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Integrated Outpatient Code Editor

User's Manual for z/OS Batch

v.21.2

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About this document

This manual contains the information needed to use version 21.2 of the Integrated Outpatient Code Editor (OCE) software (formerly known as the Outpatient Code Editor with Ambulatory Payment Classification - OCE/APC) developed and run under the z/OS operating system on a mainframe. The software edits hospital outpatient medical records for possible errors in coding; assigns APCs for Medicare's outpatient prospective payment system (OPPS).

The manual assumes that the person using the software has experience working with Basic Assembly Language (BAL) and is comfortable working with Job Control Language (JCL) in the z/OS operating system.

Appendix A of the Integrated OCE Software Installation Manual (PBL–019) contains a summary of changes in this release.

Chapter 1: Introduction to the Integrated OCE software

The Integrated Outpatient Code Editor (OCE) program edits patient data to help identify possible errors in coding, and assigns Ambulatory Payment Classification numbers based on Healthcare Common Procedure Coding System (HCPCS) codes for payment under the mandated outpatient prospective payment system (OPPS).

The Integrated OCE program also edits claims for hospitals not subject to OPPS.

Product background

The OPPS OCE (formerly called the Outpatient Code Editor with Ambulatory Payment Classification - OCE/APC) and the Non-OPPS OCE (formerly called the Outpatient Code Editor - OCE) were combined into a single program, the Integrated Outpatient Code Editor (IOCE) effective 7/1/07.

The OPPS functionality of the Integrated Outpatient Code Editor (IOCE) software was developed for the implementation of the Medicare outpatient prospective payment system mandated by the 1997 Balanced Budget Act. CMS released the proposed OPPS rules using the Ambulatory Payment Classification (APC) system in the September 8, 1998 Federal Register. Final regulations were published in the April 7, 2000 Federal Register and the system became effective for Medicare on August 1, 2000.

The APC-based OPPS developed by CMS is the outpatient equivalent of the inpatient, DRG-based PPS. The APC system establishes groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources.

Hospitals are required to use HCPCS when billing for outpatient services. HCPCS incorporates the following types of codes:

- Level I - The American Medical Association's Physicians' Current Procedural Terminology (CPT®)
- Level II - National codes developed by the Centers for Medicare & Medicaid Services (CMS)

Like the inpatient system based on Diagnosis Related Groups (DRGs), each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service.

Certain services (e.g., physical therapy, diagnostic clinical laboratory) are excluded from Medicare's prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.

Versions of the program

The following table lists the versions and date ranges of the program contained in the current release of IOCE software for OPPS processing. The third level in the version number (represented by an 'x' in the table) denotes the number of revisions created since the original OPPS release. For example, 7.1.7 would be the seventh revision of the released version 7.1 product.

Note: Separately installed versions of the non-OPPS OCE must be maintained for as long as necessary to process claims for all hospital outpatient services provided prior to August 1, 2000 when OPPS was implemented; and non-OPPS hospital outpatient services prior to July 1, 2007 when the non-OPPS program was integrated into the OPPS program.

Table 1. Program versions

Version	Effective date range
21.2.0	07/01/2020–07/01/2030[a]
21.1.x	04/01/2020–06/30/2020
21.0.x	01/01/2020–03/31/2020
20.3.x	10/01/2019–12/31/2019
20.2.x	07/01/2019–09/30/2019
20.1.x	04/01/2019–06/30/2019
20.0.x	01/01/2019–03/31/2019
19.3.x	10/01/2018–12/31/2018
19.2.x	07/01/2018–09/30/2018
19.1.x	04/01/2018–06/30/2018
19.0.x	01/01/2018–03/31/2018
18.3.x	10/01/2017–12/31/2017
18.2.x	07/01/2017–09/30/2017
18.1.x	04/01/2017–06/30/2017
18.0.x	01/01/2017–03/31/2017
17.3.x	10/01/2016–12/31/2016

Version	Effective date range
17.2.x	07/01/2016–09/30/2016
17.1.x	04/01/2016–06/30/2016
17.0.x	01/01/2016–03/31/2016
16.3.x	10/01/2015–12/31/2015
16.2.x	07/01/2015–09/30/2015
16.1.x	04/01/2015–06/30/2015
16.0.x	01/01/2015–03/31/2015
15.3.x	10/01/2014–12/31/2014
15.2.x	07/01/2014–09/30/2014
15.1.x	04/01/2014–06/30/2014
15.0.x	01/01/2014–03/31/2014
14.3.x	10/01/2013–12/31/2013

a. The ending date of the current version will be modified to the actual ending date with the next release.

Included versions

To maintain a reasonable size for the program and data files, the IOCE will include only seven years of programs and files in each update. The earliest supported version in the current release is 14.3.x (effective 10/01/13); subsequent updates will drop the version corresponding to the earliest quarter as each new quarter is added. The program version table (page 10) will be updated to reflect the versions of the program contained in the current release.

Purpose of the OPPS functionality

The IOCE software combines editing logic with the new APC assignment program designed to meet the mandated OPPS implementation. The software performs the following functions when processing a claim:

- Edits a claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated status indicators (page 18, page 22)

- Assigns payment indicators
- Computes discounts, if applicable
- Determines a claim disposition based on generated edits
- Determines if packaging is applicable
- Determines payment adjustment, if applicable

Purpose of the non-OPPS functionality

The IOCE program edits non-OPPS claims primarily for accuracy of submitted data.

Changes since OPPS

Prior to OPPS, the program focused solely on editing claims without specifying any action to take when an edit occurred. It also did not compute any information for payment purposes.

While the program has maintained the editing function of previous versions, assignment of APC numbers for services has been added to meet Medicare's mandated OPPS implementation. The revised program indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment. In this case, the line item cannot be resubmitted but can be appealed (page 25).

A major change is the processing of claims with service dates that span more than one day. Each claim is represented by a collection of data, consisting of all necessary demographic (header) data, plus all services provided (line items).

Note: It is the user's responsibility to organize all applicable services into a single claim record and pass them as a unit to the software.

The IOCE only functions on a single claim and does not have any cross claim capabilities. The software can accept up to 450 line items per claim.

Coding for Outpatient services

Diagnoses are coded in ICD-10-CM classification (ICD-9-CM classification for claims with From Dates prior to 10/1/2015); procedures are coded in HCPCS classification.

Program input

The data elements shown in the following table are entered into the program for claim processing. You are not required to have every element entered for every claim.

Data elements

Table 2. Data elements

Data element	UB-04 form locator
Type of bill	4
Period covered by statement, From, and Through dates	6
Birth date	10
Sex	11
Patient status	17
Condition codes	18-28
Occurrence codes	31-34
Value code and value code amount	39-41
HCPCS/CPT procedure code(s) and modifier(s)	44
Service date	45
Revenue code	42
Service units	46
Charge	47
National provider identifier	56
OSCAR Medicare provider number	57
ICD-10-CM or ICD-9-CM diagnosis code(s) (principal dx/secondary dx) (ICD-9-CM diagnosis codes for claims with From dates prior to 10/1/2015)	67 (PDX) 67A-Q (SDX)
ICD-10-CM diagnosis code (patient's RVDX1, RVDX2, and RVDX3) (ICD-9-CM diagnosis codes for claims with From dates prior to 10/1/2015)	70A-C (patient's RVDX)

Dispositions

Occurrence of an edit can result in one of six dispositions that act at either the line or the claim level. For example, an edit can cause a line item rejection or return the claim to the provider (RTP). A single claim can have one or more edits across all types of edit dispositions. Edit dispositions are described in more detail in OPPS program output (page 21) and Non-OPPS program output (page 83).

In addition to individual dispositions, there is a claim disposition to summarize the overall status of the claim. For example, a claim can be paid with a line item denied or rejected, or the entire claim can be denied payment. Claim dispositions are also described in more detail in OPPS program output (page 21) and Non-OPPs program output (page 83).

Multiple day claims

The span of time represented by a claim is determined by the From and Through dates on the UB-04 form. The software subdivides the claim into separate days in order to determine discounting and multiple visits on the same calendar day.

For emergency room and observation claims, all services spanning more than one day are processed as separate days according to the dates of the entered line items.

If the From and Through dates span the effective date ranges for two program versions, the From date will determine which version is used for processing.

Edits

The extensive edits in the software, which are applied to claims as well as individual diagnoses and procedures, are described in more detail in OPPS program edits (page 37).

Information on APCs for OPPS

To better understand the IOCE product, this section provides general information on the APC system.

- Each HCPCS code that represents a service paid under OPPS is assigned to an APC. Other services are identified by a status indicator representing the method of payment.
- APCs are applied in the full range of ambulatory settings, including same day surgery, hospital ER, and outpatient clinics.
- Types of APCs are:
  - Significant procedure - In general, surgical APCs are specified by the T or J1 status indicator; the status indicator for non-surgical significant procedures is S.
  - Drug/Biological pass-through - The status indicator for drug/biological pass-throughs is G.
  - Device pass-through - The status indicator for device pass-throughs is H.
  - Brachytherapy sources - The status indicator for brachytherapy sources is U.
  - Medical visit - HCPCS codes used to assign medical APCs are specified by (SI = V or J2).
  - Ancillary service - HCPCS codes used in assigning ancillary APCs are specified by the X status indicator.

    Note: SI of X is deactivated as of 1/1/2015 (v16.0).
  - Non-pass-through drug or non-implantable biologicals - The status indicator for drug or biological non-pass-throughs, including therapeutic radiopharmaceuticals, is K.
  - Blood and blood products - The status indicator for blood and blood products is R.
  - Partial hospitalization - The status indicator for partial hospitalization services is P.

Payment information

APC assignment involves codes being examined together as a group, providing payers and providers with a common language and allowing meaningful comparative analyses. The IOCE software facilitates the classification of the coding input. The system used for payment is defined separately.

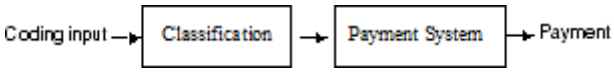

Figure 1: Logic flow for APC assignment and reimbursement

After APC group assignment, APC reimbursement is calculated using APC weights, a base rate, and payment policies. The APC weights represent the relative effort required to perform the specific procedure. The base rate is a dollar value that converts the relative weight to a reimbursement amount.

To help understand the way OPPS reimbursement is calculated, this section will explain some of the basic rules and policies mandated for OPPS using APCs.

Packaging

Ancillary packaging is the inclusion of certain ancillary services performed as part of a visit into the APC payment rate for a significant procedure or medical visit. APCs include some packaging; in some instances, the payment for services integral to the delivery of the procedure or medical visit will be packaged into the payment for the procedure or medical visit.

In addition to facility charges, other services, such as anesthesia and minor incidental services, are always packaged into the payment. Except in special circumstances (page 54), a facility will not receive additional reimbursement for packaged services.

Packaged services are specified by the N status indicator. However, OPPS logic sometimes requires packaging of services with a status indicator other than N. In these instances, a specific packaging flag may be used to indicate the packaged status or the SI may be changed to N. For more information, see the Integrated OCE Software Installation Manual.

Discounting

When multiple significant procedures are performed, or when the same service is performed multiple times, a discount may be applied. Multiple procedures done during the same operative session that will be discounted unless certain modifiers are present, are specified by the T status indicator.

The full payment amount is paid for the surgical procedure with the highest weight, and 50% of the payment amount is paid for other surgical procedures performed during the same visit. A T procedure terminated prior to anesthesia (modifier 52 or 73) is reimbursed at a discounted rate. All line items with SI other than T are subject to terminated procedure discounting when modifier 52 or 73 is present. The terminated procedure discount is 50%.

If the status indicator of a code changes during claim processing, the newly assigned indicator is used to compute the discount formula.

NCCI

The IOCE generates NCCI edits for OPPS and Non OPPS Facilities. All applicable NCCI edits are incorporated into the IOCE. Modifiers and coding pairs in the IOCE may differ from those in the NCCI because of differences between facility and professional services.

Effective January 1, 2006, NCCI edits apply to ALL services billed under bill types 12x, 13x, 14x, 22x, 23x, 34x, 72x, 74x, 75x,76x, and 85x by the following providers: Skilled Nursing Facilities (SNFs), ESRD facilities (ESRDs), Community Mental Health Clinics (CMHCs), Outpatient Physical Therapy and Speech-Language Pathology Providers (ORFs), CORFs, Home Health Agencies (HHAs), and Critical Access Hospitals (CAHs).

The NCCI edits are applied to services submitted on a single claim, and on lines with the same date of service. NCCI edits address unacceptable code combinations based on coding rules, standards of medical practice, two services being mutually exclusive, or a variety of other reasons. In some cases, the edit is set to pay the higher-priced service, in other cases the lesser-priced service.

In some instances, both codes in a NCCI code pair may be allowed if an appropriate modifier is used that describes the circumstances when both services may be allowed. The code pairs that may be allowed with a modifier are identified with a modifier indicator of “1”; code pairs that are never allowed, whether or not a modifier is present, are identified with a modifier indicator of “0”. Modifiers that are recognized/used to describe allowable circumstances are: 24, 25, 27, 57, 58, 59, 78, 79, and 91, E1-E4, F1-F9, FA, LC, LD, LM, LT, RI, RC, RT, T1-T9, TA, XE, XP, XS, and XU.

All institutional outpatient claims, regardless of facility type, process through the Integrated Outpatient Code Editor (IOCE); however, not all edits are performed for all sites of service or types of claim. Please see the Edits by Bill Type (OPPS=1) table, which contains IOCE edits that apply for each bill type under OPPS processing; please see the Edits by Bill Type (Non-OPPS=2) table, which contains OCE edits that apply to claims from hospitals not subject to OPPS.

Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have NCCI editing applied across facility and professional services appearing on the same day; NCCI editing is applied for the professional services separately from facility services.

Add-on code editing

Effective April 1, 2018 (v19.1), claims with certain bill-types are subject to add-on code edits if the primary procedure for the add-on code is not on the same day or day before. Add-on codes describe procedures or services that are always provided “in addition to” other, related services or procedures. These add-on procedure codes cannot be reported stand alone as separately reportable services. One add-on code may have multiple primary procedures with which it can be reported. In addition, there may be circumstances where reporting multiple add-on procedure codes are necessary, and in this instance the primary procedure for both add-ons

must be present on the claim. There are three different types of add-on codes defined by CMS for which the IOCE returns an edit(s) if the conditions to satisfy the edit(s) are not met.

1. Type I add-on codes have a defined list of primary procedure codes. If one or multiple Type I add-on codes are reported without their primary procedure edit 106 is returned on the add-on procedure line(s) and line item denied (LID).
2. Type II add-on codes do not have a defined list of primary procedures; individual contractors must define the list of primary procedure codes for Type II add-on codes. Type II add-on code editing in the IOCE is applied only to Critical Access Hospitals (bill type 85x) reporting professional services revenue codes (96x, 97x or 98x). Edit 107 is returned on all Type II add-on procedure line(s) for contractor review (LID).
3. Type III add-on codes have defined primary procedures but there may be additional contractor defined primary procedures. Type III add-on codes act the same as Type I in how the edit is applied, with edit 108 (LID).

Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have add-on code editing applied across facility and professional services; add on code editing is applied for the professional services separately from facility services.

Drug administration add-on procedure codes do have an exception in how add-on code edits are applied. Drug administration add-on procedure codes are not edited by date of service (primary procedure on same day or day before), instead add-on edits occur only if the primary drug administration procedure is not present on the same claim. The add-on code edit continues to be returned at the line level for the add-on procedure code missing its primary procedure (LID). All drug administration add-on procedure codes are Type I add-on codes (edit 106) and are subject to all other editing conditions applicable for Type I add-on codes.

Fee schedule

Certain services currently paid for are not assigned to an APC, but continue to be paid according to a fee schedule. Services paid by fee schedule include, but are not limited to, ambulance, diagnostic clinical laboratory, and occupational therapy.

Status indicators

Medicare has assigned each HCPCS/CPT code a letter that signifies whether they will reimburse the service, how it will be reimbursed, and to whom the claim should be submitted, e.g., MAC (Medicare Administrative Contractor), Carrier, DMERC (durable medical equipment regional carrier), etc. This indicator also helps in determining whether policy rules, such as packaging and discounting, apply.

Modifiers

The significance of modifiers increases in coding under OPPS. Modifiers add clarification and specificity to procedures and are edited in the software. Failure to use them or use of an incorrect modifier may adversely affect the payment decision for some outpatient services.

Same day medical and procedure APC

Significant procedure visits and medical visits will not usually occur on the same day. However, if a medical visit identified by an E&M (status indicator V) code with modifier 25 occurs on the same date as a significant procedure, an additional payment will be made. Modifier 25 indicates that the medical visit was significant and separately identifiable from the procedure performed. When the E&M code does not have a modifier of 25, the claim will be returned to provider.

Contractor (MAC) actions impacting IOCE processing

The Medicare Administrative Contractor may on occasion require an override or bypass of IOCE grouping or editing results, to apply payment adjustment outside of the IOCE process or for reprocessing OPPS/ Non-OPPS adjusted claims. This may be accomplished by the following actions, which may only be applied by the MAC; these actions are not meant to be input by an end-user or provider.

- Line item action flag. A value passed as input to the IOCE to override a line item denial or rejection or to allow the MAC to indicate the line item should be denied or rejected, even if no IOCE edits are present. Note: If a Line item action flag is present on any line item that also contains a contractor bypass, the line item action flag logic takes precedence and no contractor bypass is applied to the line.
- Contractor Bypass: Values passed as input to bypass IOCE edits and any payment value which may need adjusted by the MAC for payment determination. The presence of an IOCE edit in the Contractor Bypass edit field allows the bypass to execute, as defined by the contractor. A line level edit bypass for an OPPS claim requires all contractor bypass fields to be provided on input. A claim level edit bypass for an OPPS claim requires only the Contractor Bypass edits field to be populated with an applicable edit(s) in addition to providing an appropriate PMF value of V, W, X, Y, or Z in the CB Payment Method Flag field. A Non-OPPS claim with either a line level or claim level edit only require the edit(s) to be populated in the Contractor Bypass edit field with the appropriate PMF of V, W, X, Y, or Z in the CB Payment Method Flag Field. A line item where a contractor bypass is applied returns a payment method flag of V, W, X, Y, or Z to indicate that the line(s) payment is set by the Contractor. If the contractor does not supply a PMF value of either V, W, X, Y, or Z, by default a Z is supplied on output to identify that a line(s) has a contractor bypass applied.

