CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1664	**Date: JANUARY 9, 2009**
	Change Request 6315

SUBJECT: January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0

I. SUMMARY OF CHANGES: This instruction informs the Fiscal Intermediaries (FIs), A/B MACs, and the Fiscal Intermediary Standard System (FISS) that the I/OCE was updated for January 1, 2009. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. Claims with dates of service prior to July 1, 2007, should be routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim. The integration did not change the logic that is applied to outpatient bill types that previously passed through the OPPS OCE software. It merely expanded the software usage to include non-OPPS hospitals. The attached Recurring Updated Notification applies to Chapter 4, §40.1.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 164	Date: January 9, 2009	Change Request: 6315

SUBJECT: January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: This instruction informs the Fiscal Intermediaries (FIs), A/B MACs, and the Fiscal Intermediary Standard System (FISS) that the I/OCE was updated for January 1, 2009. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. Claims with dates of service prior to July 1, 2007, should be routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim. **The integration did not change the logic that is applied to outpatient bill types that previously passed through the OPPS OCE software. It merely expanded the software usage to include non-OPPS hospitals.**

B. Policy: This notification provides the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, and for all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE instructions are attached to this Change Request and will also be posted to http://www.cms.hhs.gov/OutpatientCodeEdit/.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6315.1	The Shared System Maintainer shall install the Integrated OCE (I/OCE) into their systems.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
6315.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
5344	Notification of an Integrated Outpatient Code Editor (OCE) for the July 2007 Release

B. For all other recommendations and supporting information, use this space: N\A

V. CONTACTS

Pre-Implementation Contact(s):
Maria Durham at maria.durham@cms.hhs.gov or Diana Motsiopoulos at diana.motsiopoulos@cms.hhs.gov.

For Policy related questions contact Marina Kushnirova at marina.kushnirova@cms.hhs.gov.

Post-Implementation Contact(s):
Regional Office(s) or the CMS Outpatient Code Editor Email at OCE_Integration@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The

contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS (2)

Attachment A-I/OCE Specifications Version 10.0

Attachment B-Final Summary of Data Changes

Attachment A

This attachment contains specifications issued for the January I/OCE Version 10.0. All shaded material reflects changes incorporated into the October 2008 I/OCE.

Integrated OCE (IOCE)

CMS Specifications

V10.0 - Effective 01/01/09

This 'integrated' OCE program processes claims for outpatient institutional providers including hospitals that are subject to the Outpatient Prospective Payment System (OPPS) as well as hospitals that are NOT (Non-OPPS). The Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC) will identify the claim as 'OPPS' or 'Non-OPPS' by passing a flag to the OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

This version of the OCE processes claims consisting of multiple days of service. The OCE will perform three major functions:

Edit the data to identify errors and return a series of edit flags.
Assign an Ambulatory Payment Classification (APC) number for each service covered under OPPS, and return information to be used as input to an OPPS PRICER program.
Assign an Ambulatory Surgical Center (ASC) payment group for qualifying services on claims from certain Non-OPPS hospitals (bill type 83x) – in the PC program/interface only [v8.2 – v8.3 only].

Each claim will be represented by a collection of data, which will consist of all necessary demographic (header) data, plus all services provided (line items). It will be the user's responsibility to organize all applicable services into a single claim record, and pass them as a unit to the OCE. The OCE only functions on a single claim and does not have any cross claim capabilities. The OCE will accept up to 450 line items per claim. The OCE software is responsible for ordering line items by date of service.

The OCE not only identifies individual errors but also indicates what actions should be taken and the reasons why these actions are necessary. In order to accommodate this functionality, the OCE is structured to return lists of edit numbers. This structure facilitates the linkage between the actions being taken, the reasons for the actions and the information on the claim (e.g., a specific diagnosis) that caused the action.

In general, the OCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers and ICD-9-CM diagnosis codes. Since these coding systems are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program will reduce effort and reduce the chance of inconsistent processing.

The span of time that a claim represents will be controlled by the *From* and *Through* dates that will be part of the input header information. If the claim spans more than one calendar day, the OCE will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day.

Some edits are date driven. For example, Bilateral Procedure is considered an error if a pair of procedures is coded with the same service date, but not if the service dates are different.

Information is passed to the OCE by means of a control block of pointers. Table 1 contains the structure of the OCE control block. The shaded area separates input from return information. Multiple items are assumed to be in contiguous locations.

Pointer Name		UB-04 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-9-CM diagnosis codes	70 a-c (Pt's rvdx) 67 (pdx) 67A-Q (sdx)	Up to 16	6	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First listed diagnosis is considered 'patient's reason for visit dx', second diagnosis is considered 'principal dx'
Ndxptr	Count of the number of diagnoses pointed to by *Dxptr*		1	4	Binary fullword count
Sgptr	Line item entries	42, 44-47	Up to 450	Table 2	
Nsgptr	Count of the number of Line item entries pointed to by Sgptr		1	4	Binary fullword count
Flagptr	Line item action flag Flag set by FI/MAC and passed by OCE to Pricer		Up to 450	1	(See Table 7)
Ageptr	Numeric age in years		1	3	0-124
Sexptr	Numeric sex code	11	1	1	0, 1, 2 (unknown, male, female)
Dateptr	From and Through dates (yyyymmdd)	6	2	8	Used to determine multi-day claim
CCptr	Condition codes	18-28	Up to 7	2	Used to identify partial hospitalization and hospice claims
NCCptr	Count of the number of condition codes entered		1	4	Binary fullword count
Billptr	Type of bill	4 (Pos 2-4)	1	3	Used to identify CMHC and claims pending under OPPS. It is presumed that bill type has been edited for validity by the Standard System before the claim is sent to OCE
NPIProvptr	National provider identifier (NPI)	56	1	13	Pass on to Pricer
OSCARProvptr	OSCAR Medicare provider number	57	1	6	Pass on to Pricer
PstatPtr	Patient status	17	1	2	UB-92 values
OppsPtr	Opps/Non-OPPS flag		1	1	1=OPPS, 2=Non-OPPS (A blank, zero or any other value is defaulted to 1)
OccPtr	Occurrence codes	31-34	Up to 10	2	For FI/MAC use
NOccptr	Count of number of occurrence codes		1	4	Binary fullword count
Dxeditptr	Diagnosis edit return buffer		Up to 16	Table 3	Count specified in Ndxptr
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Mdeditptr	Modifier edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Dteditptr	Date edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Rceditptr	Revenue code edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
APCptr	APC/ASC return buffer		Up to 450	Table 7	Count specified in Nsgptr
Claimptr	Claim return buffer		1	Table 5	
Wkptr	Work area pointer		1	512K	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by Wkptr		1	4	Binary fullword

Table 1: OCE Control block

The input for each line item contains the information described in Table 2.

Field	UB-04 Form Locator	Number	Size (bytes)	Comments
HCPCS procedure code	44	1	5	May be blank
HCPCS modifier	44	5 x 2	10	
Service date	45	1	8	Required for all lines
Revenue code	42	1	4	
Service units	46	1	9	A blank or zero value is defaulted to 1
Charge	47	1	10	Used by PRICER to determine outlier payments

Table 2: Line item input information

There are currently 83 different edits in the OCE. The occurrence of an edit can result in one of six different dispositions.

Claim Rejection	There are one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.
Claim Denial	There are one or more edits present that cause the whole claim to be denied. A claim denial means that the provider can not resubmit the claim but can appeal the claim denial.
Claim Return to Provider (RTP)	There are one or more edits present that cause the whole claim to be returned to the provider. A claim returned to the provider means that the provider can resubmit the claim once the problems are corrected.
Claim Suspension	There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not returned to the provider, but is not processed for payment until the FI/MAC makes a determination or obtains further information.
Line Item Rejection	There are one or more edits present that cause one or more individual line items to be rejected. A line item rejection means that the claim can be processed for payment with some line items rejected for payment. The line item can be corrected and resubmitted but cannot be appealed.
Line Item Denials	There are one or more edits present that cause one or more individual line items to be denied. A line item denial means that the claim can be processed for payment with some line items denied for payment. The line item cannot be resubmitted but can be appealed.

In the initial release of the OCE, many of the edits had a disposition of RTP in order to give providers time to adapt to OPPS. In subsequent releases of the OCE, the disposition of some edits may be changed to other more automatic dispositions such as a line item denial. A single claim can have one or more edits in all six dispositions. Six 0/1 dispositions are contained in the claim return buffer that indicate the presence or absence of edits in each of the six dispositions. In addition, there are six lists of reasons in the claim return buffer that contain the edit numbers that are associated with each disposition. For example, if there were three edits that caused the claim to have a disposition of return to provider, the edit numbers of the three edits would be contained in the claim return to provider reason list. There is more space allocated in the reason lists than is necessary for the current edits in order to allow for future expansion of the number of edits.

