲ Modified the description for Point of Origin (Admit Source) code "F" to read "TRANSFER FROM A HOSPICE FACILITY"

CR7181 - January 2011 Quarterly Update for DEMPOS Competitive Bidding Program

▲ Added new codes with the Annual HCPCS update, effective 1/1/2011

- **E2622** - ADJ SKIN PRO W/C CUS WD<22IN
- **E2623** - ADJ SKIN PRO WC CUS WD>=22IN
- **E2624** - ADJ SKIN PRO/POS CUS<22IN
- **E2625** - ADJ SKIN PRO/POS WC CUS>=22

▲ Terminated the following codes effective 1/1/2011 with the Annual HCPCS update: K0734, K0735, K0736, K0737

CR7170 - Correct Reporting of Modifiers and Revenue Codes on Claims for Therapy Services

▲ Added a new Institutional claim edit prohibiting more than one occurrence of the modifiers GN, GO or GP on the same service line (effective 4/1/2011).

CR7234 - New HCPCS Q-Codes for 2010-2011 Seasonal Influenza Vaccines

▲ Added new influenza Vaccine HCPCS codes effective 10/1/2010:

- **Q2035** - Afluria vacc, 3 yrs & >, im
- **Q2036** - Flulaval vacc, 3 yrs & >, im
- **Q2037** - Fluvirin vacc, 3 yrs & >, im
- **Q2038** - Fluzone vacc, 3 yrs & >, im
- **Q2039** - NOS flu vacc, 3 yrs & >, im

▲ Added an Institutional claim edit which prohibits transmission of these new Vaccine codes prior to 1/1/2011

▲ Modified several existing Institutional claim edits to replace Vaccine HCPCS code 90658 with new HCPCS codes Q2035, Q2036, Q2037, Q2038, and Q2039.

▲ Added an institutional claim edit which terminates Vaccine HCPCS code 90658 for Medicare claims effective 1/1/2011.

CR7248 - CY 2011 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

▲ Codes added with the HCPCS file annual update, see CR 6991

CR6777 - Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)

▲ Added two additional Occurrence Span Code/Date field sets to the institutional claim form's "Ext. General (2)" tab. This brings the total Occurrence Span Codes supported per claim to ten (10), which permits unlimited OSC billing as described in this change request.

▲ Modified the Institutional Claim Import Module, the Institutional Claim Prepare Module, and the Institutional ANSI-837 Translator as needed to accommodate this enhancement

CR7038 - Affordable Care Act (ACA) Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs

Made several modifications in anticipation of the FQHC prospective payment system. The changes include:

▲ Added an institutional claim edit requiring a valid HCPCS code on all service lines for TOB = 77x claims with service dates on or after 1/1/2011. Only service lines with Revenue Codes 025x are exempt from HCPCS reporting

▲ Modified the Revenue Code reference file to enforce the requirement that all valid Revenue Codes except for 002x, 024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x, 067x-072x, 080x-088x, 093x, or 096x-310x are now allowed on TOB = 77x claims with service dates on or after 1/1/2011

▲ Modified an existing institutional claim edit which enforces Revenue Code restrictions for TOB = 77x such that it expires effective 1/1/2011. These restrictions will now be enforced by the Revenue Code reference file settings

CR7087 - National Modifier and Condition Code to Identify Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico

▲ Added a new HCPCS modifier "CS - GULF OIL SPILL 2010 RELATED" and Condition Code "BP - GULF OIL SPILL OF 2010" for use in billing claims related to the Gulf oil spill of 2010. Both new codes are effective for service dates on or after 4/20/2010

♣ Added an institutional claim edit to enforce the 4/20/2010 effective date for the new "BP" condition code

Claim Adjustment Reason Codes Update (Source: WPC)

♣ Updated the Claim Adjustment Reason Codes reference file with the latest WPC published code set. Codes Added: 1 ; Codes Deleted/Terminated: 0 ; Codes Modified: 6. The new code is: "W2 - Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.". The modified codes are: 191, 214, 218, 219, 221 and W1.

Remittance Advice Remark Codes Update (Source: WPC)

♣ Updated the Remittance Remarks Codes reference file with the latest WPC published code set. Codes Added: 2 ; Codes Deleted/Terminated: 0 ; Codes Modified: 2. The new codes are: "N540 - Payment adjusted based on the interrupted stay policy.|Payment adjusted based on the interrupted stay policy." and "N541 - Mismatch between the submitted insurance type code and the information stored in our system.|Mismatch between the submitted insurance type code and the information stored in our system." The modified codes are: M25 and N291.

MODIFICATIONS IN SUPPORT OF ANSI (HIPAA) IG COMPLIANCE

Added Support for Version 5010 Errata (June 2010) ANSI Transactions for In-house – 837, 835, and 999

♣ Support for Version 5010 Errata (June 2010) ANSI Transactions Enhanced PC-ACE Pro32 to support changes mandated by the June 2010 errata of the Institutional ANSI-837Health Care Claim Implementation Guide (ASC X12N/005010X223A2), the ANSI-835 Health Care Claim Payment/Advice Implementation Guide (ASC X12N/005010X221A1) and the ANSI-999 Implementation Acknowledgment Implementation Guide (ASC X12N/005010X231A1). 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, and should experience no impact from these errata changes.

Support for Version 5010 (August 2008) and Version 5010 Errata (June 2010) ANSI-270/271 Transactions

Enhanced PC-ACE Pro32 to support changes mandated by the Version 5010 (August 2008) and subsequent errata (June 2010) of the Health Care Eligibility Benefit Inquiry and Response Implementation Guide (ASC X12N / 005010X279 / 005010X279A1). 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 following 5010 related changes are relevant to providers using this PC-ACE Pro32 release:

♣ The ANSI Version (270) field on the Submitter record has been widened to accept complete version and addenda specifications. The currently valid ANSI versions are "004010A1", "005010" and "005010A1". The product no longer supports the original 004010 version (pre-addenda). Users are prohibited by fatal edits from selecting the 5010 options at this time (requires distributor authorization).

♣ Several new fields have been added to the Eligibility Benefit Request Form in order to support the 5010 release. While the 4010A1 version is still the standard, these fields should simply

be ignored by users. The existence of these additional fields should not complicate the user's ability to create inquiries. New fields include:

- Subscriber Organization Name
- Subscriber Entity Qualifier
- Diagnosis Codes (1-8)
- Diagnosis Pointer {inquiry line}
- Spend Down Total Billed Amount {inquiry line}

♣ New codes have been added, and existing codes deleted, from numerous indicator and qualifier type fields on the Eligibility Benefit Request Form. These changes are reflected in the various lookup lists, with notations like "(4010 only)" added where appropriate. Users will eventually need to be educated on these changes where applicable. Code enforcement is performed by system edits based on the ANSI version (270) setting established in the Submitter reference file. This prevents users from inadvertently selecting 5010-only codes on a request to be prepared in 4010A1 format.

ANSI-835 Remittance Processors (ETRA) Version 5010 Errata (June 2010)

♣ Enhanced the ANSI-835 Remittance Processors (ETRA) to add support for the version 5010 errata (June 2010). Providers should experience no impact to current 4010A1 processing from these 5010 errata changes.

ANSI-999 Report Utility Version 5010 Errata (June 2010)

♣ Enhanced the ANSI-999 Report Utility to add support for the version 005010 errata (June 2010). Providers should experience no impact to current 4010A1 processing from these 5010 errata changes.

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.