Chapter 2: OPPS program output

This chapter describes Integrated Outpatient Code Editor (IOCE) program output for OPPS claims, including edit information, status indicators, and payment indicators. For input data elements, see "Program input" on page 13.

Line item information

The program processes input data and generates the following information for each line item on the claim:

- Healthcare Common Procedure Coding System (HCPCS) procedure code
- HCPCS APC
- Payment APC
- Status indicator
- Payment indicator
- Discounting factor
- Line item denial or rejection flag
- Packaging flag
- Payment adjustment flag
- Payment method flag
- Service units
- Charge
- Line item action flag
- Composite adjustment flag

APCs

Except when specified otherwise (e.g., partial hospitalization, mental health, observation logic, codes with an SI of 'Q#', etc.), the payment APC and the HCPCS APC are the same. For more information on APCS, see "Information on APCs for OPPS" on page 15. Appendix C contains a complete list of current APCs with their status indicators and descriptions.

Status indicators

Medicare has assigned each HCPCS/CPT code a letter that signifies whether Medicare will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. The status indicator values generated in program output are shown in the following table.

Table 3. List of status indicators

Value	Description
A	Services not paid under OPPS; paid under fee schedule or other payment system
B	Non-allowed item or service for OPPS
C	Inpatient procedure
E	Non-allowed item or service (discontinued 01/01/2017)
E1	Non-allowed item or service
E2	Items and services for which pricing information and claims data are not available
F	Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines
G	Drug/Biological pass-through
H	Pass-through device categories
J	New drug or new biological pass-through (discontinued 04/01/2002 and replaced by status indicator G for all drugs/biologicals)
J1	Outpatient department services paid through a comprehensive APC
J2	Hospital Part B services that may be paid through a comprehensive APC
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals
L	Flu/PPV vaccines
M	Service not billable to the MAC
N	Items and Services packaged into APC rates
P	Partial hospitalization service

Value	Description
Q	Packaged services subject to separate payment based on payment criteria (discontinued 01/01/2009 and replaced by status indicators Q1, Q2, Q3)
Q1	STV-packaged codes
Q2	T-packaged codes
Q3	Codes that may be paid through a composite APC
Q4	Conditionally packaged laboratory services
R	Blood and blood products
S	Procedure or service, not discounted when multiple
T	Procedure or service, multiple reduction applies
U	Brachytherapy sources
V	Clinic or emergency department visit
W	Invalid HCPCS or Invalid revenue code with blank HCPCS
X	Ancillary service (valid through v15.3)
Y	Non-implantable DME
Z	Valid revenue code with blank HCPCS and no other SI assigned

Payment indicators

The payment indicator values generated in program output are shown in the following table.

Table 4. List of payment indicators

Value	Description
1	Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V)
2	Services not paid by OPPS Pricer; paid under fee schedule or other payment system (status indicator A, G, K)
3	Not paid (status indicators E, M, Q, Q1, Q2, Q3, W, Y), or not paid under OPPS (status indicators B, C, Z)
4	Paid at reasonable cost (status indicator F, L)
5	Paid standard amount for pass-through drug or biological (status indicator G) (discontinued 10/01/2016)
6	Payment based on charge adjusted to cost (status indicator H)
7	Additional payment for new drug or new biological (status indicator J; service dates prior to 04/01/2002 only)
8	Paid partial hospitalization per diem (status indicator P)
9	No additional payment, payment included in line items with APCs (status indicator N; or no HCPCS code and certain revenue codes; or HCPCS codes G0176 - activity therapy, G0129 - occupational therapy, or G0177 - patient education and training services)
10	Paid FQHC encounter payment
11	Not paid or not included under FQHC encounter payment
12	No additional payment, included in payment for FQHC encounter
13	Paid FQHC encounter payment for New patient or IPPE/AWV
14	Grandfathered tribal FQHC encounter payment

Dispositions

Each edit is associated with a disposition. For example, there can be a rejection of the line item itself or a rejection of the entire claim. In addition to edit dispositions, the program assigns an overall disposition to the claim. Edit and claim dispositions are discussed in the sections that follow.

Edit disposition

A disposition is assigned based on the presence of any edits on a line. The meaning of each edit disposition is described in the table below. It is possible for a claim to have one or more edits in all dispositions.

Edit disposition definitions

Table 5. Edit disposition definitions

Disposition	Definition
Claim rejection	The provider can correct and resubmit the claim but cannot appeal the rejection.
Claim denial	The provider cannot resubmit the claim but can appeal the denial.
Claim returned to provider (RTP)	The provider can resubmit the claim once the problems are corrected.
Claim suspension	The claim is not returned to the provider, but it is not processed for payment until the Medicare Administrative Contractor (MAC) makes a determination or obtains further information.
Line item rejection	The claim can be processed for payment with some line items rejected for payment (i.e., the line item can be corrected and resubmitted but cannot be appealed).
Line item denial	There are one or more edits that cause one or more individual line items to be denied. The claim can be processed for payment with some line items denied for payment (i.e., the line item cannot be resubmitted but can be appealed).

For a complete list of program edits and edit dispositions, see Edit disposition summary (see "Edit disposition summary" on page 30).

Claim disposition

Since a claim can have several edit dispositions assigned to line items, the claim is assigned an overall disposition. Claim disposition values are shown in the following table.

Table 6. List of claim dispositions

Value	Description
0	No edits are present on the claim.
1	The only edits present are for line item denial or rejection.
2	Claim is for multiple days with one or more days denied or rejected.
3	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only post-payment edits.
4	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only pre-payment edits.
5	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with both post- and pre-payment edits.

Payment information

Discounting, packaging, and payment adjustment information are included in the program output, which is then passed to a pricer program for payment. For more detailed information about payment see "Payment information" on page 15.

Table 7. Packaging flag

Value	Description
0	Not packaged
1	Packaged service (status indicator N, or no HCPCS code and certain revenue codes)
2	Packaged as part of partial hospitalization per diem or daily mental health service per diem (v1.0 - v9.3 only)
3	Artificial charges for surgical procedures (submitted charges for surgical HCPCS < $1.01)
4	Packaged as part of drug administration APC payment (v6.0–v7.3 only)
5	Packaged as part of FQHC encounter payment
6	Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment

Table 8. Payment adjustment flag

Value	Description
0	No payment adjustment
1	Paid standard amount for pass-through drug or biological (status indicator G) (v3.0-v16.2 only)
2	Payment based on charge adjusted to cost (status indicator H) (v1.0-v10.3 only)
3	Additional payment for new drug or new biological applies to APC (status indicator J) (v1.0-v2.3 only)
4	Deductible not applicable (specific list of HCPCS codes) or condition code "MA" is present on the claim

Value	Description
5	Blood/blood product used in blood deductible calculation
6	Blood processing/storage not subject to blood deductible
7	Item provided without cost to provider (deactivated 01/01/2014, v.15.0)
8	Item provided with partial credit to provider (deactivated 01/01/2014, v.15.0)
9	Deductible/co-insurance not applicable
10	Co-insurance not applicable
11	Multiple service units reduced to one by IOCE processing; payment based on single payment rate
12	Offset for first device pass-through
13	Offset for second device pass-through
14	PAMA Section 218 reduction on CT scan
15	Placeholder reserved for future use
16	Terminated procedure with pass-through device
17	Condition for device credit present
18	Offset for first pass-through drug or biological
19	Offset for second pass-through drug or biological
20	Offset for third pass-through drug or biological
21	CAA Section 502(b) reduction on film X-ray
22	CAA Section 502(b) reduction on computed radiography technology
23	Co-insurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b)
24	Co-insurance deductible n/a, as well as subject to a reduction due to computed radiography technology (CAA Section 502b)
91-99	Each composite APC present, same value for prime and non-prime codes (v9.0-v9.3 only)

Table 9. Payment method flag

Value	Description
0	OPPS pricer determines payment for service
1	Service not paid based on coverage or billing rules
2	Service is not subject to OPPS
3	Service is not subject to OPPS and has an OCE line item denial or rejection
4	Line item is denied or rejected by MAC; OCE not applied to line item
5	Payment for service determined under FQHC PPS
6	CMHC outlier limitation reached
7	Section 603 service with no reduction in OPPS Pricer
8	Section 603 service with PFS reduction applied in OPPS Pricer
9	CMHC outlier limitation bypassed
A	Payment reduction for off-campus clinic visit
B	Payer only testing
C	Payment made by FQHC PPS and coinsurance is n/a (COVID-19)
V	Contractor bypass applied to FQHC PPS service and coinsurance is n/a (COVID-19)
W	Contractor bypass applied to off-campus clinic visit for payment reduction
X	Contractor bypass applied to Section 603 service with no reduction applied in OPPS Pricer
Y	Contractor bypass applied to Section 603 service with reduction applied in OPPS Pricer
Z	Contractor bypass determines payment for services

Table 10. Composite adjustment flag

Value	Description
00	Not a composite
01-ZZ	First thru the 'nth' composite APC present; same composite flag identifies the prime and non-prime codes in each composite APC group

Table 11. Composite adjustment flags for FQHC claim processing (bill type 77X)

Value	Description
01	FQHC medical clinic visit
02	FQHC mental health clinic visit
03	Subsequent FQHC medical clinic visit (modifier 59 reported)

Edit disposition summary

The following table lists each edit in the program with its disposition. For the meaning of each disposition, see "Edit disposition" on page 25. For information on what conditions will generate an edit, as well as relevant important comments for specific edits, see "OPPS program edits" on page 37.

Table 12. Edit disposition summary

Edit	Edit disposition
1. Invalid diagnosis code	Claim returned to provider
2. Diagnosis and age conflict	Claim returned to provider
3. Diagnosis and sex conflict	Claim returned to provider
4. Medicare secondary payer alert (v1.0 and v1.1 only)	Claim suspension
5. External cause of morbidity code can not be used as principal diagnosis	Claim returned to provider
6. Invalid procedure code	Claim returned to provider

Edit	Edit disposition
7. Procedure and age conflict (inactive)	
8. Procedure and sex conflict	Claim returned to provider
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial
10. Service submitted for denial (condition code 21)	Claim denial
11. Service submitted for FI/MAC review (condition code 20)	Claim suspension
12. Questionable covered service	Claim suspension
13. Separate payment for services is not provided by Medicare (v1.0–v6.3 and for v.18.0- for codes with SI = E2)	Line item rejection
14. Code indicates a site of service not included in OPPS (v1.0–v6.3 only)	Claim returned to provider
15. Service unit out of range for procedure	Claim returned to provider
16. Multiple bilateral procedures without modifier 50 (v1.0–v6.2 only)	Claim returned to provider
17. Inappropriate specification of bilateral procedure	Claim returned to provider
18. Inpatient procedure	Line item denial
19. Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (*deleted, combined with edit 20 retroactive to earliest included version*)[a]	Line item rejection
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
21. Medical visit on same day as a type T or S procedure without modifier 25	Claim returned to provider
22. Invalid modifier	Claim returned to provider
23. Invalid date	Claim returned to provider
24. Date out of OCE range	Claim suspension
25. Invalid age	Claim returned to provider
26. Invalid sex	Claim returned to provider
27. Only incidental services reported	Claim rejection
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Line item rejection
29. Partial hospitalization service for non-mental health diagnosis	Claim returned to provider

Edit	Edit disposition
30. Insufficient services on day of partial hospitalization	Line item denial
31. Partial hospitalization on same day as ECT or type T procedure (v1.0–v6.3 only)	Claim suspension
32. Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days (v1.0 - v9.3)	Claim suspension
33. Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services (v1.0 - v9.3)	Claim suspension
34. Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria (v1.0 - v9.3)	Claim suspension
35. Only Mental Health education and training services provided	Claim returned to provider
36. Extensive mental health services provided on day of ECT or type T procedure (v1.0–v6.3 only)	Claim suspension
37. Terminated bilateral procedure or terminated procedure with units greater than one	Claim returned to provider
38. Inconsistency between implanted device or administered substance and implantation or associated procedure	Claim returned to provider
39. Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (*deleted, combined with edit 40 retroactive to earliest included version*)[a]	Line item rejection
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection
41. Invalid revenue code	Claim returned to provider
42. Multiple medical visits on same day with same revenue code without condition code G0	Claim returned to provider
43. Transfusion or blood product exchange without specification of blood product	Claim returned to provider
44. Observation revenue code on line item with non-observation HCPCS code	Claim returned to provider
45. Inpatient separate procedures not paid	Line item rejection
46. Partial hospitalization condition code 41 not approved for type of bill	Claim returned to provider
47. Service is not separately payable	Line item rejection

Edit	Edit disposition
48. Revenue center requires HCPCS	Claim returned to provider
49. Service on same day as inpatient procedure	Line item denial
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Claim returned to provider
51. Multiple observations overlap in time (inactive)	
52. Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions (v3.0–v6.3 only)	Claim returned to provider
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Line item rejection
54. Multiple codes for the same service	Claim returned to provider
55. Non-reportable for site of service	Claim returned to provider
56. E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1 (v4.0–v6.3 only)	Claim returned to provider
57. E/M condition not met for observation and line item date for code G0378 is 1/1	Claim suspension
58. G0379 only allowed with G0378	Claim returned to provider
59. Clinical trial requires diagnosis code V707 as other than primary diagnosis (*deleted, retroactive to the earliest included version*)[a]	Claim returned to provider
60. Use of modifier CA with more than one procedure not allowed	Claim returned to provider
61. Service can only be billed to the DMERC	Claim returned to provider
62. Code not recognized by OPPS; alternate code for same service may be available	Claim returned to provider
63. This OT code only billed on partial hospitalization claims (v1.0 - v13.3)	Claim returned to provider
64. AT service not payable outside the partial hospitalization program (v1.0 - v13.3)	Line item rejection
65. Revenue code not recognized by Medicare	Line item rejection
66. Code requires manual pricing	Claim suspension
67. Service provided prior to FDA approval	Line item denial
68. Service provided prior to date of National Coverage Determination (NCD) approval	Line item denial
69. Service provided outside approval period	Line item denial

Edit	Edit disposition
70. CA modifier requires patient discharge status indicating expired or transferred	Claim returned to provider
71. Claim lacks required device code (v6.1–v15.3 only)	Claim returned to provider
72. Service not billable to the Medicare Administrative Contractor	Claim returned to provider
73. Incorrect billing of blood and blood products	Claim returned to provider
74. Units greater than one for bilateral procedure billed with modifier 50	Claim returned to provider
75. Incorrect billing of modifier FB or FC (v.8.0–v15.3 only)	Claim returned to provider
76. Trauma response critical care code without revenue code 068x and CPT 99291	Line item rejection
77. Claim lacks allowed procedure code (v6.1–v15.3 only)	Claim returned to provider
78. Claim lacks required radiolabeled product (v9.0–v14.3)	Claim returned to provider
79. Incorrect billing of revenue code with HCPCS code	Claim returned to provider
80. Mental health code not approved for partial hospitalization program	Claim returned to provider
81. Mental health service not payable outside the partial hospitalization program	Claim returned to provider
82. Charge exceeds token charge ($1.01)	Claim returned to provider
83. Service provided on or after effective date of NCD non-coverage	Line item denial
84. Claim lacks required primary code	Claim returned to provider
85. Claim lacks required device code or required procedure code (v.13.0–v.14.3)	Claim returned to provider
86. Manifestation code not allowed as principal diagnosis	Claim returned to provider
87. Skin substitute application procedure without appropriate skin substitute product code	Claim returned to provider
88. FQHC payment code not reported for FQHC claim	Claim returned to provider
89. FQHC claim lacks required qualifying visit code	Claim returned to provider
90. Incorrect revenue code reported for FQHC payment code	Claim returned to provider
91. Item or service not covered under FQHC PPS or for RHC	Line item rejection
92. Device-dependent procedure reported without device code	Claim returned to provider

Edit	Edit disposition
93. Corneal tissue processing reported without cornea transplant procedure	Line item rejection
94. Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)	Claim returned to provider
95. Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care (v17.2 only-RTP, v18.3-present, LIR)	Line item rejection (Informational Only, no impact to payment)
96. Partial hospitalization interim claim From and Through dates must span more than 4 days (v17.2 only)	Claim returned to provider
97. Partial hospitalization services are required to be billed weekly (v17.2 only)	Claim returned to provider
98. Claim with pass-through device lacks required procedure.	Claim returned to provider
99. Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	Claim returned to provider
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	Claim returned to provider
101. Item or service with modifier PN not allowed under PFS	Claim returned to provider
102. Modifier pairing not allowed on the same line	Claim returned to provider
103. Modifier reported prior to FDA approval date (v19.0 only)	Line item denial
104. Service not eligible for all-inclusive rate	LIne item rejection
105. Claim reported with pass-through device prior to FDA approval for procedure	Line item denial
106. Add-on code reported without required primary procedure code	Line item denial
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	Line item denial
109. Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	Claim returned to provider
110. Service provided prior to initial marketing date	Line item rejection
111. Service cost is duplicative; included in cost of associated biological	Line item rejection
112. Information only service(s)	Line item rejection

a. Edits 19, 39, and 59 are active only on claims that are more than 7 years old that are processed with previously archived software.

Chapter 3: OPPS program edits

This chapter contains information on the condition(s) which, when present, will generate an OPPS edit in the Integrated Outpatient Code Editor (IOCE) program.

At the end of this chapter is a section that contains additional information about certain cases where the logic in arriving at an edit or APC is not particularly obvious. For these details see "Special logic information" on page 51.

The following table summarizes when edits are generated and also includes other relevant information. Refer to chapter 2 (page 21) for edit dispositions and overall claim disposition information.

Table 13. Edit summary

Edit	Generated when ...
1. Invalid diagnosis code	The principal diagnosis field (fourth dx position) is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid for the selected version of the program.
2. Diagnosis and age conflict	The diagnosis code includes an age range, and the age is outside that range.
3. Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
4. Medicare secondary payer alert[a]	The procedure code has a MSP alert warning indicator. This edit applies to v1.0 and v1.1 only, and is not applicable for reason for visit diagnosis.
5. External cause of morbidity code cannot be used as principal diagnosis	The principal diagnosis code is in the range V00-Y99. (For claims containing ICD-9-CM diagnosis codes, the first letter of the principal diagnosis code is an E.)
6. Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.
7. Procedure and age conflict (inactive)	N/A
8. Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure coded on the record. This edit is bypassed if condition code 45 is present on the claim.