In addition to the six individual dispositions, there is also an overall claim disposition, which summarizes the status of the claim.

The following special processing conditions currently apply only to OPPS claims:

1) Partial hospitalizations are paid on a per diem basis; as level I or level II according to the number of services provided/coded. There is no HCPCS code that specifies a partial hospitalization related service. Partial hospitalizations are identified by means of condition codes, bill types and HCPCS codes specifying the individual services that constitute a partial hospitalization (See Appendix C-a). Thus, there are no input line items that directly correspond to the partial hospitalization service. In order to assign the partial hospitalization APC to one of the line items, the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC. All other partial hospital services on the same day are packaged – SI changed ~~from Q3~~ to N. ~~and a special packaging flag is assigned~~. A composite adjustment flag identifies the PHP APC and all the packaged PHP services on the day; a different composite adjustment flag is assigned for each PHP day on the claim.

If fewer than the minimum number of services required for PHP (level I) are reported for any day, the PHP day is denied (i.e., All PHP services on the day will be denied, no PHP APC will be assigned. Note: Any non-PHP services on the same day will be processed according to the usual OPPS rules). Lines that are denied or rejected are ignored in PHP processing. If mental health services that are not approved for the partial hospitalization program are submitted on a 13x TOB with Condition Code 41, the claim is returned to the provider.

2) Reimbursement for a day of outpatient mental health services in a non-PH program is capped at the amount of the level II partial hospital per diem. On a non-PHP claim, the OCE 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 partial hospital per-diem, the OCE 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. ~~and a special packaging flag is assigned~~ 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. (See appendix C-b). The payment rate for the Mental Health Services composite APC is the same as that for the level II partial hospitalization APC. Lines that are denied or rejected are ignored in the Daily Mental Health logic. Some psychotherapy services are specific to partial hospitalization and are not payable outside of a PH program; if any of these codes are submitted on a 12x, 13x or 14x TOB **without** Condition Code 41, the claim is returned to the provider.

3) For outpatients who undergo inpatient-only procedures on an emergency basis and 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 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. 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.

4) Inpatient-only procedures that are on the separate-procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T. The line(s) with the inpatient-separate procedure is rejected and the claim is processed according to usual OPPS rules.

5) When multiple occurrences of any APC that represents drug administration are assigned in a single day, modifier-59 is required on the code(s) in order 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 (see Appendix I). (v6.0 – v7.3 only)

6) 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.

7) Observations may be paid separately if specific criteria are met; otherwise, the observation is packaged into other payable services on the same day. (See Appendix H-a) [v3.1- v8.3].
Observation is a packaged service; may be used to assign Extended Assessment and Management composite APCs, effective v9.0 (See appendix K).

8) Direct admission from a physician's office to observation may be used in the assignment of an extended assessment and management composite, packaged into T, V or critical care service procedure if present; otherwise, the direct admission is processed as a medical visit (see Appendix H-b).

9) 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 (see Appendix J). 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 (HCPCS codes with descriptions that include packed red cells or whole blood may be billed with either revenue code).

10) Certain wound care services may be paid an APC rate or from the Physician Fee Schedule, depending on the circumstances under which the service was provided. The OCE will change the status indicator and remove the APC assignment when these codes are submitted with therapy revenue codes or therapy modifiers.

11) 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 OCE will apply the appropriate payment adjustment flag (corresponding to the FB or FC modifier) to the procedure line. The OCE will also reduce 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 or V), the claim is returned to the provider. If both the FB and FC modifiers are appended to the same line, the FB modifier will take precedence and the full offset reduction will be applied.

12) Certain special HCPCS codes are always packaged when they appear with other specified services on the same day; however, they may be assigned to an APC and paid separately if there is none of the other specified service on the same day. Some codes are packaged in the presence of any code with status indicator of S, T, V or X (STVX-packaged, SI = Q1); other codes are packaged only in the presence of codes with

status indicator T (T-packaged, SI = Q2). The OCE will change the SI from Q(#) to N for packaging, or to the ~~payable~~ SI and APC specified for the code when separately payable. If there are multiple STVX and/or T packaged HCPCS codes on a specific date and no service with which the codes would be packaged on the same date, the code assigned to the APC with the highest payment rate will be paid. All other codes are packaged.
Note: Effective 1/1/09, for the purposes of executing this packaging logic which is applied prior to the composite APC logic (see overview in appendix L), codes with SI of Q3 (composite candidates) will be evaluated using the status indicator associated with their standard APC.

13) Submission of the trauma response critical care code requires that the trauma revenue code (068x) and the critical care E&M code (99291) also be present on the claim for the same date of service. Otherwise, the trauma response critical care code will be rejected.

14) 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 ~~payment~~ composite adjustment flags identify each composite and all the packaged codes on the claim that are related to that composite. 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 (see appendix K). Some composites may ~~also~~ have additional or different assignment criteria.
Lines that are denied or rejected are ignored in the composite criteria.

15) Certain nuclear medicine procedures are performed with specific ~~radiopharmaceuticals~~ radiolabeled products. If any specified nuclear medicine procedure is submitted without a code for one of the specified ~~radiopharmaceuticals~~ radiolabeled products on the same claim, the claim is returned to the provider. Nuclear medicine procedures that are terminated (indicated by modifier 52, 73 or 74) are not returned for a missing ~~radiopharmaceutical~~ radiolabeled product.

The following special processing conditions apply Only to Non-OPPS HOPD claims:

1) Bill type of 83x is consistent with the presence of an ASC procedure on the bill and a calculated ASC payment. The Integrated OCE will assign bill type flags to Non-OPPS HOPD claims (opps flag =2) indicating that the bill type should be 83x when there is an ASC procedure code present; and, should not be 83x when there is no ASC procedure present.

Some processing conditions apply to OPPS HOPD and to some Non-OPPS institutional claims:

Antigens, Vaccine Administration, Splints, and Casts

Vaccine administration, antigens, splints, and casts are paid under OPPS for hospitals. In certain situations, these services when provided by HHA's not under the Home Health PPS, and to hospice patients for the treatment of a non-terminal illness, are also paid under OPPS.
(See appendix N for the specific list of HCPCS codes for reporting antigens, vaccine administration, splints and casts).

Correct Coding Initiative (CCI) Edits

The Integrated OCE generates CCI edits for OPPS hospitals. All applicable NCCI edits are incorporated into the IOCE. ~~with the exception of anesthesiology, E&M and mental health code pairs~~. Modifiers and coding pairs in the OCE may differ from those in the NCCI because of differences between facility and professional services.

Effective January 1, 2006, these CCI edits also apply to ALL services billed, under bill types 22X, 23X, 34X, 74X, and 75X, by the following providers: Skilled Nursing Facilities (SNF's), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPT's), CORF's, and Home Health Agencies (HHA's).

The CCI edits are applied to services submitted on a single claim, and on lines with the same date of service. CCI edits address two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. The edit is set to pay the lesser-priced service.

Version 14.3 of CCI edits is included in the January, 2009 IOCE.

NOTE: The CCI edits in the IOCE are always one quarter behind the Carrier CCI edits.

See Appendix Fa and Fb "OCE Edits Applied by Bill Type" for bill types that the IOCE will subject to these and other OCE edits.

All institutional outpatient claims, regardless of facility type, will go through the Integrated Outpatient Code Editor (IOCE)*; however, not all edits are performed for all sites of service or types of claim. Appendix F (a) contains OCE edits that apply for each bill type under OPPS processing; appendix F (b) contains OCE edits that apply to claims from hospitals not subject to OPPS.
*__Note__: Effective for dates of service on or after 1/1/08 (v9.0), claims for 83x bill type will not go through the Integrated OCE.

