PC-ACE Pro32

Release Newsletter | Version 2.32 | October 2011

Institutional Change Summary

We are pleased to announce the release of PC-ACE Pro32 version 2.32. This upgrade contains several CMS Medicare Mandates and product enhancements effective 10/1/2011, including these highlighted changes:

♦ **Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)–** ICD-9 Annual Update – 168 new diagnosis codes; 19 new procedure codes

♦ **ANSI Version 4010A1 Prohibited After 1/1/2012** - In anticipation of the switch to ANSI version 5010, please review the Institutional Provider reference file to update the billing provider ZIP code on all records to the full 9-position value. In addition, the billing provider must now always have a physical address. Post office and lock boxes are no longer permitted. Also, be sure you have the "Provider Accepts Assign" field on the Extended Info tab populated. Finally, you'll need to update the ZIP code on all Facility reference file records to the full 9-position value. These changes are necessary to meet new version 5010 requirements. Watch for additional communications from your Medicare contractor regarding any procedural changes that may be needed as you switch ANSI versions.

ENCLOSED MATERIALS

- Pre-built PC-ACE Pro32 2.32 upgrade file named PCACEUP.EXE and replacement SETUP.EXE file for any new providers
- This Newsletter

CMS MEDICARE MANDATES

CR7456 - 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: 0 ; Status Codes Deleted/Terminated: 0 ; Status Codes Modified: 16. The modified status codes are: 59, 60, 279, 288, 294, 318, 322, 360, 363, 380, 383, 386, 414, 431, 589 and 633.

CR7454 - Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

♠ Integrated the annual ICD-9 diagnosis/procedure code file from CMS into the October 2011 release. This update includes 168 new diagnosis codes, 19 new procedure codes, 63 modified diagnosis codes, and 21 modified procedure codes.

CR7431 - Antilogous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer

♠ Added an institutional claim edit which requires that either ICD-9 diagnosis code 233.4 or 185 be reported with PROVENGE HCPCS code Q2043 (effective 7/1/2011).

♠ Added an institutional claim edit which requires that Revenue Code 0636 be reported with PROVENGE HCPCS code Q2043 (TOBs 12X, 13X, 22X, 23X, and 85X ; effective 7/1/2011).

CR7476 - Quarterly Update to the End-Stage Renal Disease Prospective Payment System

♠ Added new ICD-9 codes effective 10/1/11:

- **282.43** – ALPHA THALASSEMIA
- **282.44** – BETA THALASSEMIA
- **282.45** – DELTA-BETA THALASSEMIA
- **282.46** – THALASESMIA MINOR
- **282.47** – HEMOGLOBIN E-BETA THALASSEMIA

ADDITIONAL CMS MANDATED CHANGES

Category III Code Update (Source: AMA website)

♠ Added new codes effective 1/1/2012:

- **0276T** - BRONCH THERMOPLASTY 1 LOBE
- **0277T** - BRONCH THERMOPLASTY LOBES
- **0278T** - TEMPR
- **0279T** - CTC TEST
- **0280T** - CTC TEST W/I & R
- **0281T** - LAA CLOSURE W/IMPLANT
- **0282T** - PERIPH FIELD STIMUL TRIAL
- **0283T** - PERIPH FIELD STIMUL PERM
- **0284T** - PERIPH FIELD STIMUL REVISE
- **0285T** - PERIPH FIELD STIMUL ANALYS
- **0286T** - NEAR IFR SPECTRSC OF WOUNDS
- **0287T** - NEAR IFR GUIDE OF VASC SITE
- **0288T** - ANOSCOPY W/RF DELIVERY
- **0289T** - LASER INC FOR PKP/LKP DONOR
- **0290T** - LASER INC FOR PKP/LKP RECIP
- **0291T** - IV OCT FOR PROC INIT VESSEL
- **0292T** - IV OCT FOR PROC ADDL VESSEL
- **0293T** - INS LT ATRL PRESS MONITOR
- **0294T** - INS LT ATRL PRESS MONT ADDON
- **0295T** - EXT ECG COMPELTE
- **0296T** - EXT ECG RECORDING
- **0297T** - EXT ECG SCAN W/REPORT
- **0298T** - EXT ECG REVIEW AND INTERP
- **0299T** - ESW WOUND HEALING INIT WOUND
- **0300T** - ESW WOUND HEALING ADDL WOUND
- **0301T** - MW THERAPY FOR BREAST TUMOR

