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July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2

MLN Matters Number: MM11298 Revised
Related Change Request (CR) Number: 11298
Related CR Release Date: June 28, 2019
Effective Date: July 1, 2019
Related CR Transmittal Number: R4327CP
Implementation Date: July 1, 2019

Note: We revised this article on July 3, 2019, to reflect the revised CR11298 that CMS issued on June 28. In the article, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11298 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications For the Integrated OCE that Medicare uses

- Under the Outpatient Prospective Payment System (OPPS)
- For Non-OPPS hospital outpatient departments, community mental health centers and all non-OPPS providers
- For limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System
- For a hospice patient for the treatment of a non-terminal illness.

Make sure your billing staffs are aware of these changes.

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BACKGROUND

CR11298 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for July 1, 2019. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at http://www.cms.gov/OutpatientCodeEdit/.

The table below summarizes the modifications of the I/OCE for the July 2019 V20.2 release is summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. CMS has added some I/OCE modifications in the update retroactively to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

Effective Date	Edits Affected	Modification
10/1/2012	6	Implement logic to return edit 6 if an invalid procedure code is submitted on a 770-bill type.
10/1/2012	48, 9	Update the valid revenue table and apply conditions for revenue code 760 to bypass edit 48 and instead apply edit 9, if a blank HCPCS is submitted using this revenue code.
1/1/2018	41	Update the effective date for the revenue codes 870, 871, 872, 873, 874, 875, and 891
1/1/2018	111	Implement new edit 111: Service cost is duplicative; included in cost of associated biological. (Line Item Rejection (LIR)) Edit Criteria: A claim is submitted with a procedure (HCPCS) identified as being bundled into the cost of a biological or a blank HCPCS is submitted with revenue code 870-873 (Cell/Gene Therapy). See Special Processing of Drugs and Biologicals logic section of I/OCE documentation.
1/1/2019		Implement logic to allow certain wound care services identified as being “sometimes therapy” to be excluded from comprehensive APC packaging if the conditions are present for changing the Status Indicator (SI) to A. See logic sections “Sometimes Therapy Processing for Wound Care Services” and Comprehensive APC Assignment Criteria for more information.

Effective Date	Edits Affected	Modification
7/1/2019		Add new Input Payer Value Code: QA: Offset for combining Partial Hospitalization Program (PHP) week on interim PHP claim Add new Payer Condition Codes: MV: Second portion of combined PHP week is not 20 hours MW: First portion of combined PHP week is not 20 hours
7/1/2019		Update effective date of Value Code and Value Code Amount QW 000000000 to return if an interim PHP claim has a partial week present. (July 1, 2019)
7/1/2019		Implement logic to accept Payer Value Code and Value Code Amount QA 000000000 on input to identify that the previous Partial Hospitalization Program (PHP) claim had a partial last week that needs to be combined into the first week of the processing claim to calculate one full week of services (7 days). The Value Code Amount represents the amount of days and hours of PHP services that were on the previous claims partial last week. See Partial Hospitalization Logic section for more information.
7/1/2019	95	Implement logic to return Payer Condition Code MV if the combined partial weeks (first and second portion equal 7 days) is not 20 hours. Note: MV is returned on the second interim claim based on the input of Payer Value Code and Value Code Amount QA 000000000. Additionally, line items submitted on the second portion of the combined PHP week return edit 95 if the combined week is not 20 hours. See Partial Hospitalization Logic section for more information.
7/1/2019	95	Implement logic to accept Condition Code MW on input, indicating that after combining the partial weeks together, 20 hours of services were not provided and the first portion of the combined week needs editing. All line items associated with the partial last week on the initial claim return edit 95. See Partial Hospitalization Logic section for more information.

Effective Date	Edits Affected	Modification
7/1/2019		Update logic to return Payer Condition Code MQ if an admission to discharge claim (761 or 131 CC 41) or an interim to discharge claim (764 or 134 CC 41) is submitted and the last 7-day week on the claim is not 20 hours. See Partial Hospitalization Logic section for more information.
7/1/2019		Update description of Claim Processed Flag value of 4 4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted; exit immediately.
7/1/2019		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files). - Add-on Type I (edit 106) - Add-on Type II (edit 107) - Comprehensive Ambulatory Payment Classification (APC) rank and list update - Device and Device Procedure lists (edit 92) - Terminated Device Procedure for offset APC - Edit 99 Exclusions list - FQHC Flu PPV list - FQHC Non-Covered list - Skin Substitute Hi and Low-Cost lists (edit 87) - Not recognized by OPPS (edit 62) - Valid Revenue Code list (edit 41)
7/1/2019	20, 40	Implement version 25.2 of the NCCI (as modified for applicable outpatient institutional providers).

ADDITIONAL INFORMATION

The official instruction, CR11298, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4327CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
July 3, 2019	We revised this article to reflect the revised CR11298 that CMS issued on June 28. In the article, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.
May 31, 2019	Initial article released.