The OPPS PRICER would compute the standard APC payment for a line item as the product of the payment amount corresponding to the assigned payment APC, the discounting factor and the number of units for all line items for which the following is true:

Criteria for applying standard APC payment calculations
APC value is not 00000
Payment indictor has a value of 1 or 5
Packaging flag has a value of zero or 3
Line item denial or rejection flag is zero or the line item action flag is 1
Line item action flag is not 2, 3 or 4
Payment adjustment flag is zero or 1
Payment method flag is zero
Composite adjustment flag is zero

If payment adjustments are applicable to a line item (payment adjustment flag is not 0 or 1) then nonstandard calculations are necessary to compute payment for a line item (See Appendix G). The line item action flag is passed as input to the OCE as a means of allowing the FI/MAC to override a line item denial or rejection (used by FI/MAC to override OCE and have PRICER compute payment ignoring the line item rejection or denial) or allowing the FI/MAC to indicate that the line item should be denied or rejected even if there are no OCE edits present. The action flag is also used for handling external line item adjustments. For some sites of service (e.g., hospice) only some services are paid under OPPS.

The line item action flag also impacts the computation of the discounting factor in Appendix D. The Payment Method flag specifies for a particular site of service which of these services are paid under OPPS (See Appendix E). OPPS payment for the claim is computed as the sum of the payments for each line item with the appropriate conversion factor, wage rate adjustment, outlier adjustment, etc. applied. Appendix L summarizes the process of filling in the APC return buffer.

If a claim spans more than one day, the OCE subdivides the claim into separate days for the purpose of determining discounting and multiple visits on the same day. Multiple day claims are determined based on calendar day. The OCE deals with all multiple day claims issues by means of the return information. The Pricer does not need to be aware of the issues associated with multiple day claims. The Pricer simply applies the payment computation as described above and the result is the total OPPS payment for the claim regardless of whether the claim was for a single day or multiple days. If a multiple day claim has a subset of the days with a claim denial, RTP or suspend, the whole claim is denied, RTP or suspended.

General Programming Notes:

In composite processing, prime/non-prime lines that are denied or rejected (CCI or other edits) will not be included in the composite criteria.

Edits that use status indicator (SI) in their criteria will use the final SI, after any special (SI = Q) processing that could change the SI. (Exception: edits that are stipulated in the overview to be performed before the special processing).

For codes where the default SI is a 'Q(#)', if special logic to change the SI is not performed because of the bill type or because the line is denied or rejected, the default SI will be carried through to the end of processing and will be returned as the final SI.
If the SI or APC of a code is changed during claims processing, the newly assigned SI or APC is used in computing the discount formula.

For the purpose of determining the version of the OCE to be used, the *From* date on the header information is used.

The edit return buffers consist of a list of the edit numbers that occurred for each diagnosis, procedure, modifier, date or revenue code. For example, if a 75-year-old male had a diagnosis related to pregnancy it would create a conflict between the diagnosis and age and sex. Therefore, the diagnosis edit return buffer for the pregnancy diagnosis would contain the edit numbers 2 and 3. There is more space allocated in the edit return buffers than is necessary for the current edits in order to allow future expansion of the number of edits. The edit return buffers are described in Table 3.

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	0,1-5	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 16 diagnoses.
Procedure edit return buffer	3	30	0,6,8-9,11-21, 28,30,35,37-40, 42-45,47, 49-50,52-64, 66 -74, 76- 83	Three-digit code specifying the edits that applied to the procedure.	There is one 30x3 buffer for each of up to 450 line items.
Modifier edit return buffer	3	4	0,22,75	Three-digit code specifying the edits that applied to the modifier.	There is one 4x3 buffer for each of the five modifiers for each of up to 450 line items.
Date edit return buffer	3	4	0,23	Three-digit code specifying the edits that applied to line item dates.	There is one 4x3 buffer for each of up to 450 line items.
Revenue center edit return buffer	3	5	0, 9[a] 41,48, 50[b], 65	Three-digit code specifying the edits that applied to revenue centers.	There is one 5x3 buffer for each of up to 450 line items

Table 3: Edit Return Buffers

[a]Revenue codes 099x with SI of E when submitted without a HCPCS code (OPPS only)
[b]Revenue code 0637 with SI of E when submitted without a HCPCS code (OPPS & Non-OPPS)

Each of the return buffers is positionally representative of the source that it contains information for, in the order in which that source was passed to the OCE. For example, the seventh diagnosis return buffer contains information about the seventh diagnosis; the fourth modifier edit buffer contains information about the modifiers in the fourth line item.

There are currently 83 different edits in the OCE, ten of which are inactive for the current version of the program. Each edit is assigned a number. A description of the edits is contained in Table 4.

Edit #	Description	Non-OPPS Hospitals	Disposition
1	Invalid diagnosis code	Y	RTP
2	Diagnosis and age conflict	Y	RTP
3	Diagnosis and sex conflict	Y	RTP
4[4]	Medicare secondary payor alert **(v1.0-v1.1)**		Suspend
5[4]	E-diagnosis code cannot be used as principal diagnosis	Y	RTP
6	Invalid procedure code	Y	RTP
7	Procedure and age conflict (Not activated)		RTP
8	Procedure and sex conflict	Y	RTP
9	Non-covered ~~for reasons other than statute~~ under any Medicare outpatient benefit, for reasons other than statutory exclusion.	Y	Line item denial
10	Service submitted for denial (condition code 21)	Y	Claim denial
11	Service submitted for FI/MAC review (condition code 20)	Y	Suspend
12	Questionable covered service	Y	Suspend
13	Separate payment for services is not provided by Medicare **(v1.0 – v6.3)**		Line item rejection
14	Code indicates a site of service not included in OPPS **(v1.0 – v6.3)**		Claim RTP
15	Service unit out of range for procedure [1]	Y	RTP
16	Multiple bilateral procedures without modifier 50 (see Appendix A) **(v1.0 – v6.2)**		RTP
17	Inappropriate specification of bilateral procedure (see Appendix A)	Y	RTP
18	Inpatient procedure [2]		Line item denial
19	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present		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 (see Appendix B)		RTP
22	Invalid modifier	Y	RTP
23	Invalid date	Y	RTP
24	Date out of OCE range	Y	Suspend
25	Invalid age	Y	RTP
26	Invalid sex	Y	RTP
27	Only incidental services reported [3]		Claim rejection
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Y	Line item rejection
	(See Appendix C for logic for edits 29-36, and 63-64)		
29	Partial hospitalization service for non-mental health diagnosis		RTP
30	Insufficient services on day of partial hospitalization		~~Suspend~~ Line item denial
31	Partial hospitalization on same day as ECT or type T procedure (v1.0 – v6.3)		Suspend
32	Partial hospitalization claim spans 3 or less days with insufficient services on a least one of the days **(v1.0 – v9.3)**		Suspend
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having partial hospitalization services **(v1.0 – v9.3)**		Suspend
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria **(v1.0 – v9.3)**		Suspend
35	Only Mental Health education and training services provided		RTP
36	Extensive mental health services provided on day of ECT or type T procedure (v1.0 – v6.3)		Suspend
37	Terminated bilateral procedure or terminated procedure with units greater than one		RTP
38	Inconsistency between implanted device or administered substance and implantation or associated procedure		RTP
39	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present		Line item rejection
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present		Line item rejection

Table 4: Description of edits/claim reasons (Part 1 of 2)

[1] For edit 15, units for *all line items with the same HCPCS on the same day* are added together for the purpose of applying the edit. If the total units exceeds 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 is on a list of codes that are exempt, the unit edits are not applied.

[2] Edit 18 causes all other line items on the same day to be line item denied with Edit 49 (see APC/ASC return buffer "Line item denial or reject flag"). No other edits are performed on any lines with Edit 18 or 49.

[3] If Edit 27 is triggered, no other edits are performed on the claim.