CR7460 - Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims

♠ Added an institutional claim edit for ESRD (TOB = 72x) claims which requires a route of administration modifier JA or

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JB on all service lines reporting ESA HCPCS codes Q4081 or J0882 (effective 1/1/2012)

CR7514 - Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) and PC Print Update

♠ 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: "237 - Legislated/Regulatory Penalty. 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 codes are: 191, 214, 218, 219, 221 and W1.

♠ Updated the Remittance Remarks Codes reference file with the latest WPC published code set. Codes Added: 3 ; Codes Deleted/Terminated: 0 ; Codes Modified: 2. The new codes are: "N544 - Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.", "N545 - Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program." and "N546 - Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.". The modified codes are: N542 and N543.

CR7440 - Informational Message on the 835

♠ Added new RARC, **N544** - Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.

CR7530 - Healthcare Provider Taxonomy Codes (HPTC) Update October 2011

♠ Updated the Provider Taxonomy Code reference file with the latest WPC published code set. Codes Added: 3 ; Codes Deleted/Terminated: 0 ; Codes Modified: 0. The new codes are: "207RH0005X - Internal Medicine : Hypertension Specialist", "224Y00000X - Clinical Exercise Physiologist" and "335G00000X - Medical Foods Supplier".

CR7545 - October 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

♠ Added new HCPCS codes effective 10/1/2011:

- **C1830** - POWER BONE MARROS BX NEEDLE
- **C1840** - TELESCOPIC INTRAOCULAR LENS
- **C9286** - INJECTION, BELATCEPT

MODIFICATIONS IN SUPPORT OF ANSI (HIPAA) IG COMPLIANCE

UB-04 Data Specifications Manual (Version 6.00, July 2011)

Per a review of the Official UB-04 Data Specifications Manual (Version 6.00; July 2011), made the following changes:

♠ Modified the fixed-list lookup description for Point of Origin for Admission or Visit code "5" to "Transfer from an SNF, ICF or ALF / Born In Hospital" on the institutional claim form

♠ Modified an institutional claim edit which requires the Admitting Diagnosis code on version 5010 claims such that it is now bypassed for TOBs 028x, 065x, 066x, 086x

♠ Modified an institutional claim edit which requires the Discharge Hour on inpatient claims such that it is now bypassed for the 21x bill type

♠ Modified and/or deleted several institutional claim edits referencing the Patient's Reason For Visit fields to reverse the "do not send" changes made in the July 2011 release. The Patient's Reason For Visit is no longer required for all outpatient claims, but only the specific subset of outpatient claims referenced in the UB-04 manual.

♠ Modified an existing institutional claim edit and added a new edit to tighten the Point of Origin for Admission or Visit requirement edits for version 5010 claims such that this element is now required for all claims except the 14x bill type

♠ Implemented the redefinition of the Authorization Code / Referral Number fields (Form Locator 63) such Payer A holds the submission payer's Authorization Code (Qual = 'G1'), Payer B holds the submission payer's Referral Number (Qual = '9F'), and Payer C holds the secondary payer's Authorization Code (Qual = 'G1'). The three occurrences are no longer associated with the primary, secondary, and tertiary payers in sequence. This change becomes effective automatically on 1/1/2012, and impacts the institutional claim import and claim print modules.

Enforce Valid ANSI 5010 Versions on Submitter Reference File

♠ Modified the fixed list lookups on the various ANSI version fields in the institutional Submitter record to eliminate the original 5010 versions. Only the June 2010 "errata" versions are considered valid 5010 versions at this point.

♠ Modified the system-level validation edits such that they no longer allow the original 5010 versions

♠ Added an institutional claim edit that looks into the Submitter file to insure that the original 5010 versions are not still in use

ANSI-837 Version 4010A1 Prohibited After 1/1/2012

♠ Added fatal institutional claim and eligibility/benefit request edits which prohibit preparation of ANSI-837 and ANSI-270 files in 4010A1 format on or after 1/1/2012.

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.