Edit	Generated when ...
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	The procedure code has a Non-covered for reasons other than statute service flag or Revenue code is 099x with SI of E and is submitted without a HCPCS code. This edit is bypassed when code G0428 is present with SI of E.
10. Service submitted for denial (condition code 21)	The claim has a condition code 21. Edit 10 also terminates processing early and returns Claim Processed Flag of 3 (Claim could not be processed (edit 10 - condition code 21 is present)), and a Return Code of 20 (Claim was not processed, condition code 21 exists). Edit 10, and edits 23 and 24 for from/through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.
11. Service submitted for MAC review (condition code 20)	The claim has a condition code 20.
12. Questionable covered service	The procedure code has a Questionable covered service flag.
13. Separate payment for services is not provided by Medicare[a]	The claim is OPPS and the bill type is 12/14x without condition code 41 or the bill type is 13x, and the HCPCS code is on the 'Separate payment for service not provided by Medicare' list or The claim is non-OPPS and the bill type is any other than those defined for OPPS claims (above), the HCPCS code is on the 'Separate payment for service not provided by Medicare' list, and the status indicator is not B. This edit applies to v1.0–v6.3 and v.18.0- for codes with SI = E2.
14. Code indicates a site of service not included in OPPS[a]	The procedure code has a Not included in OPPS indicator. This edit applies to v1.0–v6.3 only.

Edit	Generated when ...
15. Service unit out of range for procedure (inactive)	The maximum units allowed is greater than zero and The sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure and Modifier 91 is not present or modifier 91 is present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. Units for all line items with the same HCPCS code on the same day are added together when applying this edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS code is on a list of codes that are exempt, the unit edits are not applied.
16. Multiple bilateral procedures without modifier 50[a]	The same bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant procedure lines for dates of service prior to 10/01/05 only (v1.0–v6.2).
17. Inappropriate specification of bilateral procedure	(A) The same bilateral procedure code occurs two or more times (based on units and/or lines) on the same service date. This condition (A) is for dates of service prior to 10/01/05 only (v1.0–v6.2). (B) The same inherent bilateral procedure code occurs two or more times (based on units and/or lines) on the same service date. This edit is applied to all relevant bilateral procedure lines, except when modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code. **Note:** For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17. This edit is also bypassed if the bill type is 85x.

Edit	Generated when ...
18. Inpatient procedure	A line has a C status indicator and is not on the 'separate procedure' list. or A line has a C status indicator and is on the 'separate procedure' list, and there are no type T lines on the same day. and Modifier CA is not present. All other line items on the same day as the line with a C status indicator are denied (line item denial/rejection flag = 1, APC return buffer) and edit 49 is assigned. Edit 18 is performed before any other non-fatal edits. No other edits are run on any line(s) with edit 18 or 49. For additional information on inpatient procedure processing see "Inpatient procedures" on page 54.
19. Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (*deleted, combined with edit 20 retroactive to earliest included version*)[a]	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The procedure is identified as part of another procedure on the claim coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
21. Medical visit on the same day as a type T or S procedure without modifier 25	One or more type T or S procedures occur on the same day as a line item containing an E&M code without modifier 25.
22. Invalid modifier	The modifier is not in the list of valid modifier entries and the revenue code is not 540.
23. Invalid date	The service date and/or the from and through dates are invalid. Or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. Edit 10, and edits 23 and 24 for from/through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.

Edit	Generated when ...
24. Date out of OCE range	The From/Through date falls outside the date range of any version of the program. Presence of this edit condition terminates processing for the claim. Edit 10, and edits 23 and 24 for from/through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.
25. Invalid age	The age is non-numeric or outside the range of 0-124 years.
26. Invalid sex	The sex is non-numeric or outside the range of 0-2.
27. Only incidental services reported	All line items are incidental (status indicator N) and All line items have a line item denial/rejection flag = 0 and All line items have a line item action flag = 0. Edit 27 is run immediately when edit 18 is not triggered; no other edits are performed on a claim with edit 27.
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare' indicator.
29. Partial hospitalization service for non-mental health diagnosis	The principal diagnosis is not related to mental health.
30. Insufficient services on day of partial hospitalization	Three or more services from the partial hospitalization services list are not present, or at least one of the three is not a psychotherapy service.
31. Partial hospitalization on same day as ECT or type T procedure[a]	Electroconvulsive therapy or a significant procedure (status indicator T) occurs on the same day as partial hospitalization, and APC 33 (partial hospitalization) is assigned to a mental health service on the same day. This edit applies to v1.0–v6.3 only.
32. Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days[a]	A claim suspended for medical review (edit 30) does not span more than three days. This edit applies to v1.0–v9.3 only.
33. Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services[a]	A claim suspended for medical review (edit 30) spans more than three days. However, partial hospitalization services were not provided on at least 57% (4/7) of the days. This edit applies to v1.0–v9.3 only.

Edit	Generated when ...
34. Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria[a]	A claim suspended for medical review (edit 30) spans more than three days and partial hospitalization services were provided on at least 57% (4/7) of the days. However, on the days when partial hospitalization services were provided, less than 75% of the days met the partial hospitalization day of service criteria (i.e., edit 30 occurred on the line item). This edit applies to v1.0–v9.3 only.
35. Only Mental Health education and training services provided	Only education and training services are present without other mental health service; the claim fails mental health status. Effective with v21.2, edit 35 logic is revised retroactively to be returned if education and training services are the only service(s) reported on the claim. **Note**: Edit 27 is suppressed from being returned if conditions for edit 35 are present.
36. Extensive mental health services provided on day of type T procedure[a]	Electroconvulsive therapy or a non mental health type T procedure APC is present on the same day as extensive mental health service. This edit applies to v1.0–v6.3 only.
37. Terminated bilateral procedure or terminated procedure with units greater than one	A modifier 52 or 73 is present, as well as: a) an independent or conditional bilateral procedure with modifier 50 or b) a procedure with units greater than 1.
38. Inconsistency between implanted device or administered substance and implantation or associated procedure	The status indicator is H, U, or APC 987-997 (Implant) is present, but no type S, T, or non-implant type X procedures are present on the claim (v1.0-15.3 only). There is a code with status indicator H or U present, but no type S, T, or J1 procedures are present on the same claim.
39. Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (*deleted, combined with edit 40 retroactive to earliest included version*)[a]	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.

Edit	Generated when ...
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
41. Invalid revenue code	The revenue code is not in the list of valid revenue code entries.
42. Multiple medical visits on same day with same revenue code without condition code G0	Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other.
43. Transfusion or blood product exchange without specification of blood product	A blood transfusion or exchange is coded but no blood product is coded.
44. Observation revenue code on line item with non-observation HCPCS code	A 762 (observation) revenue code is used with a HCPCS other than G0378.
45. Inpatient separate procedures not paid	On the same day, all lines with status indicator C are on the 'separate procedure' list, and there is at least one type T or J1 line.
46. Partial hospitalization condition code 41 not approved for type of bill	Bill type 12x or 14x is present with condition code 41.
47. Service is not separately payable	The claim consists entirely of a combination of lines that: a) are denied or rejected or b) have a status indicator N Edit 47 is assigned to all lines with status indicator N, or that change from Q to N, that are not already denied or rejected and have no other service on the claim.
48. Revenue center requires HCPCS	The bill type is 13x, 74x, 75x, 76x, or 12x/14x without condition code 41, HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed when the revenue code is 100x, 210x, 310x, 099x, 0905-0907, 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932, 0521, 0522, 0524, 0525, 0527, 0528, 0637, or 0948; see also edit 65.

Edit	Generated when ...
49. Service on same day as inpatient procedure	Line item occurs on the same day as a C status indicator.
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Code is on 'statutory exclusion' list or Revenue code is 0637 with SI of E when submitted without a HCPCS code
51. Multiple observations overlap in time (inactive)	
52. Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions[a]	The observation period is less than 8 hours or There is no diagnosis of CHF, chest pain or asthma or There is a T procedure (except 90780) on the same or previous day. This edit applies to v3.0–v6.3 only.
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.
54. Multiple codes for the same service	Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035.
55. Non-reportable for site of service	A HCPCS code beginning with the letter C is entered and the bill type is not 12x, 13x or 14x.
56. E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1[a]	There is no E/M visit the day of or the day preceding the observation and The date of observation is not 12/31/yyyy or 01/01/yyyy. This edit applies to v4.0–v6.3 only.
57. E/M condition not met for observation and line item date for code G0378 is 1/1	There is no specified E/M or critical care visit the day of or the day preceding the observation and The date of observation is 01/01/yyyy.
58. G0379 only allowed with G0378	Code G0379 is present without code G0378 for the same line item date.

Edit	Generated when ...
59. Clinical trial requires diagnosis code V707 as other than primary diagnosis (*deleted, retroactive to the earliest included version*)[a]	Code G0292, G0293 or G0294 is present and Diagnosis code V707 is not present as admit or secondary diagnosis.
60. Use of modifier CA with more than one procedure not allowed	Modifier CA is present on more than one line or Modifier CA is submitted on a line with multiple units.
61. Service can only be billed to the DMERC	The procedure code has a 'DME only' indicator.
62. Code not recognized by OPPS; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare for OPPS' indicator.
63. This OT code only billed on partial hospitalization claims	Occupational therapy services are present and the bill type is 12x or 13x without condition code 41. This edit applies to v1.0–v13.3 only.
64. AT service not payable outside the partial hospitalization program	Activity therapy services are present and the bill type is 12x or 13x without condition code 41. This edit applies to v1.0–v13.3 only.
65. Revenue code not recognized by Medicare	The revenue code is 100x, 210x, 310x, 0500, 0509, 0583, 0660-0663, 0669, 0905-0907, 0931, or 0932; see also edit 48.
66. Code requires manual pricing	The HCPCS code is an unclassified drug code.
67. Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.
68. Service provided prior to date of National Coverage Determination (NCD) approval	The line item date of service of a code is prior to the code activation date.
69. Service provided outside approval period	The service was provided outside the period approved by CMS.
70. CA modifier requires patient discharge status indicating expired or transferred	CA modifier requires patient discharge status indicating expired or transferred.

Edit	Generated when ...
71. Claim lacks required device code	A specified procedure is submitted on a claim without the code(s) for the required device(s). (This edit is bypassed if the procedure is terminated - modifier 52, 73, or 74.) This edit applies to v6.1–v15.3 only
72. Service not billable to the Medicare Administrative Contractor	A code has a status indicator M. This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x. This edit is also bypassed when the bill type is 81x or 82x and the revenue code is 657. (Note: The status indicator for the HCPCS code is changed from M to A)
73. Incorrect billing of blood and blood products	Blood product claims lack two identical lines (of HCPCS code, units, and modifier BL), one line with revenue code 38x and the other line with revenue code 39x.
74. Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same line.
75. Incorrect billing of modifier FB or FC	Modifier FB or FC is present and SI is not S, T, V or X. This edit applies to v8.0–v15.3 only.
76. Trauma response critical care code without revenue code 068x and CPT 99291	Trauma response critical care code is present without revenue code 068x and CPT code 99291 on the same date of service.
77. Claim lacks allowed procedure code	A specified device is submitted on a claim without a code for an allowed procedure, and the bill type is not 12x. This edit applies to v6.1–v15.3 only.
78. Claim lacks required radiolabeled product	A specified nuclear medicine procedure is submitted on a claim without the code for a required radiopharmaceutical. This edit applies to v9.0–v14.3 only.
79. Incorrect billing of revenue code with HCPCS code	The revenue code is 381 with a HCPCS code other than packed red cells (P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9057, P9058) or The revenue code is 382 with a HCPCS code other than whole blood (P9010, P9051, P9054, P9056).
80. Mental health code not approved for partial hospitalization	Mental health HCPCS codes that are not approved for partial hospitalization program submitted on bill type 13x with condition code 41, or bill type 76x.

Edit	Generated when ...
81. Mental health service not payable outside the partial hospitalization program	Mental health HCPCS codes that are not payable outside the partial hospital program submitted on bill type 12x or 13x without condition code 41.
82. Charge exceeds token charge ($1.01)	Code C9898 is billed with charges greater than $1.01.
83. Service provided on or after effective date of NCD non-coverage	The line item date of service of a code is after the date of non-coverage determination.
84. Claim lacks required primary code	Certain claims are returned to the provider if a specified add-on code is submitted without a code for a required primary procedure on the same date of service (edit 84). Add-on codes 33225, 90785, 90833, 90836 or 90838 are submitted without one of the required primary codes on the same day. (Note: PHP add-on codes are editing with 84 until version 18.1 where PHP add-on code editing is terminated; add-on editing for 33225 is active until version 16.0).
85. Claim lacks required device code or required procedure code	Code C9732 and C1840 not submitted together on the same day. (Code for insertion of ocular telescopic lens submitted without the code for the lens, or vice versa). This edit applies to v13.0–v14.3 only.
86. Manifestation code not allowed as principal diagnosis	A diagnosis code considered to be a manifestation code from the Medicare Code Editor (MCE) manifestation diagnosis list is reported as the principal diagnosis code on a hospice bill type claim (81X, 82X).
87. Skin substitute application procedure without appropriate skin substitute product code	A List A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service.
88. FQHC payment code not reported for FQHC claim	FQHC payment code not reported for a claim with bill type 77x and without Condition Code 65. Note: If the bill type is 770 (No payment claim), edit 88 is not applicable. **Note**: Edit 88 is bypassed for FQHC PPS claims when Telehealth originating site services HCPCS code Q3014, G2025, or Chronic Care Management HCPCS is reported and there is no FQHC payment code; also edit 88 is bypassed for FQHC when only FQHC non-covered services are present with edit 91.

Edit	Generated when ...
89. FQHC claim lacks required qualifying visit code	FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS. **Note**: Edit 89 is bypassed for FQHC PPS claims when Telehealth originating site services HCPCS code Q3014, G2025 or Chronic Care Management HCPCS is reported and there is no FQHC payment code or qualifying visit code present; also edit 89 is bypassed for FQHC when only FQHC non-covered services are present with edit 91.
90. Incorrect revenue code reported for FQHC payment code	FQHC payment code not reported with revenue code 519, 52X or 900.
91. Item or service not covered under FQHC PPS or for RHC	A service considered to be non-covered under FQHC PPS or for RHC is reported.
92. Device-dependent procedure reported without device code	A device-dependent procedure is reported without a device code.
93. Corneal tissue processing reported without cornea transplant procedure	Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date.
94. Biosimilar HCPCS reported without biosimilar modifier	A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier. This edit applies to v17.0–v19.0 only.
95. Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care	A PHP claim contains weekly PH services that total less than 20 hours per 7-day span. This edit applies to v17.2 only-RTP, and v18.3-present, LIR.
96. Partial hospitalization interim claim from and through dates must span more than 4 days	An interim PHP claim (bill type 763 or 133 with condition code 41) From and Through date spans less than 5 days. This edit applies to v17.2 only.
97. Partial hospitalization services are required to be billed weekly	A PHP claim From and Through date spans more than 7 days. This edit applies to v17.2 only.
98. Claim with pass-through device lacks required procedure	A pass-through device is present without an associated, required procedure.
99. Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V.

Edit	Generated when ...
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services.
101. Item or service with modifier PN not allowed under PFS	Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603.
102. Modifier pairing not allowed on the same line	A line item is reported with a pair of modifiers that have conflicting meaning and should not be reported together. Please reference the data files for a report named Modifier Pairs, which contains an up to date list of modifiers not allowed to be reported on the same line.
103. Modifier reported prior to FDA approval date	A modifier is reported prior to the mid-quarter activation date. This edit applies to v19.0 only.
104. Service not eligible for all-inclusive rate	RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.
105. Claim reported with pass-through device prior to FDA approval for procedure	A procedure is reported with a pass-through device prior to the FDA approval date for the procedure paired with the device. The line item denial is returned on the device line.
106. Add-on code reported without required primary procedure code	A claim is submitted with a Type I add-on code(s) without the applicable defined primary procedure(s). The edit is returned on the add-on code line(s) when conditions of the edit are not met.
108. Add-on code reported without required primary procedure or required contractor-defined primary procedure code	A claim is submitted with a Type III add-on code(s) without a defined primary(s) or contractor defined primary(s) procedure. This edit is returned on the add-on code line(s) when conditions are not met.
109. Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	A code first diagnosis is submitted on a PHP claim (Bill type 76x or 13x with CC41) without a mental health diagnosis in the Sdx position.
110. Service provided prior to initial marketing date	The line item date of service of a code is prior to the initial marketing date for which it can be reported.

Edit	Generated when ...
111. Service cost is duplicative; included in cost of associated biological	The reported line item is considered duplicative as the routine costs of all steps in creating a biological are bundled into the covered benefit, the biological. Any procedure identified as being "bundled into biological," and reported as a line item are rejected. Additionally, this edit is returned if revenue codes 870-873 are submitted as line items with blank HCPCS.
112. Information only service(s)	The reported line item is a non-covered service as it is for informational reporting purposes only. Any HCPCS identified as being an information only service is assigned a non-covered status indicator and is line item rejected and has no impact on payment.

a. Edits are active only on claims that are more than 7 years old that are processed with previously archived software.

Special logic information

This section describes special conditions that apply to the IOCE software program logic for OPPS.

Medical visit processing

Medical visits and procedure processing on the same day

Under some circumstances, medical visits on the same date as a procedure result in additional payments. Modifier 25 reported with an Evaluation and Management (E&M) code, status indicator V, is used to report a medical visit that takes place on the same date that a procedure with status indicator S or T is performed, but that is significant and separately identifiable from the procedure. However, if any E&M code that occurs on a day with a type "T" or "S" procedure does not have a modifier of 25, then edit 21 applies and the claim is returned to the provider.

Multiple medical visit conditions

If there are multiple E&M codes on the same day, on the same claim, the rules associated with multiple medical visits are shown in the following table.