[4] Not applicable for patient's reason for visit diagnosis

Edit	Description	Non-OPPS Hospitals	Disposition
41	Invalid revenue code	**Y**	RTP
42	Multiple medical visits on same day with same revenue code without condition code G0 (see Appendix B)		RTP
43	Transfusion or blood product exchange without specification of blood product		RTP
44	Observation revenue code on line item with non-observation HCPCS code		RTP
45	Inpatient separate procedures not paid		Line item rejection
46	Partial hospitalization condition code 41 not approved for type of bill	Y*	RTP
47	Service is not separately payable		Line item rejection
48	Revenue center requires HCPCS		RTP
49	Service on same day as inpatient procedure		Line item denial
50	Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Y	RTP
51	Multiple observations overlap in time (**Not activated**)		RTP
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions **(V3.0-V6.3)**		RTP
53	Codes G0378 and G0379 only allowed with bill type 13x or 85x	Y*	Line item rejection
54	Multiple codes for the same service	Y	RTP
55	Non-reportable for site of service		RTP
56	E/M-condition not met and line item date for obs code G0244 is not 12/31 or 1/1 **(Active V4.0 – V6.3)**		RTP
57	Composite E/M condition not met for observation and line item date for code G0378 is 1/1		Suspend
58	G0379 only allowed with G0378		RTP
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis		RTP
60	Use of modifier CA with more than one procedure not allowed		RTP
61	Service can only be billed to the DMERC	Y	RTP
62	Code not recognized by **OPPS**; alternate code for same service may be available		RTP
63	This OT code only billed on partial hospitalization claims (See appendix C)		RTP
64	AT service not payable outside the partial hospitalization program (See appendix C)		Line item rejection
65	Revenue code not recognized by Medicare	Y	Line item rejection
66	Code requires manual pricing		Suspend
67	Service provided prior to FDA approval	Y	Line item denial
68	Service provided prior to date of National Coverage Determination (NCD) approval	Y	Line item denial
69	Service provided outside approval period	Y	Line item denial
70	CA modifier requires patient status code 20		RTP
71	Claim lacks required device code		RTP
72	Service not billable to the Fiscal Intermediary/Medicare Administrative Contractor	Y	RTP
73	Incorrect billing of blood and blood products		RTP
74	Units greater than one for bilateral procedure billed with modifier 50		RTP
75	Incorrect billing of modifier FB or FC		RTP
76	Trauma response critical care code without revenue code 068x and CPT 99291		Line item rejection
77	Claim lacks allowed procedure code		RTP
78	Claim lacks required ~~radiopharmaceutical~~ radiolabeled product		RTP
79	Incorrect billing of revenue code with HCPCS code		RTP
80	Mental health code not approved for partial hospitalization program		RTP
81	Mental health service not payable outside the partial hospitalization program		RTP
82	Charge exceeds token charge ($1.01)		RTP
83	Service provided on or after effective date of NCD non-coverage	Y	Line item denial

Table 4: Description of edits/claim reasons (Part 2 of 2)

* Non-OPPS hospital bill types allowed for edit condition
Y = edits apply to Non-OPPS hospital claims

The claim return buffer described in Table 5 summarizes the edits that occurred on the claim.

	Bytes	Number	Values	Description
Claim processed flag	1	1	0-3, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, 46[a] , TOB 83x or other invalid bill type). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 9 - Fatal error; OCE can not run - the environment can not be set up as needed; exit immediately.
Num of line items	3	1	nnn	Input value from Nsgptr, or 450, whichever is less.
National provider identifier (NPI)	13	1	aaaaaaaaaaaa	Transferred from input, for Pricer.
OSCAR Medicare provider number	6	1	aaaaaa	Transferred from input, for Pricer.
Overall claim disposition	1	1	0-5	0 - No edits present on claim. 1 - Only edits present are for line item denial or rejection. 2 - Multiple-day claim with one or more days denied or rejected. 3 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only post payment edits. 4 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only pre-payment edits. 5 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w both post-payment and pre-payment edits.
Claim rejection disposition	1	1	0-2	0 - Claim not rejected. 1 - There are one or more edits present that cause the claim to be rejected. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be rejected.
Claim denial disposition	1	1	0-2	0 - Claim not denied. 1 - There are one or more edits present that cause the claim to be denied. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be denied, or single day claim with all lines denied (edit 18 only).
Claim returned to provider disposition	1	1	0-1	0 - Claim not returned to provider. 1 - There are one or more edits present that cause the claim to be returned to provider.
Claim suspension disposition	1	1	0-1	0 - Claim not suspended. 1 - There are one or more edits present that cause the claim to be suspended.
Line item rejection disposition	1	1	0-1	0 - There are no line item rejections. 1 - There are one or more edits present that cause one or more line items to be rejected.
Line item denial disposition	1	1	0-1	0 - There are no line item denials. 1 - There are one or more edits present that cause one or more line items to be denied.
Claim rejection reasons	3	4	27	Three-digit code specifying edits (See Table 6) that caused the claim to be rejected. There is currently one edit that causes a claim to be rejected.
Claim denial reasons	3	8	10	Three-digit code specifying edits (see Table 6) that caused the claim to be denied. There is currently one active edit that causes a claim to be denied.
Claim returned to provider reasons	3	30	1-3, 5-6, 8, 14-17, 21, 22-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 50, 52, 54, 55,56, 58-63, 70-75, 77-82	Three-digit code specifying edits (see Table 6) that caused the claim to be returned to provider. There are 48 edits that could cause a claim to be returned to provider.
Claim suspension reasons	3	16	4, 11, 12, 24, 31-34, 36, 57, 66	Three-digit code specifying the edits that caused the claim to be suspended (see Table 6). There are 11 edits that could cause a claim to be suspended.
Line item rejection reasons	3	12	13, 19, 20, 28, 39, 40, 45, 47, 53, 64, 65, 76	Three-digit code specifying the edits that caused the line item to be rejected (See Table 6). There are 12 edits that could cause a line item to be rejected.
Line item denied reasons	3	6	9, 18, 30, 49, 67-69, 83	Three-digit code specifying the edits that caused the line item to be denied (see Table 6). There are currently 8 ~~active~~ edits that cause a line item denial.
APC/ASC return buffer flag	1	1	0-1	0 - No services paid under OPPS. APC/ASC return buffer filled in with default values and ASC group number (See App F). 1 - One or more services paid under OPPS. APC/ASC return buffer filled in with APC.
VersionUsed	8	1	yy.vv.rr	Version ID of the version used for processing the claim (e.g., 2.1.0).
Patient Status	2	1		Patient status code - transferred from input.
Opps Flag	1	1	1-2*	OPPS/Non-OPPS flag - transferred from input. *A blank, zero or any other value is defaulted to 1
Non-OPPS bill type flag	1	1	1-2	Assigned by OCE based on presence/absence of ASC code 1 = Bill type should be 83x (v8.2 - v8.3 only; ASC list & 83x TOB removed v9.0) 2 = Bill type should not be 83x

Table 5: Claim Return Buffer

[a]Edit 46 terminates processing only for those bill types where no other edits are applied (See App. F).

Table 6 summarizes the edit return buffers, claim disposition and claim reasons. Table 6 also summarizes the pre and post payment status of each edit.

Table 6: Relationship between Edits, Disposition and Reasons (part 1 of 2)

Day denial or rejection means that all line items occurring on the day of the day denial or rejection will have the line item denial or rejection indicator (Table 7) set to 1.

	Edit Buffers (see Table 3)					Claim Disposition (see Table 5)						Claim Reason (see Table 4)						Edit Occurs on Multi-day Claim					
	DX	Proc	Mod	Line Item Date	Rev Code	Deny	Reject	RTP	Susp	Line Item Denial	Line Item Reject	Deny	Reject	RTP	Susp	Line Item Denial	Line Item Reject	RTP Whole Claim	Susp Whole Claim	Reject or Deny Claim	Reject Day	Deny or Reject Day *	Pre/ Post Status
1	1							1						1				Yes					Pre
2	2							1						2				Yes					Pre
3	3							1						3				Yes					Pre
~~4~~	~~4~~	-	-	-	-	-	-	-	-	-	-	-	-	-	~~4~~	-	-	-	-	-	-	-	Post
5	5							1						5				Yes					Pre
6		6						1						6				Yes					Pre
7		7						1						7				Yes					Pre
8		8						1						8				Yes					Pre
9		9			9[a]					1						9							Pre
10		-				1						10								Yes			Pre
11		11							1						11				Yes				Pre
12		12							1						12				Yes				Pre
13		13									1						13						Pre
14		14						1						14				Yes					Pre
15		15						1						15				Yes					Pre
16		16						1						16				Yes					Pre
17		17						1						17				Yes					Pre
18		18				1						18								Yes		Yes	Pre
19		19									1						19						Pre
20		20									1						20						Pre
21		21						1						21				Yes					Pre
22			22					1						22				Yes					Pre
23				23				1						23				Yes					Pre
24				-					1						24				Yes				Pre
25								1						25				Yes					Pre
26								1						26				Yes					Pre
27							1						27							Yes			Pre
28		28									1						28						Pre
29								1						29				Yes					Pre
30		30								1						30							Pre
31									1						31				Yes				Pre
32									1						32				Yes				Pre
33									1						33				Yes				Pre
34									1						34				Yes				Pre
35		35						1						35				Yes					Pre
36									1						36				Yes				Pre
37		37						1						37				Yes					Pre
38		38						1						38				Yes					Pre

Table 6: Relationship between Edits, Disposition and Reasons (part 2 of 2)

* Day denial or rejection means that all line items occurring on the day of the day denial or rejection will have the line item denial or rejection indicator (Table 7) set to 1.