Table 14. Multiple medical visit conditions

E&M code	Revenue center	Condition code	Action	Edit
2 or more	Revenue center is different for each E&M code, and all E&M codes have units equal to 1	Not G0	Assign medical APC to each line item with E&M code	-
2 or more	Two or more E&M codes have the same revenue center **OR** One or more E&M codes with units greater than one had same revenue center	Not G0	Assign medical APC to each line item with E&M code and Return Claim to Provider	42

E&M code	Revenue center	Condition code	Action	Edit
2 or more	Two or more E&M codes have the same revenue center **OR** one or more E&M codes with units greater than one had same revenue center	G0*	Assign medical APC to each line item with E&M code	-

The condition code G0 specifies that multiple medical visits occurred on the same day with the same revenue center, and that these visits were distinct and constituted independent visits (e.g., two visits to the ER for chest pain, one in the morning and one in the afternoon, and/or two visits to the ER, one in the morning for a fractured arm and one later in the day for chest pain).

Note: For codes with SI of V that are also on the Inherent Bilateral list, condition code 'G0' takes precedence over the bilateral edit to allow multiple medical visits on the same day.

Medical visit processing and COVID-19 related services

Effective 03/18/2020 (v21.2), OPPS claims (bill type 13x w/o CC 41) with (E&M) visit code(s) reported with modifier CS apply a payment adjustment flag (PAF) of 9 if the SI is V or J2. Critical Care visit code 99291 and HOPD specimen collection code C9803 reported with modifier CS and SI= S are also applicable for a PAF assignment of 9. The reporting of modifier CS indicates that the line(s) is a COVID-19 visit with testing-related services, deductible and coinsurance is not applicable for the visit. In the circumstance the visit line with modifier CS is packaged (SI=N), the payment adjustment flag is not set to 9. See Observation Processing under C-APCs (page 68) as this logic also applies to Comprehensive Observation C-APCs (SI= J2).

Computation of discounting fraction

There are nine different discount formulas that can be applied to a line item:

D = Discounting Fraction (Currently 0.5)

U = Number of Units

T = Terminated Procedure Discount (Currently 0.5)

1. 1.0
2. (1.0 + D(U-1))/U
3. T/U
4. (1 + D)/U

5. D
6. TD/U (Discontinued 1/1/2008, v9.0)
7. D(1 + D)/U (Discontinued 1/1/2008, v9.0)
8. 2.0
9. 2D

Note: Formula six and seven are discontinued and replaced with formula 3 and 9.

Type "T" multiple and terminated procedure discounting

Line items with a status indicator of "T" are subject to multiple-procedure discounting unless modifiers 76, 77, 78 and/or 79 are present. The "T" line item with the highest payment amount is not multiple procedure discounted, and all other "T" line items are multiple procedure discounted. All line items that do not have a status indicator of "T" are ignored in determining the multiple procedure discount. A modifier of 52 or 73 indicates that a procedure was terminated prior to anesthesia. A terminated type "T" procedure is also discounted although not necessarily at the same level as the discount for multiple type "T" procedures. Terminated bilateral procedures or terminated procedures with units greater than one should not occur, and have the discounting factor set so as to result in the equivalent of a single procedure. Claims submitted with terminated bilateral procedures or terminated procedure with units greater than one are returned to the provider (edit 37).

Bilateral procedures are identified from the "bilateral" field in the physician fee schedule. Bilateral procedures have the following values in the "bilateral" field:

1. Conditional bilateral (i.e. procedure is considered bilateral if the modifier 50 is present)
2. Inherent bilateral (i.e. procedure in and of itself is bilateral)
3. Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures))

Inherent bilateral procedures are treated as non-bilateral procedures since the bilateralism of the procedure is encompassed in the code. For bilateral procedures the type "T" procedure discounting rules take precedence over the discounting specified in the physician fee schedule.

All line items for which the line item denial or reject indicator is 1 and the line item action flag is zero, or the line item action flag is 2, 3 or 4, are ignored in determining the discount; packaged line items, (the packaging flag is not zero or 3), is also ignored in determining the discount. The discounting process utilizes an APC payment amount file. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

Note: There may be some procedure codes that have a SI value assigned that differs from the APC SI (for example, HCPCS SI = T, but APC SI =S). In these circumstances, the discounting formula is assigned based on the HCPCS SI; the APC with the highest payment rate (if multiple 'T' procedures are present) although having a different SI, is used to determine the discounted amount for the multiple procedures that may be present.

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) and any applicable offset, is applied prior to selecting the type T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset is applied first, before the terminated procedure discount.

If modifier 50 is present on an independent or conditional bilateral line that has a composite APC, or a separately paid STVX/T-packaged procedure, or a comprehensive APC, the modifier is ignored in assigning the discount formula.

Non-type T procedure discounting

All line items with SI other than "T" are subject to terminated procedure discounting when modifier 52 or 73 is present.

For Discount Formulas applied to non-type T procedures: If not terminated, non-type T Conditional bilateral procedures with modifier 50 are assigned discount formula eight; non-type T Independent bilateral procedures with modifier 50 are also assigned to formula eight (*8).

Inpatient procedures

Through IOCE version 16.3, for outpatients who undergo inpatient-only procedures on an emergency basis who expire before they can be admitted to the hospital, a specified APC payment is made to the provider as reimbursement for all services on that day. The presence of modifier CA (procedure payable inpatient) on the inpatient-only procedure line assigns the specified payment APC and associated status and payment indicators to the line. The packaging flag is turned on for all other lines on that day. Payment is only allowed for one procedure with modifier CA. If multiple inpatient-only procedures are submitted with the modifier CA, the claim is returned to the provider (edit 60). If modifier CA is submitted with an inpatient-only procedure for a patient who did not expire (patient status code is not 20), the claim is returned to the provider (edit 70). See also Inpatient Procedure Processing under Comprehensive APCs for processing logic (v17.0-Current).

Conditional APC processing

Processing procedures with status indicators of Q1 and Q2

Effective January 1, 2017 (v18.0), conditional APC assignment and packaging discussed in this section for procedures with SI = Q1 or Q2 are executed across the claim if multiple service dates are present, and not by individual date of service. References noted as processed by day are to be considered for claims with From Dates prior to January 1, 2017. Procedure codes with SI of Q1 or Q2 are packaged when they appear with other specified services on the same day or claim; however, they may be assigned to a payable SI and APC and paid separately if there are no other specified services on the same day or claim. Procedures with SI = Q1 are packaged in

the presence of any payable procedure code with SI of S, T, or V (and through version 15.3, SI = X). Procedures with SI = Q2 are packaged only in the presence of payable codes with SI = T or effective with version 16.0, J1. The SI is changed from Q1 or Q2 to N for packaging if present with other payable services, or to the standard SI and APC specified for the code when separately payable. If there are multiple Q1 or Q2 procedures on a specific date or claim and no service with which the codes would be packaged on the same date or claim, the Q1/Q2 code assigned to the APC with the highest payment rate is paid and all other codes are packaged. If a procedure with SI = Q1 or Q2 has been previously packaged (SI = N) prior to the execution of the conditional APC processing logic, the packaged Q1 or Q2 is ignored from the selection as the service with the highest paying APC payment rate. Additionally, procedures with SI = Q1 or Q2 that are packaged with SI = N under conditional APC processing logic are not evaluated in any subsequent processing (e.g. composite or comprehensive APC processing).

There are several codes with SI = Q2 that may resolve to a final SI of J1 (comprehensive APC procedure) if they are present with no other payable procedures. In the event this occurs, the Q2 procedure is not subject to comprehensive APC procedure ranking or complexity adjustment, but all other comprehensive APC packaging and exclusion processing is applied.

In the execution of conditional APC processing logic, which occurs prior to the composite APC logic, procedure codes with SI of Q3 (composite candidates) that may be present with Q1 or Q2 procedures are evaluated as payable procedures using the standard SI associated with the Q3 procedure's standard APC.

If a Q1 or Q2 procedure is an independent or conditional bilateral code with modifier 50 and resolves to a standard SI and APC assignment (i.e. not packaged), the modifier is ignored in assigning the discount formula.

Procedures with SI = Q1 or Q2 that are denied or rejected are not included in any subsequent conditional packaging logic, and the default SI (Q1, Q2) is retained as the final SI. If codes with SI of Q1 or Q2 that are denied or rejected are present with other non-denied/rejected Q1 or Q2 codes, if no other payable procedure is present, the non-denied/rejected Q1 or Q2 codes are evaluated and processed for separate payment. There is an exception if Line Item Action Flag = 1 is assigned to the line; the denial or rejection is ignored, and the line is included in subsequent conditional packaging logic, from which the final SI is determined.

Service units are reduced to 1 for any line where an SI of Q1 or Q2 is changed to a separately payable SI and APC and Payment Adjustment Flag 11 is assigned. The reduction of units for procedures designated as sometimes therapy that may have default SI assignment of Q1 or Q2 does not occur if the reporting of the sometimes therapy service under a therapy plan of care results in final assignment of SI = A.

Sometimes therapy processing for wound care services

Certain wound care services considered "sometimes therapy" may be paid an APC rate or from the Physician Fee Schedule, depending on the circumstances under which the service was provided. The IOCE changes the status indicator to A and removes the APC assignment when sometimes therapy codes are appended with therapy modifiers (GP for physical therapy, GO for

occupational therapy, or GN for speech language pathology) or therapy revenue codes (042x, 043x, 044x). If the SI is changed to A these services are excluded from being packaged in the presence of a comprehensive APC. (See Comprehensive APC processing (page 65).)

Critical care processing

Processing of certain ancillary services with SI of Q1 or Q3 that are reported with critical care code 99291 are packaged when reported on the same service date, or effective with version 18.0, on the same claim, as the critical care code. If procedure code 99291 is present with any of the specified ancillary procedure codes, the IOCE changes the SI of the ancillary procedure code from Q1 or Q3 to N for packaging. An exception applies if code 99291 is present and modifier 59, XE, XP, XS or XU are present on any line with the same date of service or on the same claim, the specified critical care ancillary codes are not packaged; the SI is changed to the standard SI and APC specified for the code. If 99291 is not present on the same date of service or the same claim, the SI for the ancillary procedures is changed to the standard SI and APC specified for the code when separately payable, or packaged under previous conditional APC processing logic for specified ancillary services with SI = Q1, if there are other payable procedures present.

If critical care code 99291 is present and the claim meets the criteria for assignment under the Comprehensive Observation APC (version 17.0), the exception for the presence of modifier 59, XE, XP, XS or XU does not occur; all ancillary, adjunctive services are packaged under the Comprehensive Observation APC.

Critical care-packaged ancillary service code 94762 is not subject to the modifier 59, XE, XP, XS, XU exception, and always packages when present with critical care code 99291. If reported in the absence of 99291, 94762 (SI = Q3) is subject to packaging under comprehensive APC processing, otherwise it is assigned its standard APC and SI for separate payment.

Note: effective with version 18.3, critical care ancillary service code 36600 is no longer subject to the modifier exception.

Advance care planning

Effective January 1, 2016 (v17.0), Advance Care Planning services reported with procedure codes 99497 and 99498, that are also reported on the same date of service with the Medicare annual wellness visit (initial or subsequent), are paid under the Medicare Physician Fee Schedule (SI changed to A); otherwise, advance care planning is subject to conditional packaging. If advance care planning procedure 99497 is reported with no other payable OPPS service, it is assigned its standard SI and APC values; if reported with other OPPS payable services (SI = S, T, V, J1, J2, Q1, Q2, Q3), on the same claim, it is packaged (SI = N).

Note that procedure code 99498 is an add-on procedure code with standard SI = N. If 99498 is reported with the annual wellness visit but the primary code 99497 is not present, it continues to be packaged with SI = N. If 99498 is not reported with the annual wellness visit, it retains packaging status with SI = N.

Conditional processing for laboratory procedures

Effective 1/1/2014 (v15.0 – v16.3), packaged laboratory codes (with status indicator of N) that are submitted on a claim with bill type 12x or 14x, or 13x when the L1 modifier is appended to a packaged laboratory code, have the SI changed to A and set the packaging flag to 0 (not applicable to edit 27) . If packaged laboratory codes are submitted on a claim with bill type 12x and condition code W2 is present, the laboratory codes remain packaged (status indicator N).

Effective January 1, 2016 (v17.0), laboratory codes with SI = Q4 are subject to conditional packaging criteria in determining the final SI assignment, i.e., paid under the clinical lab fee schedule (SI = A), or packaged (SI = N): If a laboratory code with an SI= Q4 results in a final SI assignment of A, it returns a PMF value of 2.

For claims with bill type 13x: if the laboratory code(s) with SI Q4 is reported with modifier L1 and is present with other payable OPPS services that have SI = J1, J2, S, T, V, Q1, Q2, or Q3 on the same claim, the SI is changed to A; otherwise the laboratory code(s) is packaged with SI=N. If there are only laboratory codes present, all laboratory codes with SI=Q4 are changed to SI=A.

Note: Modifier L1 is deactivated as of January 1, 2017 (v18.0), and the provision to change the SI to A if modifier L1 is present is discontinued. If laboratory codes with SI = Q4 are present with other payable OPPS procedures, the laboratory codes are packaged with SI = N.

- Effective January 1, 2017 (v18.0), special conditions apply to OPPS services that have a final SI of Q1, Q3, S, T, or V and a line item action flag of 2 or 3 present. If the payable OPPS service(s) has the line item action flag (2/3) present, the laboratory codes with SI = Q4, are processed for payment by having the SI changed from SI=Q4 to SI=A.
- For claims with bill type 12x without condition code W2, and for claims with bill type 14x: if a laboratory code(s) is present with SI Q4, the SI is changed to A. Laboratory services on claims with bill type 12x that do contain condition code W2 remain packaged (SI = N).

Note: Some laboratory codes (e.g. molecular pathology codes) are always assigned SI = A, and are not subject to the conditional packaging logic. There are also laboratory codes that are assigned SI = N and are not subject to conditional packaging logic; laboratory codes with SI = N are always packaged.

Composite APC processing

Certain codes may be grouped together for reimbursement as a "composite" APC when they occur together on the same claim with the same date of service (SI = Q3). When the composite criteria for a group are met, the primary code is assigned the composite APC and status indicator for payment; non-primary codes, and additional primary codes from the same composite group, are assigned status indicator N and packaged into the composite APC. Special composite adjustment flags identify each composite and all the packaged codes on the claim that are related to that composite. Composite adjustment flags are not assigned for composite-packaged lines that are included on a claim containing a comprehensive APC. Multiple composites, from different composite groups, may be assigned to a claim for the same date. Terminated codes

(modifier 52 or 73) are not included in the composite criteria. If the composite criteria are not met, each code is assigned an individual SI/APC for standard OPPS processing. Some composites may have additional or different assignment criteria. Lines that are denied or rejected are ignored in the composite criteria.

Partial hospitalization and community mental health center processing

Effective January 1, 2017 (v18.0), partial hospitalization program (PHP) reimbursement is paid a single level per diem PH APC dependent on the provider type (hospital-based PH program or a CMHC program), condition codes, bill types and HCPCS codes. To obtain the PH APC a minimum of three or more PH_SERVICE(s) must be reported per day, one of which must be from the PH_PRIMARY list. (Please reference the DATA_HCPCS TABLE within the data files for the PH_PRIMARY list as well as the list for PH_SERVICE(s)) The first line item containing the HCPCS code from the PH_PRIMARY list is assigned the PH APC and the final SI = P. All other partial hospitalization services on the same day are packaged, SI is changed to N. A composite adjustment flag identifies the PH APC and all the packaged PH services on the day; a different composite adjustment flag is assigned for each PHP day on the claim. Effective 4/1/2015 through the current version, the payment adjustment flag value of 11 is assigned to the PH payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

If there is an inpatient only procedure (SI = C) on the same claim as PH or Daily Mental Health services, no Partial Hospitalization or Daily Mental Health processing logic is performed.

If less than the minimum amount (number and type) of services required for PHP are reported for any day, the PHP day is denied, i.e., all PH services on the day are denied and no PH APC is assigned (edit30). Note that certain PH services that are add-on codes are not included in the count of number of services for the day (Please reference the DATA_HCPCS table within the data files for list of PH_ADDON services). Any non-PH services on the same day are processed per the usual OPPS rules. Lines that are denied or rejected are ignored in PH processing. If mental health services that are not approved for partial hospitalization are submitted on a PH claim (13x TOB with condition code 41 or TOB 76x), the claim is returned to the provider (edit 80).

Effective October 1, 2017 (v18.3), edit 95 is reactivated for informational purposes only, with no impact on payment. Edit 95 is returned if a PH claim contains weekly services with less than 20 hours of PH services per week. Hours of service for PH services that result in packaging (SI = N) due to PH APC processing are included in the total count of hours per week; however, certain PH services that are add-on codes are not included towards the weekly count of hours. If the PH service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week. If conditions are present for edit 95, an informational only line item denial or rejection flag value of 3 is returned, indicating that although the conditions for edit 95 exist, payment is not impacted, and the line item rejection disposition flag in the claim return buffer is not set. The IOCE continues to process lines with edit 95 for payment by the OPPS Pricer. The IOCE does not apply edit 95 on the admission week submitted on an admission PH claim (761, 762, 131 w CC 41, or 132 w CC41); instead, if the admission week has less than 20 hours of PH services,

Payer Condition Code MP is provided. The IOCE also does not apply edit 95 on the discharge week when submitted on a PH discharge claim (761, 764, 131 w CC 41, or 134 w CC41); instead, Payer Condition Code MQ is provided if the discharge week contains less than 20 hours of PH services. Effective July 1, 2019 (v20.2), the discharge week is identified as the last full (7 days) week on the claim and is never edited with 95 nor any partial days that follow; instead, MQ is returned if the last full week contains less than 20 hours of PH services.