	Edit Buffers (see Table 3)					Claim Disposition (see Table 5)						Claim Reason (see Table 4)						Edit Occurs on Multi-day Claim					
	DX	Proc	Mod	Line Item Date	Rev Code	Deny	Reject	RTP	Susp	Line Item Denial	Line Item Reject	Deny	Reject	RTP	Susp	Line Item Denial	Line Item Reject	RTP Whole Claim	Susp Whole Claim	Reject or Deny Claim	Reject Day	Deny or Reject Day *	Pre/ Post Status
39		39									1						39						Pre
40		40									1						40						Pre
41					41			1						41				Yes					Pre
42		42						1						42				Yes					Pre
43		43						1						43				Yes					Pre
44		44						1						44				Yes					Pre
45		45									1						45						Pre
46								1						46				Yes					Pre
47		47									1						47						Pre
48					48			1						48				Yes					Pre
49		49								1						49						Yes	Pre
50		50			50[b]			1						50				Yes					Pre
51		51						1						51				Yes					Pre
52		52						1						52				Yes					Pre
53		53									1						53						Pre
54		54						1						54				Yes					Pre
55		55						1						55				Yes					Pre
56		56						1						56				Yes					Pre
57		57							1						57				Yes				Pre
58		58						1						58				Yes					Pre
59		59						1						59				Yes					Pre
60		60						1						60				Yes					Pre
61		61						1						61				Yes					Pre
62		62						1						62				Yes					Pre
63		63						1						63				Yes					Pre1
64		64									1						64						Pre
65					65						1						65						Pre
66		66							1						66				Yes				Pre
67		67								1						67							Pre
68		68								1						68							Pre
69		69								1						69							Pre
70								1						70				Yes					Pre
71		71						1						71				Yes					Pre
72		72						1						72				Yes					Pre
73		73						1						73				Yes					Pre
74		74						1						74				Yes					Pre
75			75					1						75				Yes					Pre
76		76									1						76						Pre
77		77						1						77				Yes					Pre
	DX	Proc	Mod	Line Item	Rev Code	Deny	Reject	RTP	Susp	Line Item	Line Item	Deny	Reject	RTP	Susp	Line Item	Line Item	RTP Whole	Susp Whole	Reject or	Reject Day	Deny or	Pre/ Post

				Date						Denial	Reject					Denial	Reject	Claim	Claim	Deny Claim		Reject Day *	Status
78		78						1						78				Yes					Pre
79		79						1						79				Yes					Pre
80		80						1						80				Yes					Pre
81		81						1						81				Yes					Pre
82		82						1						82				Yes					Pre
83		83								1						83							Pre

[a]Edit 9 will be returned in the Revenue code edit return buffer for revenue code 099x when no HCPCS code is on the line
[b]Edit 50 will be returned in the Revenue code edit return buffer for revenue code 0637 when no HCPCS code is on the line

Table 7 describes the APC/ASC return buffer. The APC/ASC return buffer contains the APC for each line item along with the relevant information for computing OPPS payment for OPPS hospital claims. Two APC numbers are returned in the APC/ASC fields: HCPCS APC and payment APC. Except when specified otherwise (e.g., partial hospitalization, mental health, observation logic, codes with SI of Q(#), etc.), the HCPCS APC and the payment APC are always the same. The APC/ASC return buffer contains the information that will be passed to the OPPS PRICER. The APC is only returned for claims from HOPDs that are subject to OPPS, and for the special conditions specified in Appendix F-a.

The APC/ASC return buffer for the PC program interface also contains the ASC payment groups for procedures on certain Non-OPPS hospital claims. The ASC group number is returned in the payment APC/ASC field, the HCPCS ASC field is zero-filled [v8.2 – v8.3 only].

Table 7: APC/ASC Return Buffer (Part 1 of 2)

	Size (bytes)	Values	Description
HCPCS procedure code	5	Alpha	For potential future use by Pricer. Transfer from input
Payment APC/ASC*	5	00001-nnnnn	APC used to determine payment. If no APC assigned to line item, the value 00000 is assigned. For partial hospitalization, some inpatient-only, and other procedure claims, the payment APC may be different than the APC assigned to the HCPCS code. ASC group for the HCPCS code.
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status indicator**	2	Alpha [Right justified, blank filled]	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 F - Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines G - Drug/Biological Pass-through H – Pass-through device categories, ~~brachytherapy sources and~~ therapeutic radiopharmaceuticals ~~agents~~ J - New drug or new biological pass-through [1] K - Non pass-through drugs and biologicals. ~~blood and blood products~~ L – Flu/PPV vaccines M – Service not billable to the FI/MAC N - Items and Services packaged into APC rates P - Partial hospitalization service Q - Packaged services subject to separate payment based on payment criteria[2] Q1 – STVX-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC R – Blood and blood products S - Significant procedure not subject to multiple procedure discounting T - Significant procedure subject to multiple procedure discounting U – Brachytherapy sources V - Clinic or emergency department visit W – Invalid HCPCS or Invalid revenue code with blank HCPCS X - Ancillary service Y – Non-implantable DME Z – Valid revenue with blank HCPCS and no other SI assigned
Payment indicator**	2	Numeric (1- nn) [Right justified, blank filled].	1 - Paid standard hospital OPPS amount (status indicators K, R, S, T, V, X) 2 - Services not paid under OPPS; paid under fee schedule or other payment system (SI A) 3 - Not paid (Q, Q1, Q2, Q3, M, W,Y, E), or not paid under OPPS (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) 6 – Payment based on charge adjusted to cost (status indicator H, U) 7 – Additional payment for new drug or new biological (status indicator J) 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 service))
Discounting formula number**	1	1-9	See Appendix D for values
Line item denial or rejection flag**	1	0-2	0 - Line item not denied or rejected 1 - Line item denied or rejected (edit return buffer for line item contains a 9, 13, 18, 19, 20, 28, 30, 39, 40, 45, 47 ,49, 53, 64, 65, 67, 68, 69, 76, 83) 2- The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/1/02 - v3.0).

Name	Size (bytes)	Values	Description
Packaging flag**	1	0-4	0 - Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of partial hospital per diem or daily mental health service per diem (v1.0 - v9.3 only)[3] 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01) 4 – Packaged as part of drug administration APC payment (v6.0 – v7.3 only)
Payment adjustment flag**	2	0-8, 91-99 [Right justified, blank filled]	0 - No payment adjustment 1 – Paid standard amount for pass-through drug or biological (status indicator G) 2 – Payment based on charge adjusted to cost (status indicator H, U) 3 – Additional payment for new drug or new biological applies to APC (status indicator J) [1] 4 – Deductible not applicable (specific list of HCPCS codes) 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 8 – Item provided with partial credit to provider 91 – 99 Each composite APC present, same value for prime and non-prime codes (v9.0 – v9.3 only)[4]
Payment Method Flag**	1	0-4	0 - OPPS pricer determines payment for service 1 - Based on OPPS coverage or billing rules, the service is not paid 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 FI/MAC; OCE not applied to line item
Service units	9	1-x	Transferred from input, for Pricer. For the line items assigned APCs 33, 172, 173 or 34, the service units are always assigned a value of one by the OCE even if the input service units were greater than one [Input service units also may be reduced for some Drug administration APCs, based on Appendix I (v6.0 – v7.3 only)]
Charge	10	nnnnnnnnn	Transferred from input, for Pricer; COBOL pic 9(8)v99
Line item action flag**	1	0-4	Transferred from input to Pricer, and can impact selection of discounting formula (AppxD). 0 - OCE line item denial or rejection is not ignored 1 - OCE line item denial or rejection is ignored 2 - External line item denial. Line item is denied even if no OCE edits 3 - External line item rejection. Line item is rejected even if no OCE edits 4 - External line item adjustment. Technical charge rules apply.
Composite Adjustment Flag**	2	Alphanumeric	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 7: APC/ASC Return Buffer (Part 2 of 2)

[1] Status indicator J was replaced by status indicator G starting in April, 2002 (V3.0)
[2] Status indicator Q was replaced by status indicators Q(#) in January, 2009 (v10.0)
[3] Packaging flag 2 was replaced by the composite adjustment flag starting in January, 2009 (v10.0)
[4] Payment adjustment flag values 91 thru 99 discontinued 1/1/09, replaced by the composite adjustment flag (v10.0)
***** ASC # returned **only** for TOB 83x, on the PC version output report, for v8.2 & v8.3
****** Not activated for claims with Opps flag = 2 (blanks are returned in the APC/ASC Return Buffer)

Appendix A (OPPS & Non-OPPS)
Bilateral Procedure Logic

There is a list of codes that are exclusively bilateral if a modifier of 50 is present*. The following edits apply to these bilateral procedures*.