Effective July 1, 2019 (v20.2), the IOCE returns Payer Value Code and Value Code Amount QW on Interim PH claims that have a partial last week present. The last 5 values of the Value Code Amount provided with QW represents the count of days and hours in which PH services are provided for the partial week (first portion of week). For example, if the last week on an interim PH claim is not 7 days but instead only 3 days, and in those 3 days 15 ½ hours of PH services are provided, the last 5 values in the Value Code Amount is 000031550. Note that the partial week represented by the QW output is not edited with 95. The IOCE receives the next claim with Value Code QA and the associated value code amount from the QW output which was on the previous claim (first portion). Note that the Shared System Maintainer (SSM) may only supply this information on input. The IOCE then combines the partial week information from the previous claim and the claim being processed into one full week (7 days), if the full week does not contain up to 20 hours of PH services, the lines on the second portion used in calculating the full week are edited with 95 and Payer Value Code MV is output. The output of MV requires the SSM to adjust the claim containing the first portion of the partial week, as the partial weeks after combining is not 20 hours. The SSM submits Condition Code MW on input for the PH adjustment claim, indicating that the IOCE needs to edit the partial (last) week present on the claim. The IOCE edits with 95 on the line items associated with the partial week and outputs QW with the value code amount applicable.

Effective January 1, 2017 (v18.0), CMHC providers may be subject to outlier payment limitations. If condition code 66 (Provider does not wish outlier payment) is present for a CMHC claim with bill type 76x, payment method flag value of 6 is provided on each OPPS payable line (OPPS paid lines are those that would have previously had payment method flag 0). If condition code MY (Outlier cap bypass) is passed to the IOCE by the MAC, with or without condition code 66, payment method flag value of 9 is returned and the outlier payment limitation is bypassed.

Effective October 1, 2018 (v19.3), PH claims submitting a claim with a code first diagnosis in the principal diagnosis position without a mental health diagnosis in the first secondary diagnosis position, return edit 109. Please reference the DATA_DX10 table within the data files for diagnoses flagged as CODE_FIRST and/or MENTAL_HEALTH. PH claims submitted without a MENTAL_HEALTH diagnosis reported as the principal diagnosis are RTP, except in the instance of a CODE_FIRST diagnosis condition present.

The program logic determining level I or level II APCs is no longer required effective January 1, 2017. Effective 1/1/2011 (v12.0-v17.3), different PH APCs, Level I and Level II, are assigned for hospital-based and Community Mental Health Center (CMHC) partial hospitalization programs according to the number of services provided. In obtaining the level II PH APC a minimum of 4 or more services is provided, with at least one of those services being from the PH_PRIMARY list. To obtain the level I PH APC a minimum of 3 or more services is provided, with at least one of those services also being from the PH_PRIMARY list. As mentioned above the line item that

obtains the PH APC is the first reported PH_PRIMARY HCPCS reported (SI=P), and all other services on the claim are packaged with an SI of N.

Effective 7/1/2016 (v17.2), additional editing is implemented for PH claims to monitor weekly claim submission of at least 20 hours of PH services. PH claims with a From and Through date greater than 7 days are returned to the provider (edit 97). Interim PH claims, identified by bill type 133 with condition code 41 or bill type 763 for CMHC, that have a From and Through date span of less than 5 days are returned to the provider (edit 96). PH claims with less than 20 hours of PH services per week are returned to the provider (edit 95). Hours of service for PH services that result in packaging (SI = N) due to PH APC processing are included in the total count of hours per week. If the PH service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week.

Note: Edits 95, 96 and 97 are deactivated with the October 2016 (v17.3) release, retroactively to 7/1/2016. Edit 95 is reactivated effective October 1, 2017 as an information only edit with no impact to payment.

Daily mental health processing

Effective January 1, 2017 (v18.0), the comparison for summing the payment of the individual MH services to the level II partial hospital-based per diem APC payment rate is changed to compare the sum to the single level PHP hospital-based per diem APC payment rate. All other processing logic listed below occurs as indicated in the flowchart that follows.

Reimbursement for a day of outpatient mental health services in a non-PH program is capped at the amount of the level II hospital-based partial hospital per diem. On a non-PH claim, the IOCE totals the payments for all the designated MH services with the same date of service; if the sum of the payments for the individual MH services exceeds the level II hospital-based partial hospital per-diem, the IOCE assigns a special “Mental Health Service” composite payment APC to one of the line items that represent MH services. All other MH services for that day are packaged; SI changed from Q3 to N. A composite adjustment flag identifies the Mental Health Service composite APC and all the packaged MH services on the day that are related to that composite. The payment rate for the Mental Health Services composite APC is the same as that for the level II hospital-based partial hospitalization APC. Lines that are denied or rejected are ignored in the Daily Mental Health logic. Some mental health services are specific to partial hospitalization and are not payable outside of a PH program; if any of these codes is submitted on a 12x, or 13x TOB without condition code 41, the claim is returned to the provider (edit 81).

Effective 4/1/2015 (v16.1), payment adjustment flag value 11 is assigned to the Mental Health payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

The use of code G0177 (Education and Training) is allowed on MH claims that are not billed as Partial Hospitalization. If Education and Training is the only service(s) submitted on a day or on the claim, the claim is returned to the provider (edit 35).

LDR prostate brachytherapy composite APC processing and assignment criteria

Note: The LDR composite APC is effective only for versions 9.0 – 18.3; LDR claims with From Dates on or after 1/1/2018 (v19.0) are included in the comprehensive APC processing logic.

- If a "prime" code is present with at least one non-prime code from the same composite on the same date of service, assign the composite APC and related status indicator to the prime code; assign status indicator N to the non-primary code(s) present.
- Assign units of service = 1 to the line with the composite APC.
- Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
- If there is more than one prime code present, assign the composite APC to the prime code with the lowest numerical value and assign status indicator N to the additional prime code(s) on the same day.
- Assign the indicated composite adjustment flag to the composite and all component codes present.
- If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.
- Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.
- Procedures that are packaged (SI changed to 'N' in an earlier processing step) are not included in the composite assignment logic.
- Effective 1/1/2017 (v18.0), prime code 55875 may be subject to comprehensive APC processing when reported without non-prime code 77778.

Electrophysiology/ablation composite APC processing and assignment criteria

Note: The electrophysiology/ablation composite APC is effective only for versions 9.0 – v15.3; electrophysiology/ablation claims with From Dates on or after 1/1/2015 (v16.0) are included in the comprehensive APC processing logic.)

- If there is a single code present from group C, or one 'prime' code (group A) and at least one non-prime code (group B) on the same date of service, assign status indicator N to the non-primary code(s) present.
- Assign units of service = 1 to the line with the composite APC.
- If multiple codes from group C are present, assign the composite APC to the code with the lowest numerical value and assign status indicator N to additional group C codes on the same day.
- If there is more than one prime code present, assign the composite APC to the prime code with the lowest numerical value and assign status indicator N to the additional prime code(s) on the same day.

- If the criteria for APC assignment are met with a code from group C as well as from groups A&B, assign the composite APC to the group C code and assign SI of N to the codes from groups A&B.
- If there is one or more codes from group C present with one or more codes from either group A or group B; assign the composite APC to the group C code and assign the standard APC and related SI to any separate group A or group B codes present.
- Assign the indicated composite adjustment flag to the composite and all component codes present.
- If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component group A and group B codes present.
- Terminated codes (modifier 52 or 73 present) in group C are assigned to the composite APC; terminated codes in groups A and B are ignored in composite APC assignment
- Procedures that are packaged (SI changed to 'N' in an earlier processing step) are not included in the composite assignment logic.

EAM composite APC level I and level II assignment criteria

Note: Level I and II EAM APCs deleted effective 1/1/2014 (v9.0-v14.3)

- G0378 is used to identify all outpatient observation services, regardless of the reason for observation (diagnosis), the duration of the service, or whether the criteria for the EAM composite APCs are met.
- G0379 is used to identify direct referral from a physician in the community to hospital for observation care, regardless of the reason for observation (diagnosis).
- If there is at least one Level I APC Prime List A clinic visit codes on the day of or day before observation (G0378), or code G0379 is present on the same day as G0378, assign the Level I composite APC and related status indicator to the clinic visit or direct referral code.
- If there is at least one Level II APC Prime List A critical care or emergency room visit code on the day of or day before observation (G0378), assign the composite APC and related SI to the critical care or emergency visit code.
- Hours/Units of service for observation (G0378) must be at least 8 or the composite APC is not assigned. A composite adjustment flag will be applied to the visit line that gains the CAPC and the line for G0378. Note: The SI for G0378 is always N.
- If the criteria is met for a level I and a level II EAM composite APC, assignment of the Level II takes precedence.
- Extended assessment and management composite APCs have SI = V if paid and are assigned units of service =1.

- If multiple qualifying Prime Codes (visit or CC) appear on the day of or day before G0378, assign the composite APC to the prime code with the highest separately paid payment rate; assign the standard APC to any/all other visit codes present.
- Additional clinic, critical care, or emergency room visit codes (whether or not on the prime lists) are assigned to their standard APCs as separately paid items. Exception: Additional reporting of G0379 is always packaged (SI = N) if there is an extended assessment and management APC on the claim. Note: Only one EAM composite APC is assigned per claim.
- If a "T" or "J1" procedure occurs on the day of or day before observation, the composite APC is not assigned.
- Lines with G0378 and G0379 are rejected if the bill type is not 13x (or 85x).
- EAM logic is performed only for claims with bill type 13x, with or without condition code 41.

Extended assessment and management composite APC criteria

Note: Effective 1/1/14, (v15.0-v16.3) a new EAM composite APC was created, replacing Level I and Level II EAM composite APCs. Any logic point referenced above is still relevant to how the EAM composite is assigned or not assigned unless stated otherwise below.

- If there is at least one of the critical care, emergency room, or clinic visit codes on the day of or day before observation (G0378), or code G0379 is present on the same day as G0378, assign the composite APC and related status indicator to the critical care, emergency department, clinic visit, or direct referral code.
- Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, the units will be reduced to 1 and a payment adjustment flag value of 11 will be returned.
- Sometimes therapy codes subject to conditional APC processing due to default SI= Q1 with standard SI=T that meet therapy requirements and have final SI= A, are not considered for "T" procedure criteria that would prevent EAM composite APC assignment (v15.0-v16.3 only).

Note: Effective 1/1/2016 (v17.0), all EAM Composite APC logic is deactivated; observation claims meeting specified criteria are assigned under a comprehensive observation APC. See Comprehensive Observation Logic for more information.

Direct referral logic

Prior to version 17.0, direct referral from a physician in the community to a hospital for observation care may be used in the assignment of an extended assessment and management composite APC or packaged into T, V or critical care service procedure if present; otherwise, the direct referral is processed as a medical visit. Direct referral for observation that is denied or rejected is not included in any subsequent special direct referral logic, and the default SI is

retained as the final SI. Exception: If line item action flag = 1 has been assigned to the line with G0379, the denial/rejection is ignored, the line is included in subsequent direct referral logic, and that logic determines the final SI.

Multiple imaging composite assignment rules & criteria

- Multiple imaging composite APCs are assigned for three "families" of imaging procedures – ultrasound, computed tomography and computed tomographic angiography (CT/CTA), and magnetic resonance imaging and magnetic resonance angiography (MRI/MRA).
- Within two of the imaging families (i.e, CT/CTA and MRI/MRA), imaging composite APCs are further assigned based on procedures performed with contrast and procedures performed without contrast. There is currently a total of five multiple imaging composite APCs (8004, 8005, 8006, 8007, and 8008). For a list of procedures eligible for the composite assignment, refer to the report within the data files labeled, Multiple Imaging Composite APC's.
- If multiple imaging procedures from the same family are performed on the same DOS, a multiple imaging composite APC is assigned to the first eligible code encountered; all other eligible imaging procedures from the same family on the same day are packaged (the status indicator is changed to N).
- Multiple lines or multiple units of the same imaging procedure count to assign the composite APC; independent or conditional bilateral imaging procedures with modifier 50 count as 2 units.
- If multiple imaging procedures within the CT/CTA family, or the MRI/MRA family are performed with contrast and without contrast during the same session (same DOS), the 'with contrast' composite APC is assigned.
- Imaging procedures that are terminated (modifier 52 or 73 present), are not included in the multiple imaging composite assignment logic; standard imaging APC is assigned to the line(s) with modifier 52 or 73 (SI changed from Q3 to separately payable SI and APC).
- Imaging procedures that are packaged (SI changed from Q# to N in an earlier processing step) are not included in the multiple imaging composite assignment logic.
- If the imaging composite APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.
- Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, the OCE re-assigns units of service = 1 and returns a payment adjustment flag = 11.
- Effective 1/1/2016 (v17.0), certain CT scan codes performed on equipment not meeting NEMA standards are reported with modifier CT. If multiple CT scan codes reported with modifier CT are present, and contribute to the assignment of a composite APC, the first eligible line assigned to the composite APC receives payment adjustment flag 14, whether or not modifier CT is reported on the line. All other CT scan codes reported with modifier CT that are included for composite APC assignment are packaged (SI = N), and do not have payment adjustment flag 14 assigned.

- Lines that are candidates for composite APC assignment that are present on a comprehensive APC claim do not have the composite adjustment flag applied; composite candidates are packaged with SI = N under comprehensive APCs.
- Special consideration is given to code 75635, which is a current composite candidate under ultrasound with SI = Q2 which makes it eligible for conditional APC processing. If 75635 is present, consideration of separate payment under conditional APC processing is evaluated prior to composite candidate consideration. If composite conditions are not present, then 75635 is processed for separate payment or packaging under conditional APC processing.

Comprehensive APC processing

Effective 1/1/2015 (v16.0), certain high cost procedures which have an SI=J1 are paid an all-inclusive rate to include all services submitted on the claim, except, for services excluded by statute. All allowed, adjunctive services submitted on the claim are packaged into the "comprehensive" APC payment rate (i.e., the status indicator is changed to N). Multiple comprehensive procedures, if present on the claim in specified combinations, may be assigned to a higher-paying comprehensive APC representing a complexity adjustment. Services that are excluded from the all-inclusive payment retain their standard APC and SI for standard processing.

Effective v17.0, if SRS planning and preparation codes are present on the same claim with the SRS C-APC, the planning and preparation codes are excluded from the C-APC packaging logic.

General comprehensive APC assignment rules and criteria: v16.0 - current

- Comprehensive APC processing is performed only for OPPS claims with bill type 13x, or claims with bill type 12x with condition code W2.
- Comprehensive APCs are assigned using the following hierarchy:
- Inpatient-Only Patient Expired (SI = J1)
- High-Cost Procedures (SI = J1)
- Comprehensive Observation (SI = J2)
- If there are multiple comprehensive APC procedures existing on the same claim from the different categories listed above, the comprehensive APC procedures are packaged (SI = N) according to the hierarchy of services present; the procedure or service highest in the hierarchy is assigned the comprehensive APC for the claim. Additional processing conditions for each of the different categories is listed separately below.
- Claims containing a payable inpatient procedure (modifier CA and patient status 20) suppress comprehensive APC processing for v16.0 – v16.3, and are processed under inpatient procedure processing previously in place.

- Multiple service units reported on a comprehensive APC line are reduced to one for processing payment based on a single comprehensive APC payment rate; payment adjustment flag 11 is assigned.
- Services that are excluded by statute from packaging include; ambulance, brachytherapy (SI=U), mammography, pass-through drugs, biologicals and devices (SI= G or H), preventive care including influenza and pneumococcal vaccines (SI=L), corneal tissue acquisition, certain CRNA services and Hepatitis B vaccines (SI = F). Certain blood products (i.e. packed red cells or whole blood) reported with the appropriate revenue code are also excluded from packaging under comprehensive APCs. Additionally, certain wound care services identified as "sometimes therapy" when reported with therapy modifiers and therapy revenue codes are excluded from comprehensive APC packaging.
- Procedures that are not allowed on OPPS claims (SI = B, C, E, E1, E2 or M) are edited as usual and retain the standard SI, with the exception of procedure codes representing DME services with SI = Y (Billable only to DMERC); DME codes with SI = Y are packaged into the comprehensive APC payment; edit 61 is not returned.
- Comprehensive APC claims containing lines that may be composite APC candidates do not have the composite adjustment flag applied.

Comprehensive APC assignment for high-cost procedures: v16.0 - current

- If a single comprehensive procedure (SI = J1) is present on a claim, assign the standard comprehensive APC for all-inclusive claim payment.
- If multiple comprehensive APC procedures are present, select the highest ranked comprehensive procedure for standard comprehensive APC assignment.
- Once the highest ranked comprehensive procedure is determined, if there are multiple comprehensive procedures present with SI = J1 or there are qualifying add-on procedure codes present (SI = N), determine if there are any pairings that may qualify for a complexity adjustment. Multiple occurrences or service units of the same comprehensive procedure, or the reporting of modifier 50, may qualify for complexity adjustment. If there is a qualifying pair present associated with the highest ranked comprehensive procedure, assign the complexity-adjusted comprehensive APC.
- If the highest ranked comprehensive procedure has service units greater than one, reduce the service units to one and assign payment adjustment flag 11.
- If a comprehensive APC procedure is terminated by the reporting of modifier 52, 73 or 74, no complexity adjustment is performed for the claim; the standard comprehensive APC is assigned to the comprehensive procedure with the highest rank. Usual terminated procedure discounting is applied if modifiers 52 or 73 are reported (modifier 74 does not apply the terminated procedure discount).
- If the comprehensive APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.

- Effective 1/1/2016 (v17.0), when SRS (stereotactic radiosurgery) planning and preparation codes are reported on the same claim as the comprehensive APC for SRS (APC 5627), the planning and preparation codes are excluded from packaging; the standard SI and APC, or the composite APC and SI (if criteria is met for multiple CT scan imaging procedures) are assigned. If the SRS planning and preparation codes are reported on a claim with any other comprehensive APC procedure, the codes are packaged under the comprehensive APC packaging criteria.
- Effective 1/1/2016 (v17.0), if conditions are present for pass-through device offset, a single device offset is provided for comprehensive APC claims only if the comprehensive APC procedure is paired with the pass-through device. Otherwise, no device offset is provided for device offset conditions that may be present for procedures that are packaged (SI = N) as a result of comprehensive APC processing.
- Effective 1/1/2019 (v20.0), procedure codes assigned to New Technology APC's are excluded from packaging under comprehensive APC processing logic for J1 or J2 services; standard SI and APC are assigned. Note: Procedure codes assigned to New Technology APC's which have a standard SI = T, prevent a J2 comprehensive observation APC from being assigned, due to standard Observation C-APC assignment criteria.