Condition	Action	Edit
The same code which can be performed bilaterally occurs two or more times on the same date of service, all codes *without* a 50 modifier	Return claim to provider	16
The same code which can be performed bilaterally occurs two or more times (based on units and/or lines) on the same date of service, all or some codes *with* a 50 modifier	Return claim to provider	17

There is a list of codes that are considered inherently bilateral even if a modifier of 50 is not present. The following edit applies to these bilateral procedures**.

Condition	Action	Edit
The same bilateral code occurs two or more times (based on units and/or lines) on the same date of service	Return claim to provider	17***

There are two lists of codes, one is considered conditionally bilateral and the other independently bilateral if a modifier 50 is present. The following edit applies to these bilateral procedures (effective 10/1/06). [OPPS claims only]

Condition	Action	Edit
The bilateral code occurs with modifier 50 and more than one unit of service on the same line	Return claim to provider	74

Note: For ER and observation claims, all services on the claim are treated like any normal claim, including multiple day processing.

*Note: The "exclusively bilateral" list was eliminated, effective 10/1/05 (v6.3); edits 16 and 17 will not be triggered by the presence/absence of modifier 50 on certain bilateral codes for dates of service on or after 10/1/05.

** Exception: For codes with 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 nor be returned to provider.

*** Exception: Edit 17 is not applied to Non-OPPS TOB 85x

Appendix B (OPPS Only)
Rules for Medical and Procedure Visits on the Same Day and for Multiple Medical Visits on Same Day

Under some circumstances, medical visits on the same date as a procedure will result in additional payments. A modifier of **25** 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 will apply and the claim will be returned to provider.

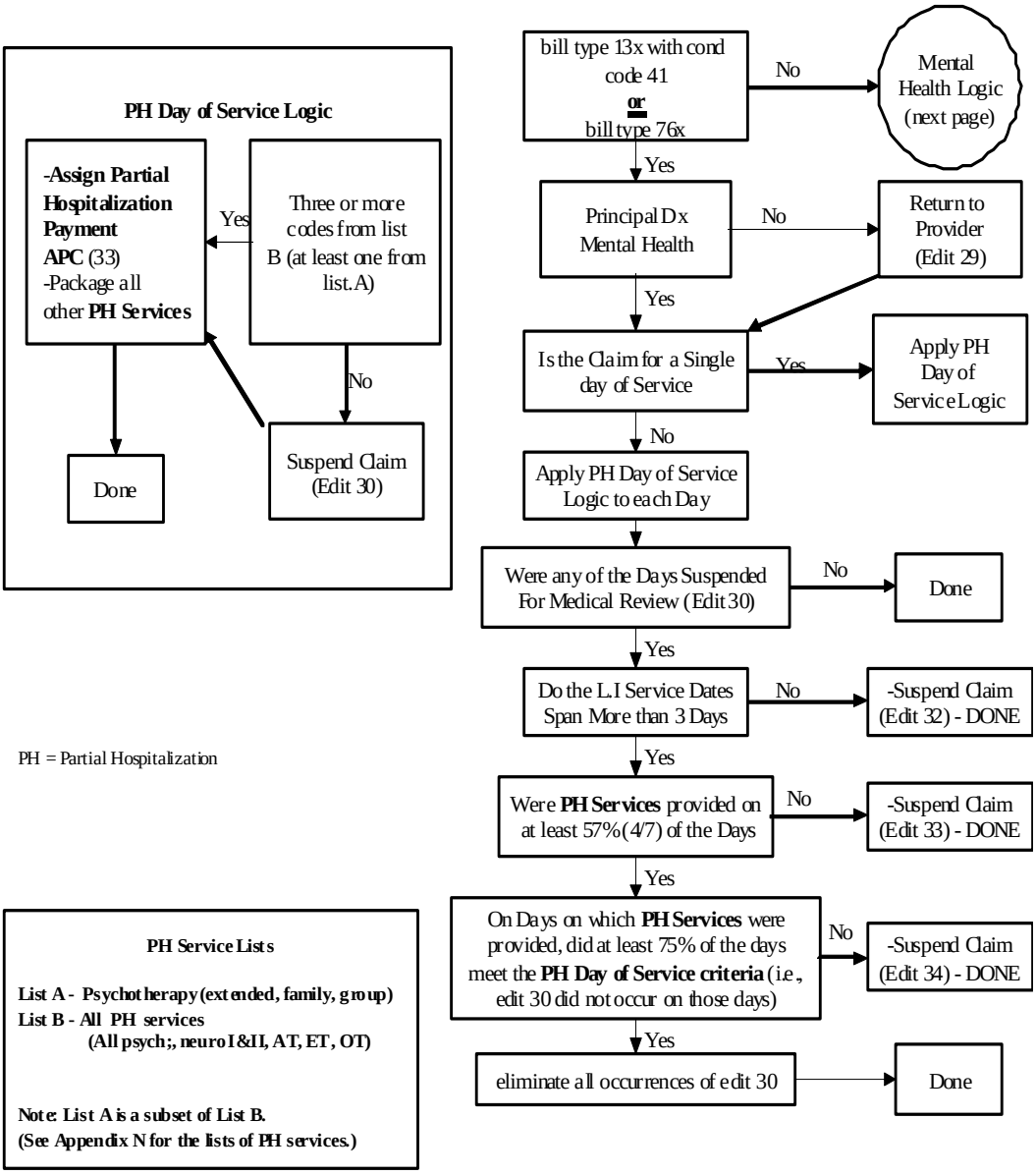
If there are multiple E&M codes on the same day, on the same claim the rules associated with multiple medical visits are shown in the following table.

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
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).

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

Appendix C-a (OPPS Only)
Partial Hospitalization Logic (v1.0 – v9.3)



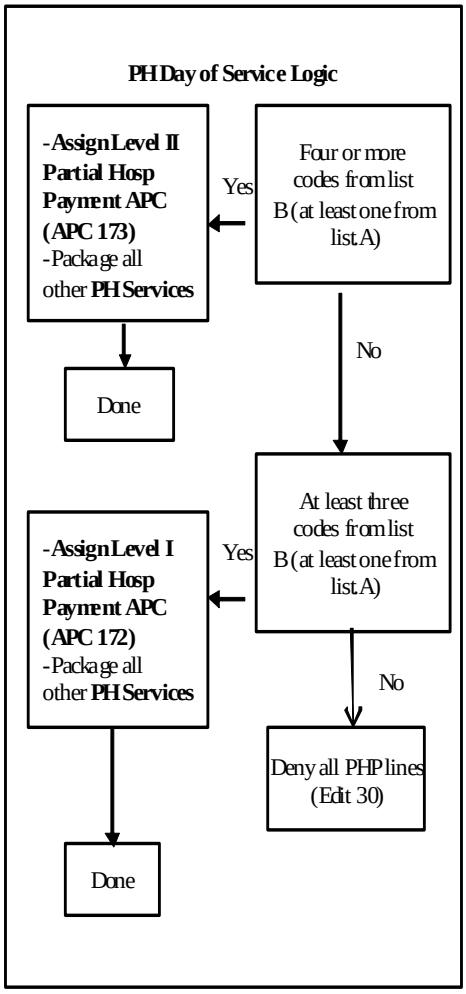
+ Multiple occurrences of services from list A or B are treated as separate units in determining whether 3 or more PH services are present..

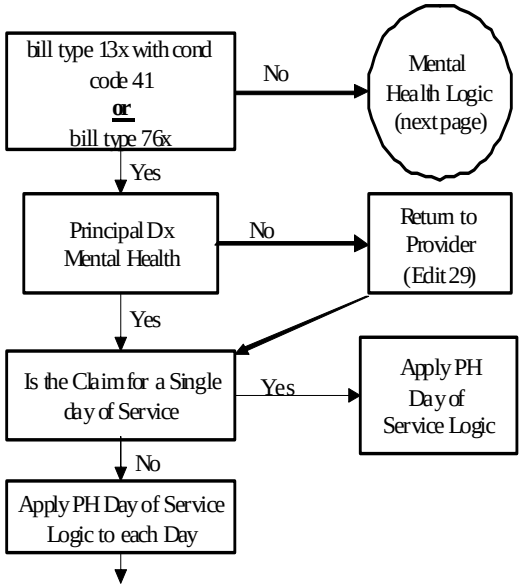
Assign Partial Hospitalization Payment APC

For any day that has a PH service, the first listed line item from the following hierarchical list (List A, other codes in list B) is assigned a payment APC of 33, a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, and a service unit of 1

For all other line items with a **partial hospital service** (List B), the SI is changed to N and packaging flag is set to 2
For ALL lines with a partial hospital service (List B), the HCPCS APC is set to 0 (effective **1/1/08**)
Note: If mental health services which are not approved for the partial hospitalization program are submitted on a 13x TOB with CC 41, the claim is returned to the provider (edit 80).