Inpatient procedure processing under comprehensive APCs

Effective January 1, 2016 (v17.0), if an inpatient-only procedure is present with modifier CA for a patient who expires or transfers to another hospital (patient status code is 2, 5, 20, 62, 63, 65, 66, 82, 85, 90, 91, 93 or 94), the inpatient procedure is assigned under a comprehensive APC (SI = J1), and all other services reported on the claim are packaged (SI= N), except for those items excluded under comprehensive APC processing. Excluded items with non-covered SI = B, E, C or M return the standard SI; any edits associated with the non-covered SI are not returned. If modifier CA is reported for an inpatient-only procedure and the discharge status does not indicate the patient expired or transferred, the claim is returned to the provider (edit 70). Additional comprehensive APC procedures (SI = J1 or J2) reported on the same claim as the inpatient-only procedure where the patient expired or transferred are packaged (SI = N). If multiple lines, or one line with multiple units, have SI = C and modifier CA, generate edit 60 for all lines with SI = C and modifier CA.

Inpatient-only procedures that are on the s procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T, or effective 1/1/2015, if reported on a claim with a comprehensive APC procedure (SI = J1). The line(s) with the inpatient-separate procedure is rejected (edit 45) and the claim is processed per usual OPPS rules.

Effective January 1, 2018 if procedure code 01402 (Anesthesia for TKA) is reported on the same day as procedure code 27447 (Total Knee Arthroplasty) the SI of 01402 changes from C to N and will always package. If code 01402 is reported with any other procedure without 27447 reported on the same claim, the SI remains its standard SI = C and processes as usual.

See Inpatient Procedure Processing through v16.3 for older logic in which Inpatient Procedures were not processed under Comprehensive APCs.

Observation processing under C-APCs

Effective January 1, 2016 (v17.0), claims for observation services (SI = J2) meeting specified criteria are paid under a single Comprehensive Observation C-APC payment rate, to include all services submitted on the claim. The same exception criteria for excluded services under high cost procedure comprehensive APCs (SI = J1) apply to the Comprehensive Observation APC, and all allowed adjunctive services submitted on the claim with the Comprehensive Observation APC are packaged (SI is changed to N). If multiple visits are present for qualified Comprehensive Observation C-APC assignment, the visit code with the highest standard APC payment rate is assigned the Comprehensive Observation APC; all other visits are packaged.

Effective 03/18/2020 (v21.2), OPPS claims (bill type 13x w/o CC 41) with E&M visit code(s) reported with modifier CS that meet the criteria for Observation C-APC assignment (SI = J2) or are assigned standard SI=V, return a payment adjustment flag of 9. Critical Care code 99291 reported with modifier CS with an SI = S instead of SI=J2, is also applicable for a PAF assignment of 9. The reporting of modifier CS indicates that the line(s) is a COVID-19 visit with testing-related services, deductible and coinsurance is not applicable for the visit. If the final status indicator for a visit line(s) with modifier CS is packaged (SI=N), the payment adjustment flag is not set to 9. See Medical Visit Processing and COVID-19 Testing-Related Services (page 52) as this logic is applicable to medical visit processing.

Comprehensive observation APC assignment criteria

- There is no procedure with SI = T present for the claim. If a procedure with SI = T is present, no comprehensive observation APC is assigned. If a new technology APC with SI = S is present on a Comprehensive Observation APC claim, it is excluded from packaging and assigned its standard APC.
- HCPCS G0378 is reported with 8 or more service units.
- There is a visit code present from the following list on the same day or one day before HCPCS G0378: Type A/Type B emergency department visits, critical care, outpatient clinic visit, or HCPCS G0379 for direct referral is present on the same day as G0378.
- The claim does not contain a comprehensive APC procedure with SI = J1.
- If multiple visit codes with SI = J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged (SI = N).
- If the claim does not meet the conditions for comprehensive observation APC assignment, the visit code(s) is/are assigned their standard APC and SI.
- If HCPCS G0379 is present and criteria is not met for comprehensive observation APC, and there are other visit codes present (SI = J2 resulting in standard APC and SI = V), G0379 is packaged. Additional reporting (subsequent occurrences) of HCPCS G0379 are packaged (SI = N).

Device-dependent procedure editing and processing

The use of a device, or multiple devices, is necessary to the performance of certain outpatient procedures. If any of these procedures is submitted without a code for the required device(s), the claim is returned to the provider. Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code. Conversely, some devices are allowed only with certain procedures, whether or not the specific device is required. If any of these devices is submitted without a code for an allowed procedure, the claim is returned to the provider (v6.1 – v15.3).

Effective 1/1/2015 (v16.0), the submission of a device-dependent procedure also requires that a device be submitted on the same claim/day. If any device-dependent procedure is submitted without a code for a device on the same claim with the same date of service, the claim is returned to the provider (edit 92). Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code.

Effective 1/1/2019 (v20.3), certain device-dependent procedures codes are applicable for bypassing edit 92 if an insertion of a device is not completed (i.e., revised only). In order for the edit to be bypassed a device procedure on the “Mod CG device bypass” list is reported with modifier CG. For a list of applicable device procedures, reference the corresponding column in the DATA_HCPCS table in the quarterly data files.

Effective 1/1/2016 (v17.0), if there is a terminated device intensive procedure from a specified list reported with modifier 73, the device portion cost of the procedure APC is output by the IOCE with a Payer Value Code of QQ. The device portion amount is used by the OPPS Pricer program to reduce the APC payment rate prior to application of the terminated procedure discount. A unique payment adjustment flag value of 16 identifies the device intensive procedure reported with modifier 73. In the event there are multiple terminated device intensive procedures present with modifier 73, the device portion amounts are summed and the total device portion is provided; the payment adjustment flag of 16 is assigned for each terminated procedure. Terminated procedure lines present with modifier 73 that may be packaged (SI = N) do not contribute to the device portion amount, and a payment adjustment flag is not returned.

Note: Effective January 1, 2017 (v18.0), the device portion cost for the terminated procedure offset is determined at the individual HCPCS code level, regardless of the APC assignment.

Some implanted devices and some administered substances (SI = H, U), require an implantation or other associated procedure (SI = S, T or X) to be billed on the same claim. If an associated procedure is not present, the claim is returned to the provider (edit 38).

Special conditions apply for a specified procedure pair, Cardioverter Defibrillator and Pacing Electrode, 33249 and 33225. Both codes have a default SI of Q3, however they are not components of a composite APC. The SIs for 33249 and 33225 is changed from Q3 to the specified SI/APC for standard OPPS processing when they do not appear on the same claim with the same date of service. When both procedures are submitted together on the same date of service, the primary procedure is assigned to the standard APC for payment and the secondary procedure is packaged. [v13.0 – v15.3]

Device credit conditional processing

Providers must append modifier 'FB' to procedures that represent implantation of devices that are obtained at no cost to the provider; modifier 'FC' is appended if a replacement device is obtained at reduced cost. If there is an offset payment amount for the procedure with the modifier, and if there is a device present on the claim that is matched with that procedure on the offset procedure/device reduction crosswalk, the IOCE applies the appropriate payment adjustment flag (corresponding to the FB or FC modifier) to the procedure line. The IOCE also reduces the APC rate by the full offset amount (for FB), or by 50% of the offset amount (for FC) before determining the highest rate for multiple or terminated procedure discounting. If the modifier is used inappropriately (appended to procedure with SI other than S, T, X, V or Q3), the claim is returned to the provider [edit 75, v8.0 – 14.3]. If both the FB and FC modifiers are appended to the same line, the FB modifier takes precedence and the full offset reduction is applied [v10.0 - v14.3].

Effective 1/1/2014, if modifier FB or FC is reported on a claim with a device implantation procedure, the claim is returned to the provider [edit 75, v15.0 – 15.3].

Standard device requirements apply to both procedures under all circumstances; however, modifier FB or FC on the secondary procedure is ignored for offset reduction if the SI for the procedure is changed to N. (Device requirements changed; modifier FB/FC no longer used for offset reduction, effective v15.0).

Effective 1/1/2016 (v17.0), if conditions exist for full or partial device credit for a device intensive APC represented by the presence of Condition Code 49, 50 or 53, the device credit amount is output by the IOCE with Payer Value Code QU, which is used by the OPPS Pricer program to reduce the device intensive APC payment rate by the device credit amount. A unique payment adjustment flag value of 17 identifies the device intensive procedure for which the device credit applies. In the event there are multiple device intensive APCs present for device credit, the credits are summed and the total is provided in the value code amount field; the payment adjustment flag of 17 is assigned for each device intensive procedure associated with the device credit. Device intensive procedures that are packaged (SI = N) do not contribute to the device credit amount, and a payment adjustment flag is not returned. If the device intensive procedure is a comprehensive APC procedure and is also eligible for complexity-adjusted APC assignment under comprehensive APCs, the device credit amount for the complexity-adjusted comprehensive APC is provided.

Note: Effective January 1, 2017 (v18.0), the full or partial device credit amount is determined at the individual HCPCS code level, regardless of the APC assignment.

Pass-through device processing

Claims with pass-through device HCPCS codes (SI = H) furnished with certain device-intensive procedures require a payment offset to the APC payment rate for the procedure. Effective January 1, 2016 (v17.0), the IOCE shall identify the offset condition for the pass-through device HCPCS and associated device-intensive procedure by providing a unique claim level Payer Value

Code (QN), with Value Code amount representing the payment offset in the claim return buffer. A payment adjustment flag is returned to identify the pass-through device HCPCS line(s) associated with the payment offset(s) multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through device HCPCS lines present that are associated with the same device-intensive procedure. An additional claim level Payer Value Code (QO) and payment adjustment flag value may be returned if there is an additional condition present for a separate device offset on the same claim (Payment adjustment flag values of 12 & 13 identify the pass-through devices which require offsets). Claims with pass-through devices reported without the associated device-intensive procedure are returned to the provider (edit 98).

Effective April 1, 2018 (v19.1), certain procedure and pass-through device pairings may have a mid-quarter activation date associated with FDA approval. Claims reporting pass-through devices prior to the mid-quarter activation date are line item denied (edit 105). The edit will be returned on the line containing the pass-through device.

Note: Effective January 1, 2017 (v18.0), the pass-through device offset amounts are determined at the HCPCS code level, regardless of the APC assignment.

If there is a comprehensive APC procedure present (SI = J1) and there are conditions present on the claim for pass-through device payment offset, if there is a pass-through device associated (paired) with the primary comprehensive APC procedure, then a single device offset condition is identified for the claim (Payer Value Code QN only with corresponding offset amount). Conditions that may be present for pass-through device offset on a claim with a comprehensive APC that result in packaging of the device intensive procedure (SI = N) paired with the pass-through device do not produce a pass-through device payment offset.

An exception is made for claims containing the comprehensive APC for an inpatient-only procedure reported with modifier CA for a patient who expires that also contain conditions for pass-through device payment offset; the pass-through device payment offset is provided.

Drug administration

When multiple occurrences of any APC that represents drug administration are assigned in a single day, modifier 59 is required on the code(s) to permit payment for multiple units of that APC, up to a specified maximum; additional units above the maximum are packaged. If modifier 59 is not used, only one occurrence of any drug administration APC is allowed, and any additional units are packaged (v6.0–v7.3 only).

Blood and blood storage processing

In some circumstances, in order for Medicare to correctly allocate payment for blood processing and storage, providers are required to submit two lines with different revenue codes for the same service when blood products are billed. One line is required with revenue code 39X and an identical line (same HCPCS, modifier and units) with revenue code 38X. Revenue code 381 is

reserved for billing packed red cells, and revenue code 382 for billing whole blood; if either of these revenue codes is submitted on a line with any other service, the claim is returned to the provider (edit 79) (HCPCS codes with descriptions that include packed red cells or whole blood may be billed with either revenue code).

Effective 1/1/2015, packed red cells reported with revenue code 381 and whole blood reported with revenue code 382 that appear on a claim with a comprehensive APC procedure (SI = J1) are excluded from packaging; the standard SI is retained.

Nuclear medicine procedure processing

Providers must append modifier 'FB' to specified Nuclear Medicine procedures when the diagnostic radiopharmaceutical is received at no cost/full credit. The IOCE appends the corresponding payment adjustment flag of 7 to the nuclear medicine procedure line as indication to Pricer to deduct the standard policy packaged offset amount from the APC rate. (Assignment of the discounting formula by IOCE is not affected; nuclear medicine procedures are non-type T) (v12.0 - v14.3).

Certain nuclear medicine procedures are performed with specific radiolabeled products. If any specified nuclear medicine procedure is submitted without a code for one of the specified radiolabeled products on the same claim, the claim is returned to the provider (edit 78) (v9.0 – v14.3).

Managed care processing

OPPS claims for Managed Care beneficiaries, as identified by the MAC (Payer only condition code MA – Managed Care enrollee), are not subject to line level deductible. Payment adjustment flag 4 is applied to all line items except for those that are packaged (SI = N) with line item charges = $0.00.

Preventative services processing

Deductible and co-insurance may be waived for certain preventive services (See HCPCS Map within the data files for services flagged as preventive) and for any services submitted with modifier Q3 (Live kidney donor surgery and related services) on the line. A payment adjustment flag value of 9 or 10 is applied to preventive services to specify that either the deductible/ co-insurance is not applicable (PAF 9) or that the Co-insurance is not applicable (PAF 10) (v12.0 - Current). Preventive services or services reporting modifier Q3 that are packaged (SI = N) with line item charges = $0.00 do not have a payment adjustment flag assigned for deductible and/ or coinsurance waiver.

Deductible is waived for all services coded in the CPT range 10000 – 69999, on any day/date of service when modifier PT (Colorectal cancer screening test converted to diagnostic test or other

procedure) is also present on a valid code in the same range on the claim. The IOCE sets the specified payment adjustment flag of 4 on the line, except when any other payment adjustment flag is already applied to the same line. If a line reporting modifier PT is packaged (SI = N) with charges = $0.00, the payment adjustment flag for deductible waiver is not applied.

Special processing for drugs and biologicals

Effective April 1, 2016 (v17.1), claims containing specified pass-through drugs or biologicals furnished with an associated procedure require pass-through payment offset. If conditions exist for pass-through drug or biological payment offset, the IOCE shall provide a unique Payer Value Code with Value Code amount representing the amount of the payment offset. A payment adjustment flag will be assigned to the pass-through drug or biological to identify which line(s) is associated with the corresponding Payer Value Code and Value Code amount; PAF 18, identify the first pass-through drug or biological, while PAFs 19 and 20 identify the second and third pass-through drug or biologicals. Multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through drugs or biologicals present that are associated with the same offset condition. Claims that may contain multiple conditions eligible for pass-through drug or biological offset return additional Payer Value Codes.

Conditions that may be present for pass-through drug or biological payment offset on a claim with a comprehensive APC that result in packaging of the associated procedure (SI = N) paired with the pass-through drug or biological continue to produce a pass-through drug or biological payment offset. Specific pass-through drugs and biologicals that are not reported with an associated procedure for APC payment offset do not have coinsurance applied. Each PT drug present must be paired with an associated procedure (APC) in order to complete processing (edit 98).

There are four categories of pass-through drug and biological conditions eligible for payment offset: radiopharmaceuticals, skin substitute products, contrast agents and stress agents. Conditions for payment offset for pass-through radiopharmaceuticals reported with an associated nuclear medicine procedure are considered across the claim; otherwise conditions for payment offset for other pass-through drug and biological categories reported with an associated procedure are performed for the same service date.

Effective October 1, 2016 (v17.3), claims containing drugs and biological HCPCS codes with pass-through status (SI =G) or non-pass-through status (SI = K) that are reported without an OPPS payable procedure (SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V) are returned to the provider (edit 99). There are exceptions for blood clotting factor HCPCS which may be self-administered, and certain biologic response modifier HCPCS, which do not require that an OPPS procedure is present. Additionally, payment for pass-through and non-pass-through drugs is no longer determined by the OPPS Pricer; the IOCE assigns payment indicator value of 2 for pass-through and non-pass-through drug HCPCS codes, representing drugs HCPCS priced by fee schedule (e.g. ASP drug file), although the final payment APC is provided.

Effective January 1, 2018 (v19.0), any service that is identified as a method used in manufacturing a drug or biological are not paid separately; these services are bundled into the

total cost of the drug or biological. Claims submitted using these bundled services (HCPCS) are line item rejected with edit 111, indicating that the service cost is duplicative. If the service identified as being bundled into the cost of the biological has a SI=B, edit 62 is not returned and instead edit 111 is applied. Additionally, if revenue code 870, 871, 872, or 873 (cell/gene therapy) are reported with blank HCPCS, edit 111 is returned (LIR) to identify that the charges associated with the revenue center are bundled into the cost of a drug or biological.

Skin substitute editing and processing

Certain skin substitute products are separately paid, based on their standard SI/APC assignment, only when billed with specified skin substitute application procedure codes. If one of the specified application procedure codes is not present on the same date of service as the skin substitute, the skin substitute product is packaged (has its SI changed to N) (v13.0 – v14.3).

Effective 1/1/2014 (v15.0), the submission of certain skin substitute application procedures require the reporting of a skin substitute product for the same day. Certain skin substitute application procedures and skin substitute products are divided into two lists based on high or low cost. Claims containing a high cost skin substitute application procedure without any of the high cost skin substitute product codes, and conversely any low cost skin substitute application procedure without a low cost skin substitute product code for the same day, are returned to the provider (edit 87). (See the DATA_HCPCS table within the data files for skin substitute products flagged as either high or low cost.)

Effective 10/1/2015 (v16.3), if a skin substitute product code is present with line item action flag value of 2 representing an external line item denial, the line is not ignored by the IOCE for the purposes of applying edit 87. If the denied skin substitute product is on the list of skin substitute products and the skin substitute application procedure is also present, edit 87 is not returned.

Biosimilar HCPCS processing

Effective January 1, 2016 (v17.0), OPPS and non-OPPS claims containing biosimilar HCPCS codes without a corresponding modifier representing the biosimilar manufacturer, are returned to the provider (edit 94).

Effective July 1, 2017, certain modifiers used for biosimilar HCPCS reporting may have a mid-quarter activation date associated with the FDA approval. Claims reporting these specific modifiers prior to the mid-quarter activation date are line item denied (edit 103).

Note: Edits 94 and 103 are discontinued effective April 1/2018 (v19.1). These edits are returned on claims submitted within their respective effective dates.

HSCT and donor acquisition services processing

Effective January 1, 2017 (v18.0), claims containing HSCT (hematopoietic stem cell transplantation) allogenic transplantation procedure 38240 require the reporting of a separate line representing donor acquisition costs with revenue code 815. If the separate line with revenue code 815 is not present, the claim is returned to the provider (edit 100).

Radiological processing

CT scan equipment not meeting NEMA standards

Effective January 1, 2016 (v17.0), if modifier CT is reported for certain imaging codes for CT scans performed on equipment not meeting NEMA standards, a payment adjustment flag value of 14 is passed to the OPPS Pricer indicating the line is subject to payment reduction. Codes from the specified list that are reported with modifier CT and are packaged (SI = N) due to multiple imaging composite APC assignment or comprehensive APC assignment, do not receive payment adjustment. The first code assigned to a multiple imaging composite APC receives the payment adjustment flag if there are CT scan codes reported with modifier CT that are constituents of the composite APC (i.e., the composite APC line may or may not have modifier CT reported).

Note: Modifier CT should not be reported on the same hcpcs line with X-ray Modifiers FX or FY as they are modifier conflicts, edit 102 is returned to the provider.

Film x-ray HCPCS processing

Effective January 1, 2017 (v18.0), if modifier FX (x-ray taken using film) is reported with a film x-ray HCPCS code, a payment adjustment flag value of 21 is passed to the OPPS Pricer program indicating the line is subject to payment reduction. If the film x-ray reported with modifier FX is packaged (SI = N), no payment adjustment flag is assigned. If a film x-ray HCPCS code is reported with modifier FX and is also on the coinsurance deductible n/a procedure list, payment adjustment flag 23 is returned to pricer indicating that the line is subject to a payment reduction as well as the coinsurance/ deductible being not applicable.

Computed radiography technology HCPCS processing

Effective January 1, 2018 (v19.0), if modifier FY (X-ray using computed radiography technology/cassette-based imaging) is reported with an x-ray HCPCS code using computed radiography technology, a payment adjustment flag value of 22 is passed to the OPPS Pricer program indicating the line is subject to payment reduction. If the computed radiography x-ray reported with modifier FY is packaged (SI = N), no payment adjustment flag is assigned. If an x-ray HCPCS code is reported with modifier FY and is also on the coinsurance deductible n/a procedure list, payment adjustment flag 24 is returned to pricer indicating that the line is subject to a payment reduction as well as the coinsurance/ deductible being not applicable.

Note: Effective January 1, 2018 (v19.0), edit 102 is returned if modifiers FX and FY are reported together on the same line as they are identified as a modifier pairing conflicts. To review the list of modifier conflicts subject to edit 102, please reference the MAP_MODIFIER_CONFLICT and table within the data files.

Hospice and home health processing

In order to allow the MAC to process and pay for certain services on Hospice claims, any HCPCS code with status indicator M that is submitted with revenue code 657 on 81x or 82x bill types have the status indicator changed from M to A; the claim is not returned to the provider.

Note: This logic is discontinued effective 1/1/2014 as edit 61 and 72 are excluded from hospice claims processing (bill type 81x, 82x).

Home health claim submissions are episode-based with dates of service that can span a maximum of 60 days. To allow for the claims to be processed through the IOCE, diagnosis codes reported on a claim with dates of service that span the annual October diagnosis update and the previous release are not edited.

Effective 10/1/2014, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis on hospice claims and effective 1/1/2015 for home health claims submitted with bill type 32x. Hospice and Home Health claims submitted with a manifestation code as principal diagnosis are returned to the provider with (edit 86).

Vaccine administration, antigens, splints, and casts are paid under OPPS for hospitals. In certain situations, these services when provided by HHAs not under the Home Health PPS, and to hospice patients for the treatment of a non-terminal illness, are also paid under OPPS.

Effective January 1, 2017 (v18.0), Negative Pressure Wound Therapy (NPWT), reported with procedure codes 97607 or 97608, are separately payable OPPS services for HHAs when submitted on claims with bill type 34x, not under the Home Health PPS. If the NPWT codes are reported as a therapy service (therapy modifier and/or therapy revenue code present for the line), the codes are not processed as “sometimes therapy” and changed to SI=A by the IOCE; the standard SI and APC are retained for payment purposes. For the specified lists of services mentioned above please refer to the DATA_HCPCS table within data files.

Effective with the July 2018 release (v19.2), HHA claims (bill type 32x) are subject to procedure based edits 6 (Invalid Procedure) and 22 (Invalid Modifier); except in the instance of reporting a HIPPS code with revenue code 0023. Effective with the April 2019 release (v20.1), HHA’s (32x) submitting claims with dates of services that span the annual (January) release and the previous quarter do not return edit 6 if the service provided is effective for the reported line item date of service.

Non-excepted items or services in off-campus provider-based hospitals

Effective January 1, 2017 (v18.0), certain items and services, when provided in an off-campus provider-based hospital outpatient department, may be considered non-excepted under Section 603 of the Bipartisan Budget Act of 2015. Non-excepted services are reported with modifier PN (Non-excepted off-campus svc), and are subject to special processing in the IOCE for determination of whether or not payment is to be made or reduced under an alternative method (i.e. Physician Fee Schedule (PFS)). Claims containing certain services that are not allowable with modifier PN are returned to the provider (edit 101). Claims that are reported with two of the following modifiers (PO, PN, or ER) on the same line item are returned to the provider, (edit 102).

Criteria for non-excepted services reported with modifier PN

- Special processing occurs only for hospital outpatient claims with bill type 13x with and without condition code 41, and bill type 76x (CMHC).
- Non-excepted processing logic occurs after all other IOCE processing.
- Services reported with modifier PN are identified using the Payment Method Flag for determination of payment method or reduction by the OPPS Pricer (PMF 7 or PMF 8).

Hospital outpatient claims with bill type 13x without condition code 41 reporting modifier PN

- Emergency department visits and critical care encounters that have standard assignment under SI = V or S (critical care) are not allowed with modifier PN. Edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.
- Payment Method Flag Value 7 is applied for the following:
  - Services with SI = F, H, L, R and U that are excepted under Section 603
  - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T and V that have Payment Adjustment Flag Value 4, 9 or 10 assigned (preventive services)
  - Certain HCPCS codes for radiation treatment with SI = B when reported with modifier PN have the SI changed to S and are assigned a special APC (see quarterly data file reports for a list of procedure codes)
- Payment Method Flag Value 8 is applied for the following:
  - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T, and V, except for emergency department visits with SI = V and critical care encounters with SI = S.

    Note: HCPCS G0463 for clinic visit with SI = J2 (for comprehensive observation APC) or standard SI = V is always assigned Payment Method Flag 8; it is not included in the list of emergency department visit codes or critical care encounters that are subject to edit 101.
  - Effective January 1, 2019, off-campus provider-based outpatient departments submitting clinic visit HCPCS code G0463 with modifier PO also have payment method

flag of 8 returned, to apply the physician fee schedule reduction in the OPPS Pricer. Note: Modifiers PO and PN cannot be submitted on the same hcpcs line item, edit 102 is returned to the provider.

- Services with SI = A, G, K and N have no impact; Payment Method Flag values 7 and 8 are not applicable.

Hospital outpatient claims with bill type 13x with condition code 41 (PHP) reporting modifier PN

- PHP services with SI = P have a change in APC assignment to the CMHC PHP APC, with Payment Method Flag 7 applied.

Note: Non-PHP services reported with modifier PN that may be present on a hospital PHP claim are subject to the logic listed above for claims with bill type 13x without condition code 41.

CMHC PHP outpatient claims with bill type 76x reporting modifier PN

- PHP services with SI = P are not allowed with modifier PN. Edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.

Hospital off-campus provider-based outpatient departments submitting claims with Modifier PO

- Effective January 1, 2015, modifier PO is added as a valid modifier to voluntarily report items or services furnished in an off-campus provider-based outpatient department of a hospital. Effective January 1, 2016, reporting modifier PO is required to be reported for items or services performed in a hospital off-campus provider-based outpatient department.
- Effective January 1, 2019, off-campus provider-based outpatient departments submitting clinic visit HCPCS code G0463 with modifier PO have payment method flag A returned, to apply a payment reduction in the OPPS Pricer. Note: Modifiers PO, PN, or ER cannot be submitted on the same HCPCS line item, edit 102 is returned to the provider.

FQHC processing under FQHC PPS

Effective for claims with From Dates on or after October 1, 2014, claims submitted through the IOCE with bill type 77x for Federally Qualified Health Centers (FQHC) are processed under FQHC PPS. Processing occurs for each date of service if the claim contains multiple dates. FQHC claims are paid under a per encounter basis for qualified clinic visits. Any supporting ancillary services provided on the day of the FQHC visit are packaged into the encounter payment. If the FQHC claim contains multiple dates of service, each day is processed separately through the IOCE. Special output flag values are assigned during FQHC processing under the IOCE to facilitate identification of FQHC payment processing by the Pricer program.

Criteria for FQHC encounters/visit processing logic

FQHC encounters require the reporting of both a unique FQHC payment HCPCS code indicating the type of visit (New or established medical visit, new or established mental health visit, or Initial Preventive Physical Exam/Annual Wellness Visit), and a qualifying visit HCPCS related to the services performed. FQHC claims that do not contain a required FQHC payment HCPCS code are returned to the provider (edit 88). The FQHC HCPCS payment code must be reported with revenue code 519, 52x or 900. FQHC payment HCPCS codes reporting revenue codes other than those listed are returned to the provider (edit 90). FQHC claims that do not contain both the FQHC payment HCPCS code and a qualifying visit code are also returned to the provider (edit 89). The FQHC payment HCPCS code identifies the line where the Pricer program applies the FQHC encounter payment. (For a list of paired qualifying visit codes, reference the MAP_FQHC_VISIT table within the data files.)

Specific revenue code to FQHC payment code requirements are as follows:

- Medical visit codes require revenue code 52x or 519
- Mental health visit codes require revenue code 900 or 519

FQHC encounters for new patient visits or for the IPPE/AWV are identified by the IOCE for additional payment adjustment by the Pricer program. Only one FQHC payment code per day is identified for the new patient/IPPE/AWV payment adjustment.

Payable FQHC payment code lines are flagged with a Payment Indicator (PI) = 10, unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported, PI= 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. If multiple visits are reported, only one new patient FQHC payment HCPCS is assigned PI=13 per day. Any additional FQHC payment codes present for the same day are assigned PI=10. Qualifying visit codes that accompany the FQHC payment code are flagged with PI=12 and are packaged with Packaging Flag =5.

If a mental health visit is provided on the same day as a medical clinic visit, both visits are recognized for FQHC encounter payments, providing the claim meets the criteria for payment of each visit, i.e. FQHC payment HCPCS codes are present for each visit, qualifying visit HCPCS codes are present, and appropriate revenue codes are reported.

If there is an additional FQHC payment code for an established medical visit reported on the same day with modifier 59, this indicates that the visit is a subsequent, unrelated illness or injury provided on the same day as another FQHC visit. The subsequent visit may be eligible for FQHC encounter payment, provided the appropriate FQHC visit criteria are met for the established patient FQHC visit reported with modifier 59. Any additional FQHC visits reported on the same day, reported with or without modifier 59, are packaged.

A composite adjustment flag is assigned for lines reporting FQHC payment codes, identifying the type of FQHC visit(s) present for a date of service, whether for: 01) medical visit or IPPE/AWV, 02) mental health visit, or 03) a subsequent visit reported with modifier 59. The composite adjustment flag is used by the Pricer program to identify line item charges associated with each type of FQHC encounter. All FQHC payment codes are assigned a composite adjustment flag by

the IOCE; the assignment of the composite adjustment flag has no bearing on whether or not the visit is eligible for separate FQHC encounter payment.

Services with SI = M are not billable to the MAC and are subject to edit 72. Effective 4/1/2018 (v19.1), there is a list of HCPCS codes with SI = M that are reportable for FQHC claims and therefore bypass edit 72 processing. For the list of HCPCS applicable to the edit 72 bypass condition, see the DATA_HCPCS table within the quarterly data files and reference the BYPASS_E72_FQHC_RHC column.

FQHC PPS – Mental Health Visit Processing (v15.3-v16.0)

For claims with From dates on or after October 1, 2014 through March 31, 2015 (v15.3 – v16.0), mental health visits reporting psychotherapy services that are add-on codes require the reporting of a primary service code. A subset of the primary service codes for psychotherapy are also considered qualifying visit codes under the FQHC PPS. In order to satisfy the criteria for a FQHC mental health visit reporting a psychotherapy add-on code, if a psychotherapy add-on code is present with a mental health FQHC payment code, the psychotherapy add-on code is paired to a qualifying visit code that represents a primary service for the psychotherapy add-on code. If the primary service code is missing from a claim containing a FQHC mental health visit with a psychotherapy add-on code, the claim shall be returned to the provider (edit 84). If there are multiple visits present for the day, once the criteria for a FQHC mental health visit with psychotherapy is satisfied for the add-on code, the paired qualifying visit code cannot be used as a qualifying visit code for other FQHC payment codes that may be present. However, the processing of psychotherapy add-on codes occurs after the assignment of any new patient, IPPE/AWV, or other medical visit processing; qualifying visit codes that are utilized for previous medical visit assignment are not available for pairing with the psychotherapy add-on code for FQHC mental health clinic visits. For claims with From dates on or after April 1, 2015 (v16.1), mental health visits reporting psychotherapy add-on codes are no longer considered qualifying visits under the FQHC PPS. The psychotherapy add-on codes are packaged into the FQHC encounter payment when reported with a qualifying visit.

Additional criteria for FQHC processing

Effective January 1, 2016 (v17.0), Grandfathered Tribal FQHC providers are identified by the presence of payer only condition code MG passed to the IOCE on a claim for FQHC PPS services. Claims submitted for Grandfathered Tribal FQHC providers have different encounter requirements than other FQHC PPS providers. Only one visit is payable per day; if multiple visits are present for the same day, the first medical visit (or first mental health visit if no medical visits are reported) is identified to OPPS Pricer for payment with a payment indicator (PI=14); all other visits are packaged.

FQHC PPS - Preventive services

Preventive services under the FQHC PPS shall be packaged into the FQHC encounter payment; however, line items reporting preventive services are subject to a waiver of coinsurance

payment. The IOCE shall identify to the Pricer program the FQHC packaged preventive services by way of a specific packaging flag value 6 (Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment).

Effective January 1, 2016, Advance Care Planning services reported with code 99497 are considered a preventive service under FQHC PPS when reported with an annual wellness visit (initial or subsequent). If advance care planning is reported with the annual wellness visit it is identified as a packaged preventive service. If advance care planning is reported without the annual wellness visit, it is treated as a qualifying visit code to satisfy the FQHC encounter requirements and is packaged as a qualifying visit code.

Influenza and pneumococcal vaccines and associated vaccine administration services continue to be paid under reasonable cost through the cost report and are not packaged into the FQHC encounter payment. If influenza and/or pneumococcal vaccine and vaccine administration is reported on the FQHC claim, the services are identified for the Pricer program as non-packaged services that are excluded from the FQHC encounter payment (PI=11).

FQHC PPS - Non-covered services

Items or services that are not covered under the FQHC are line item rejected PPS (DME, ambulance, laboratory, and other non-covered services). Non-covered lines are assigned line item action flag 5 and PI=3, and although SI is ignored under FQHC, all non-covered lines are assigned to SI=E1. If line items with non-covered charges are passed into the IOCE with Line Item Action flag 5 previously assigned, these lines are not line item rejected. Note: All line items submitted on a claim with bill type 770 (No payment claim) are submitted to the IOCE with Line Item Action Flag 5 assigned; edit 91 is not returned for claims with bill type 770, nor is any other FQHC editing performed.

FQHC non-covered items or services include durable medical equipment submitted with revenue code 29X, ambulance services submitted with revenue code 54X, laboratory services paid under the Clinical Lab Fee Schedule (excluding venipuncture, 36415, which is packaged), hospital-based care, group services and non-face-to-face services.

Effective October 1, 2015 (v16.3), claims containing only FQHC non-covered services reported without a FQHC payment code and qualifying visit code are not returned to the provider.

FQHC PPS – Chronic care management services

Effective 1/1/2016 (v17.0), Chronic Care Management (CCM) services are not packaged under FQHC PPS. If Chronic Care Management is reported, PI = 2 is assigned, indicating that it is paid under the Medicare Physician Fee Schedule. CCM services reported without a FQHC payment code or qualifying visit code bypass edits 88 and 89.

FQHC PPS – telehealth services

Telehealth services (HCPCS Q3014 and G2025) are paid by the Medicare physician fee schedule and are not packaged into the FQHC encounter payment. If applicable FQHC telehealth services are reported on an FQHC claim, the service is processed through the IOCE and identified as a non-packaged service for the Pricer program in order to be processed for fee schedule payment (packaging flag = 0). Effective July 1, 2015 (v16.2), applicable FQHC Telehealth services reported without an FQHC payment code and qualifying visit code are not returned to the provider (edit 88 and edit 89).

FQHC PPS - COVID-19 services

Effective 3/18/2020 (v21.2), FQHC claims with a HCPCS line item(s) reported with modifier CS return payment method flag (PMF) value C. A PMF of C indicates that payment is made by the FQHC PPS and coinsurance is not applicable as the item is a COVID-19 testing-related service.

Rural health clinic visit processing

Effective 4/1/2016 (v17.1), the non-covered services list for FQHC is applied to RHC (Rural Health Clinic) claims with bill type 71x. Program logic associated with the execution of edit 91 and the return of line item action flag 5 is included for RHC claims (Note: RHC claims are not subject to any additional FQHC PPS logic.)

Services with SI = M are not billable to the MAC and are subject to edit 72. Effective 4/1/2018 (v19.1), there is a list of HCPCS codes with SI = M that are reportable for RHC claims and therefore bypass edit 72 processing. For the list of HCPCS applicable to the edit 72 bypass condition, see the DATA_HCPCS table within the quarterly data files and reference the BYPASS_E72_FQHC_RHC column.