Appendix C-a (cont'd)
Partial Hospitalization Logic (effective v10.0)





PH = Partial Hospitalization

PH Service Lists

List A - Psychotherapy (extended, family, group)
List B - All PH services
(All psych;, neuro I&II, AT, ET, OT)

Note: List A is a subset of List B.
(See Appendix N for the lists of PH services.)

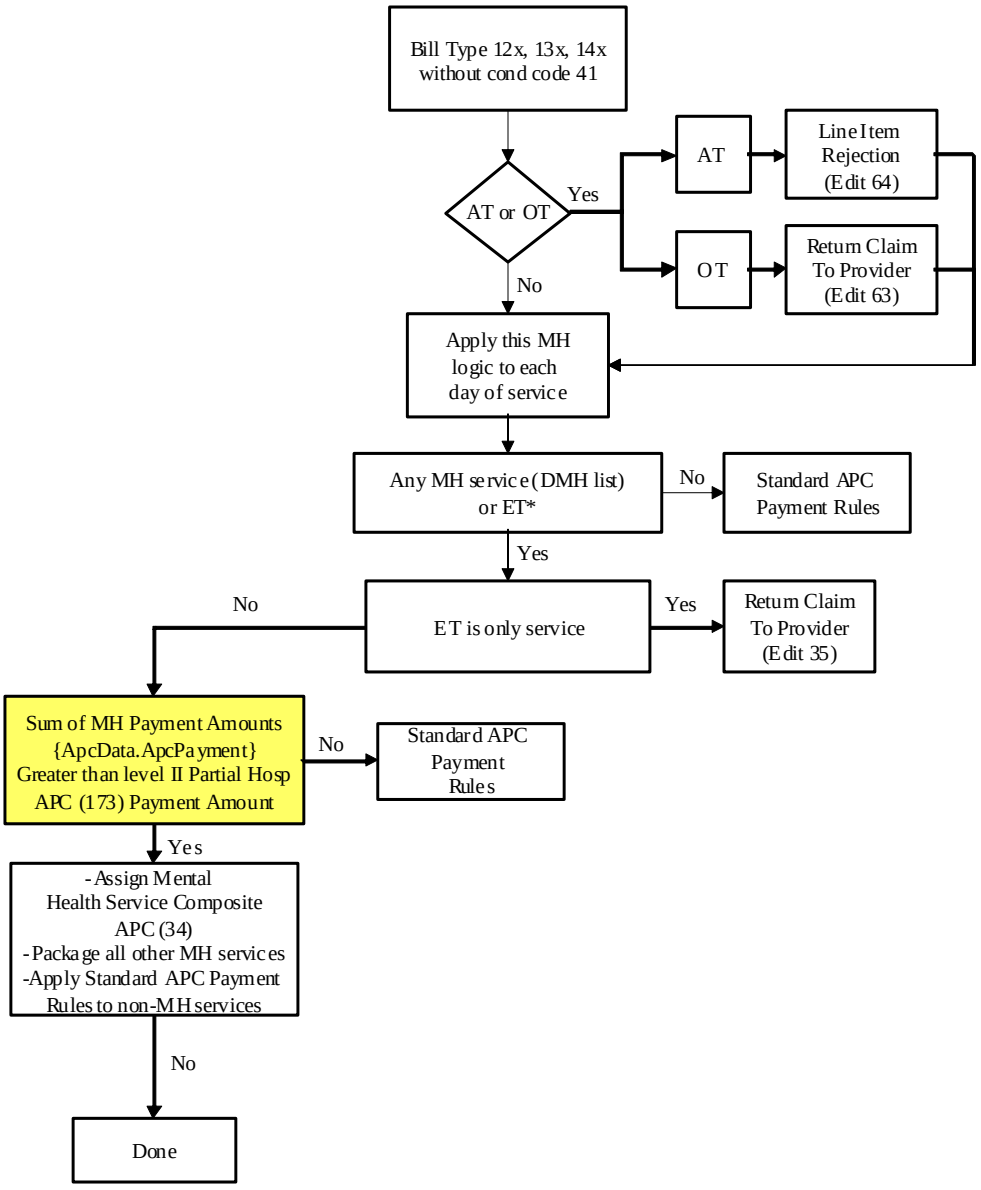
+ Multiple occurrences of services from list A or B are treated as separate units in determining whether 3 or more PH services are present..

Assign Partial Hospitalization Payment APC
For any day that meets the criteria for level II or level I PHP APC, the first listed line item from the following hierarchical list (List A, other codes in list B) is assigned the PHP payment APC (173 or 172), a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1 and a composite adjustment flag value.

For all other line items with a **partial hospital service** (List B) on the day, the SI is changed to N, the packaging flag is set to 1 and the same composite adjustment flag value as for the PHP APC, is assigned.

For ALL lines with a partial hospital service (List B), the HCPCS APC is set to 0 (effective **1/1/08**)
Note: If mental health services which are not approved for the partial hospitalization program are submitted on a 13x TOB with CC41, the claim is returned to the provider (edit 80).

Appendix C-b
Mental Health Logic



Assign Mental Health Service Composite APC
The first listed line item with HCPCS code from the list of Daily MH services (DMH list) is assigned a payment APC of 34, a status indicator of S, a payment indicator of 1, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1 and a composite adjustment flag value..

For all other line items with a **daily mental health service** (DMH list), the SI is changed to N, the packaging flag is set to 1 and the same composite adjustment flag value as for the APC 34 line is assigned..

*NOTE: The use of code G0177 (ET) is allowed on MH claims that are not billed as Partial Hospitalization
**NOTE: If mental health services that are not payable outside the PH program are submitted on a 12x, 13X or 14x TOB without CC41; the claim is returned to the provider (edit 81).

Appendix D
Computation of Discounting Fraction (OPPS Only)

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 will *not* be multiple procedure discounted, and all other "T" line items will be multiple procedure discounted. All line items that do not have a status indicator of "T" will be 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 will also be 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 will be 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 will 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, will be ignored in determining the discount; packaged line items, (the packaging flag is not zero or 3), will also be ignored in determining the discount. The discounting process will utilize an APC payment amount file. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

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.

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

1. 1.0
2. (1.0 + D(U-1))/U
3. T/U
4. (1 + D)/U
5. D
6. *TD/U
7. *D(1 + D)/U
8. 2.0
9. 2D/U

Where

D = discounting fraction (currently 0.5)
U = number of units
T = terminated procedure discount (currently 0.5)

***Note**: Effective 1/1/08 (v9.0), formula #6 and #7 discontinued; new formula #9 created.

The discount formula that applies is summarized in the following table.