Effective 4/1/2018 (v19.1), certain services deemed incorrectly reported with modifier CG (Policy criteria applied) for RHC claims are line item rejected (edit 104) as not being included in the RHC all-inclusive rate.

Chapter 4: Non-OPPS program output

This chapter describes Integrated Outpatient Code Editor (IOCE) program output for non-OPPS claims, including edit information, status indicators, and payment indicators. For a list of Input data elements see "Program input" on page 13.

Versions and date ranges

The following table lists the versions contained in this release of IOCE software for non-OPPS hospital claims processing. The date entered in the program as Date of Service From determines the version used for processing.

Table 15. Program versions

IOCE version	Effective date range
21.2.0	07/01/2020–07/01/2030[a]
21.1.x	04/01/2020–06/30/2020
21.0.x	01/01/2020–03/31/2020
20.3.x	10/01/2019–12/31/2019
20.2.x	07/01/2019–09/30/2019
20.1.x	04/01/2019–06/30/2019
20.0.x	01/01/2019–03/31/2019
19.3.x	10/01/2018–12/31/2018
19.2.x	07/01/2018–09/30/2018
19.1.x	04/01/2018–06/30/2018
19.0.x	01/01/2018–03/31/2018
18.3.x	10/01/2017–12/31/2017
18.2.x	07/01/2017–09/30/2017
18.1.x	04/01/2017–06/30/2017
18.0.x	01/01/2017–03/31/2017
17.3.x	10/01/2016–12/31/2016
17.2.x	07/01/2016–09/30/2016

IOCE version	Effective date range
17.1.x	04/01/2016–06/30/2016
17.0.x	01/01/2016–03/31/2016
16.3.x	10/01/2015–12/31/2015
16.2.x	07/01/2015–09/30/2015
16.1.x	04/01/2015–06/30/2015
16.0.x	01/01/2015–03/31/2015
15.3.x	10/01/2014–12/31/2014
15.2.x	07/01/2014–09/30/2014
15.1.x	04/01/2014–06/30/2014
15.0.x	01/01/2014–03/31/2014
14.3.x	10/01/2013–12/31/2013

a. The ending date of the current version will be modified to the actual ending date with the next release.

Line item information

The program processes input data and generates the following information for each line item on the claim:

- Healthcare Common Procedure Coding System (HCPCS) procedure code
- Service units
- Charge

Dispositions

Each edit is associated with a disposition. For example, there can be a rejection of the line item itself or a rejection of the entire claim. In addition to edit dispositions, the program assigns an overall disposition to the claim. Edit and claim dispositions are discussed in the sections that follow.

Edit disposition

A disposition is assigned based on the presence of any edits on a line. The meaning of each edit disposition is described in the following table. It is possible for a claim to have one or more edits in all dispositions.

Edit disposition definitions

Table 16. Edit disposition definitions

Disposition	Definition
Claim rejection	The provider can correct and resubmit the claim but cannot appeal the rejection.
Claim denial	The provider cannot resubmit the claim but can appeal the denial.
Claim returned to provider (RTP)	The provider can resubmit the claim once the problems are corrected.
Claim suspension	The claim is not returned to the provider, but it is not processed for payment until the Medicare Administrative Contractor (MAC) makes a determination or obtains further information.
Line item rejection	The claim can be processed for payment with some line items rejected for payment (i.e., the line item can be corrected and resubmitted but cannot be appealed).
Line item denial	There are one or more edits that cause one or more individual line items to be denied. The claim can be processed for payment with some line items denied for payment (i.e., the line item cannot be resubmitted but can be appealed).

The Edit disposition summary contains a complete list of program edits and edit dispositions.

Claim disposition

Since a claim can have several edit dispositions assigned to line items, the claim is assigned an overall disposition. Claim disposition values are shown in the following table.

Table 17. List of claim dispositions

Value	Description
0	No edits are present on the claim.
1	The only edits present are for line item denial or rejection.
2	Claim is for multiple days with one or more days denied or rejected.
3	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only post-payment edits.
4	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only pre-payment edits.
5	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with both post- and pre-payment edits.

Payment information

Non-OPPS payment is not directed by the IOCE.

Edit disposition summary

The following table lists the edits currently applied to non-OPPS hospital outpatient claims. Note that edits are not numbered sequentially; IOCE edits that are not currently applied to non-OPPS hospital claims are not listed. For information on what conditions will generate an edit, as well as relevant important comments for specific edits, see "Non-OPPS program edits" on page 91

Table 18. Edit disposition summary

Edit	Edit disposition
1. Invalid diagnosis code	Claim returned to provider
2. Diagnosis and age conflict	Claim returned to provider
3. Diagnosis and sex conflict	Claim returned to provider
5. External cause of morbidity code cannot be used as principal diagnosis	Claim returned to provider
6. Invalid procedure code	Claim returned to provider
8. Procedure and sex conflict	Claim returned to provider
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial
10. Service submitted for denial (condition code 21) Edit 10 also terminates processing early and returns Claim Processed Flag of 3 (Claim could not be processed (edit 10 - condition code 21 is present)), and a Return Code of 20 (Claim was not processed, condition code 21 exists). Edit 10, and edits 23 and 24 for from /through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.	Claim denial
11. Service submitted for FI/MAC review (condition code 20)	Claim suspension
12. Questionable covered service	Claim suspension
15. Service unit out of range for procedure	Claim returned to provider
17. Inappropriate specification of bilateral procedure	Claim returned to provider
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
22. Invalid modifier	Claim returned to provider
23. Invalid date	Claim returned to provider
24. Date out of OCE range	Claim suspension

Edit	Edit disposition
25. Invalid age	Claim returned to provider
26. Invalid sex	Claim returned to provider
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Line item rejection
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection
41. Invalid revenue code	Claim returned to provider
46. Partial hospitalization condition code 41 not approved for type of bill	Claim returned to provider
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Claim returned to provider
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Line item rejection
54. Multiple codes for the same service	Claim returned to provider
61. Service can only be billed to the DMERC	Claim returned to provider
65. Revenue code not recognized by Medicare	Line item rejection
67. Service provided prior to FDA approval	Line item denial
68. Service provided prior to date of National Coverage Determination (NCD) approval	Line item denial
69. Service provided outside approval period	Line item denial
72. Service not billable to the Medicare Administrative Contractor	Claim returned to provider
74. Units greater than one for bilateral procedure billed with modifier 50	Claim returned to provider
83. Service provided on or after effective date of NCD non-coverage	Line item denial
94. Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)	Claim returned to provider
102. Modifier pairing not allowed on the same line	Claim returned to provider
103. Modifier reported prior to FDA approval date (v19.0 only)	Line item denial
106. Add-on code reported without required primary procedure code	Line item denial
107. Add-on code reported without required contractor-defined primary procedure code	Line item denial

Edit	Edit disposition
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	Line item denial
110. Service provided prior to initial marketing date	Line item rejection
111. Service cost is duplicative; included in cost of associated biological.	Line item rejection
112. Information only service(s)	Line item rejection

Chapter 5: Non-OPPS program edits

This chapter contains information on the condition(s) which, when present, will generate an edit in the Integrated Outpatient Code Editor (IOCE) program for non-OPPS claims.

At the end of this chapter, see "Special logic information" on page 96 for additional information about specific non-OPPS editing logic in the IOCE.

The following table summarizes when edits are generated and also includes other relevant information. Note that edits are not numbered sequentially; IOCE edits that are not currently applied to non-OPPS hospital claims are not listed. For edit dispositions and overall claim disposition information, see "Dispositions" on page 25.

Table 19. Edit summary

Edit	Generated when ...
1. Invalid diagnosis code	The principal diagnosis field (fourth dx position) is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid for the selected version of the program.
2. Diagnosis and age conflict	The diagnosis code includes an age range, and the age is outside that range.
3. Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.
5. External cause of morbidity code cannot be used as principal diagnosis	The principal diagnosis code is in the range V00-Y99. (For claims containing ICD-9-CM diagnosis codes, the first letter of the principal diagnosis code is an E.)
6. Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.
8. Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure coded on the record. This edit is bypassed if condition code 45 is present on the claim.
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	The procedure code has a Non-covered for reasons other than statute service flag. This edit is bypassed when code G0428 is present with SI of E.

Edit	Generated when ...
10. Service submitted for denial (condition code 21)	The claim has a condition code 21 present. Edit 10 also terminates processing early and returns Claim Processed Flag of 3 (Claim could not be processed (edit 10 - condition code 21 is present)), and a Return Code of 20 (Claim was not processed, condition code 21 exists). Edit 10, and edits 23 and 24 for from/through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.
11. Service submitted for MAC review (condition code 20)	The claim has a condition code 20.
12. Questionable covered service	The procedure code has a Questionable covered service flag.
15. Service unit out of range for procedure (inactive)	The maximum units allowed is greater than zero and The sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure and Modifier p is not present or modifier 91 is present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. Units for all line items with the same HCPCS code on the same day are added together when applying this edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS code is on a list of codes that are exempt, the unit edits are not applied.
17. Inappropriate specification of bilateral procedure	The same inherent bilateral procedure code occurs two or more times (based on units and/or lines) on the same service date. This edit is applied to all relevant bilateral procedure lines, except when modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code. **Note**: For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17. This edit is also bypassed if the bill type is 85x.

Edit	Generated when ...
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The procedure is identified as part of another procedure on the claim coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
22. Invalid modifier	The modifier is not in the list of valid modifier entries and the revenue code is not 540.
23. Invalid date	The service date and/or the from and through dates are invalid. Or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. Edit 10, and edits 23 and 24 for from/through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.
24. Date out of OCE range	The From/Through date falls outside the date range of any version of the program. Presence of this edit condition terminates processing for the claim. Edit 10, and edits 23 and 24 for from/through dates, are not dependent on the Edits by Bill Type Tables for OPPS or Non-OPPS.
25. Invalid age	The age is non-numeric or outside the range of 0-124 years.
26. Invalid sex	The sex is non-numeric or outside the range of 0-2.
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare' indicator.
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
41. Invalid revenue code	The revenue code is not in the list of valid revenue code entries.
46. Partial hospitalization condition code 41 not approved for type of bill	Bill type 12x or 14x is present with condition code 41.

Edit	Generated when ...
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Code is on 'statutory exclusion' list or Revenue code is 0637 with SI of E when submitted without a HCPCS code.
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.
54. Multiple codes for the same service	Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035.
61. Service can only be billed to the DMERC	The procedure code has a 'DME only' indicator.
65. Revenue code not recognized by Medicare	The revenue code is 100x, 210x, 310x, 0500, 0509, 0583, 0660-0663, 0669, 0905-0907, 0931, or 0932.
67. Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.
68. Service provided prior to date of National Coverage Determination (NCD) approval	The line item date of service of a code is prior to the code activation date.
69. Service provided outside approval period	The service was provided outside the period approved by CMS.
72. Service not billable to the Medicare Administrative Contractor	A code has a status indicator M. This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x. This edit is also bypassed when the bill type is 81x or 82x and the revenue code is 657. (Note: The status indicator for the HCPCS code is changed from M to A)
74. Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same or multiple lines, and the bill type is 85x with revenue code 96x, 97x, or 98x.
83. Service provided on or after effective date of NCD non-coverage	The line item date of service of a code is after the date of non-coverage determination.
94. Biosimilar HCPCS reported without biosimilar modifier	A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier. This edit applies to v17.0–v19.0 only.

Edit	Generated when ...
102. Modifier pairing not allowed on the same line	A line item is reported with a pair of modifiers that have conflicting meaning and should not be reported together. Please reference the data files for a report named Modifier Pairs, which contains an up to date list of modifiers not allowed to be reported on the same line
103. Modifier reported prior to FDA approval date	A modifier is reported prior to the mid-quarter activation date. This edit applies to v19.0 only.
106. Add-on code reported without required primary procedure code	A claim is submitted with a Type I add-on code(s) without the applicable defined primary procedure(s). The edit is returned on the add-on code line(s) when conditions of the edit are not met.
107. Add-on code reported without required contractor-defined primary procedure code	A claim with bill type 85x (CAH) is submitted with a Type II add-on code(s) reported with a professional services revenue code (96x, 97x or 98x), to allow for contractors to review and define the primary procedure on the claim.
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	A claim is submitted with a Type III add-on code(s) without a defined primary(s) or contractor defined primary(s) procedure. This edit is returned on the add-on code line(s) when conditions are not met..
110. Service provided prior to initial marketing date	The reported line item date of service of a code is prior to the initial marketing date, for which it can be reported.
111. Service cost is duplicative; included in cost of associated biological	The reported line item is considered duplicative as the routine costs of all steps in creating a biological are bundled into the covered benefit, the biological. Any procedure identified as being “bundled into biological,” and reported as a line item are rejected. Additionally, this edit is returned if revenue codes 870-873 are submitted as line items with blank HCPCS.
112. Information only service(s)	The reported line item is a non-covered service as it is for informational reporting purposes only. Any HCPCS identified as being an information only service is assigned a non-covered status indicator and is line item rejected and has no impact on payment.

Special logic information

There is no longer any special logic applied for non-OPPS claims. For a list of applicable non-OPPS edits, please see Edit summary for non-OPPS (page 91).

Appendix A: Summary of changes

Modifications made to the current release of the Integrated Outpatient Code Editor (IOCE) are summarized in the following sections.

Software

- Basic changes to accommodate table and date range modifications.
- IOCE will maintain only seven years of programs and codes. The earliest supported version in this release is 14.3.x and the earliest version date is 10/01/13.
- Program logic updated to add new payment method flag value C (Payment made by FQHC PPS and coinsurance is n/a COVID-19) to be returned on FQHC claims (Bill type 77x) when HCPCS line items are reported with modifier CS.
- Program logic updated to add new payment method flag V (Contractor bypass applied to FQHC PPS service and coinsurance is n/a (COVID-19)) and W (Contractor bypass applied to off-campus clinic visit for payment reduction) to be returned on output if supplied on input to the CB Payment Method Flag field.
- Program logic updated to add new payment method flag value B (Payer only testing). Not to be used other than for CMS testing purposes.
- Program logic updated to add new HCPCS code G2025 to the FQHC telehealth logic in order to receive appropriate FQHC payment values.
  Note: G2025 is added to the FQHC telehealth logic based on the component quarter start date of 01/01/2020, but the code should not be reported prior to its effective date of 01/27/2020.
- Program logic updated to implement and program the following new bill types for Non-OPPS Hospital bill type processing and editing (OPPS flag = 2, Non-OPPS):
  - 78x (Licensed Freestanding Emergency Medical Facility)
  - 83x (Ambulatory Surgery Center)
  - 84x (Freestanding Birthing Center)
  - 89x (Special Facility – Other)
- Program logic updated to apply the payment adjustment flag (PAF) of 9 (Deductible/co-insurance not applicable) for a visit line(s) that have modifier CS reported and the final Status Indicator (SI) for the line(s) is V or J2 for OPPS claims (bill type 13x w/o CC 41) . Critical Care visit code 99291 and HOPD specimen collection code C9803 reported with modifier CS and SI= S are also applicable for a PAF assignment of 9.

Edits

- Added the following edits to list of applicable edits that may be used for the Contractor Bypass:
  - 48
  - 50
  - 61
  - 62
  - 67
  - 68
  - 69
  - 72
  - 88
  - 89
  - 90
  - 91
  - 110
- Updated edit 35 logic to allow for the edit to be returned if incidental education and training services are the only service(s) reported on the claim.
- Added revenue code 892 (Special Processed Drugs – FDA Approved Gene Therapy) to the list of valid revenue codes, effective 04/01/2019.
- Applied mid-quarter edit 68 (Service provided prior to date of National Coverage Determination (NCD) approval) to the following HCPCS:
  - U0003 - 04/14/2020
  - U0004 - 04/14/2020
  - 86328 - 04/10/2020
  - 86769 - 04/10/2020
  - 98966 - 03/01/2020
  - 98967 - 03/01/2020
  - 98968 - 03/01/2020
  - G2010 - 03/01/2020
  - G2012 - 03/01/2020
  - G2023 - 03/01/2020

  - G2024 - 03/01/2020
  - G2025 - 01/27/2020
  - C9803 - 03/01/2020
- Applied mid-quarter edit 110 (Service provided prior to initial marketing date) to the following HCPCS:
  - Q5113 - 03/16/2020
  - Q5116 - 02/23/2020
  - C9058 - 11/15/2019
  - Q5119 - 02/03/2020
  - Q5120 - 11/15/2019

Files

The code description file was updated; diagnosis and/or procedure codes have been updated with current additions, revisions, and deletions.

Tables

Updates were made to the following lists (please review the Quarterly Data Table Reports for additional detail). Due to the new table and file structure for Jan 2020, the tables that are updated that reference a list are specified below.

Updates were made to the following lists:

- MAP_ADDON_TYPEI
  - Addon Type I procedures (edit 106)
- DATA_CAPC
  - Comprehensive APC list (updated list and rank)
- OFFSET_HCPCS
  - Terminated Device Procedures for offset APC
- OFFSET_CODEPAIRS
  - Device Offset Code Pairs (code pair updates for pass-through device offset logic)
- DATA_HCPCS
  - Device-Dependent Procedure list (edit 92)
  - Device Procedure Edit 92 Bypass list (edit 92)

  - Terminated Device Procedure list
  - Device list
  - FQHC non-covered list
  - FQHC flu-PPV list
  - High and Low-Cost Skin Substitute list (edit 87)
  - Edit 99 Exclusions list (edit 99)
  - Non-covered services lists (SI = E1, edits 9)
  - Non-reportable for OPPS list (SI = B, edit 62)
  - Services not billable to MAC list (SI = M, edit 72)
  - Separate payment by Medicare not provided (SI = E2, edit 13)
  - Procedure and Sex Conflict (edit 8) (Male and Female px list)
  - Comprehensive APC exclusion list
  - Inherent Bilateral list
- MAP_CONFLICT_RHC
  - RHC CG modifier non-payable conflict
- DATA_MODIFIER
  - Valid Modifier list (Description update only)
- DATA_EDIT_BYPASS
  - Contractor Bypass Edits list

The following Data Table Report(s) is updated to include new fields:

- DATA_HCPCS
  - Unused (New Column implemented for CMS testing only purposes)

Please review the File Layout document for the descriptions of all Data Table Reports and associated fields and field values.

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