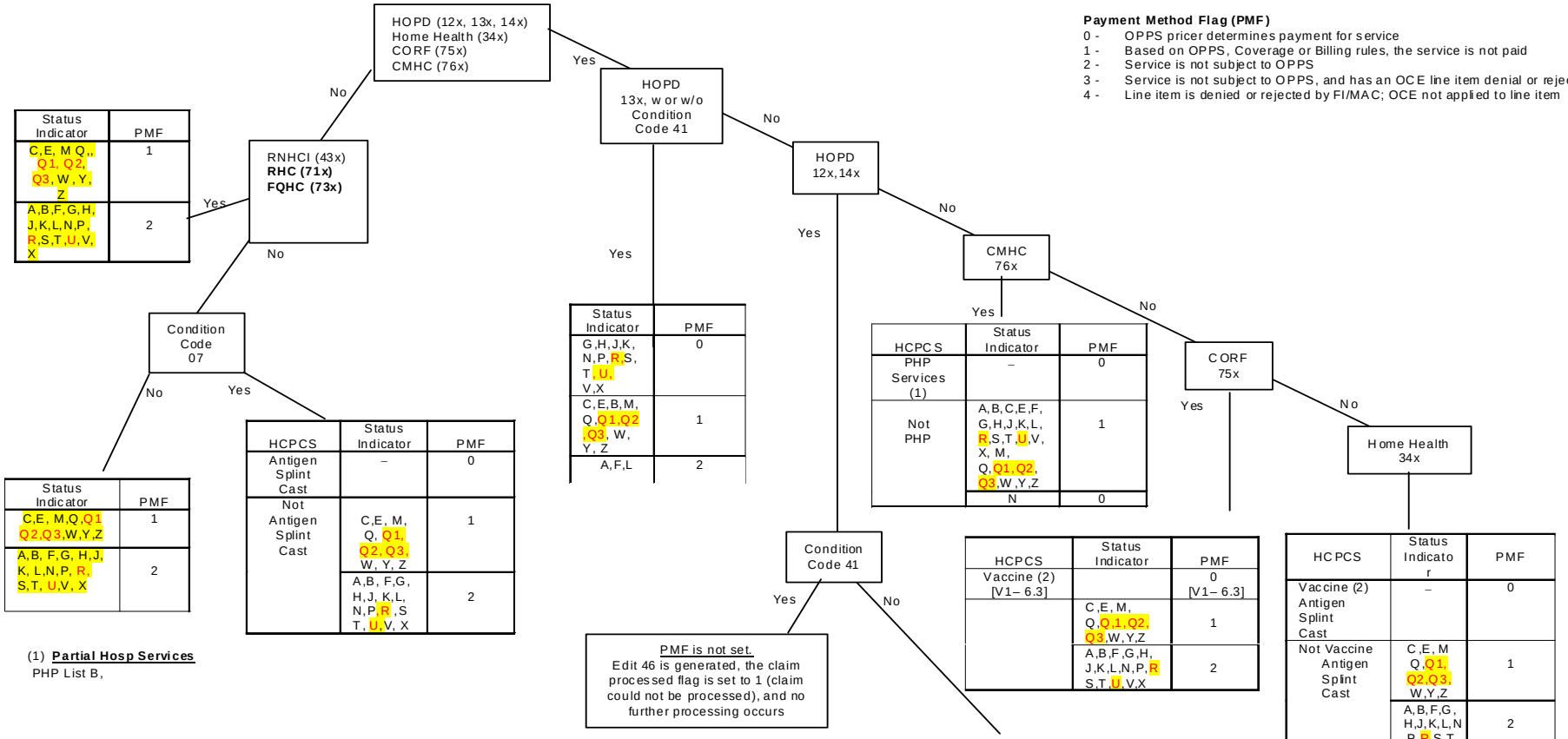
			Discounting Formula Number			
			Type "T" Procedure		Non Type "T" Procedure	
Payment Amount	**Modifier 52 or 73**	**Modifier 50**	**Conditional or Independent Bilateral**	**Inherent or Non Bilateral**	**Conditional or Independent Bilateral**	**Inherent or Non Bilateral**
Highest	No	No	2	2	1	1
Highest	Yes	No	3	3	3	3
Highest	No	Yes	4	2	8*	1
Highest	Yes	Yes	3	3	3	3
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	3	3	3	3
Not Highest	No	Yes	9	5	8*	1
Not Highest	Yes	Yes	3	3	3	3

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

*If not terminated, non-type T Conditional bilateral procedures with modifier 50 will be assigned discount formula #8 effective 10/1/08. Non-type T Independent bilateral procedures with modifier 50 will be assigned to formula #8.

Effective 1/1/08 (v9.0), Use of formula #6 and formula #7 discontinued; replaced by formula #3 and new formula #9

Appendix E(a) [OPPS flag =1]
Logic for Assigning Payment Method Flag Values



Status Indicator	PMF
C,E, M Q,, Q1, Q2, Q3, W, Y, Z	1
A,B,F,G,H, J,K,L,N,P, R,S,T,U,V, X	2

Status Indicator	PMF
C,E, M,Q,Q1 Q2,Q3,W,Y,Z	1
A,B, F,G, H,J, K, L,N,P, R, S,T, U,V, X	2

HCPCS	Status Indicator	PMF
Antigen Splint Cast	–	0
Not Antigen Splint Cast	C,E, M, Q, Q1, Q2, Q3, W, Y, Z	1
	A,B, F,G, H,J, K,L, N,P,R,S T, U,V, X	2

Status Indicator	PMF
G,H,J,K, N,P,R,S, T, U, V,X	0
C,E,B,M, Q,Q1,Q2 ,Q3, W, Y, Z	1
A,F,L	2

HCPCS	Status Indicator	PMF
PHP Services (1)	–	0
Not PHP	A,B,C,E,F, G,H,J,K,L, R,S,T,U,V, X, M, Q,Q1,Q2, Q3,W,Y,Z	1
	N	0

HCPCS	Status Indicator	PMF
Vaccine (2) [V1– 6.3]		0 [V1– 6.3]
	C,E, M, Q,Q,1,Q2, Q3,W,Y,Z	1
	A,B,F,G,H, J,K,L,N,P,R S,T,U,V,X	2

HCPCS	Status Indicator	PMF
Vaccine (2) Antigen Splint Cast	–	0
Not Vaccine Antigen Splint Cast	C,E, M Q,Q1, Q2,Q3, W,Y,Z	1
	A,B,F,G, H,J,K,L,N ,P,R,S,T, U,V,X	2

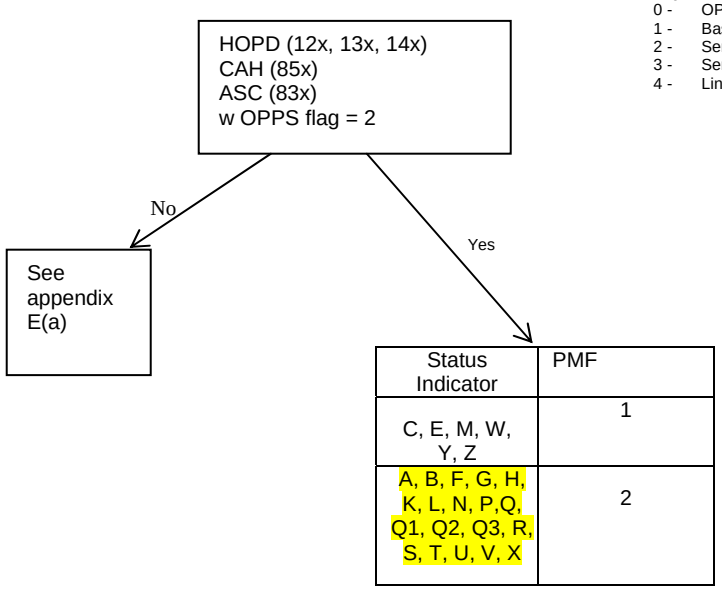
Status Indicator	PMF
G,H,J,K,N, P,R,S,T,U, V,X	0
C,E,B,M,Q ,Q1,Q2,Q3 W,Y,Z	1
A,F,L	2

1. ***If the claim is not processed (claim processed flag is greater than 0), the PMF is not set and is left blank.***
2. ***If the line item denial or rejection flag is 1 or 2, and the PMF has been set to 2 by the process flowcharted here, the PMF is reset to 3.***
3. ***If the line item action flag is 2 or 3 the PMF is reset to 4.***
4. ***If the line item action flag is 4, the PMF is reset to 0.***
5. ***If PMF is set to a value greater than 0, reset HCPCS and Payment APC to 00000.***
6. ***Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)***

a/apc/pmf

Appendix E(b) [OPPS flag = 2] **[Not activated]**.
Logic for Assigning Non-OPPS Hospital Payment Method Flag Values

[PMF values not returned on claims with OPPS flag = 2]



Status Indicator	PMF
C, E, M, W, Y, Z	1
A, B, F, G, H, K, L, N, P,Q, Q1, Q2, Q3, R, S, T, U, V, X	2

Payment Method Flag (PMF)
0 - OPPS pricer determines payment for service
1 - Based on OPPS, Coverage or Billing rules, the service is not paid
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 FI/MAC; OCE not applied to line item

1. ***If the claim is not processed (claim processed flag is greater than 0), the PMF is not set and is left blank.***
2. ***If the line item denial or rejection flag is 1 or 2, and the PMF has been set to 2 by the process flowcharted here, the PMF is reset to 3.***
3. ***If the line item action flag is 2 or 3 the PMF is reset to 4.***
4. ***If the line item action flag is 4, the PMF is reset to 0.***

Appendix F(a) - OCE Edits Applied by Bill Type [OPPS flag =1]

FLOW CHART CELL (*)	Provider/Bill Types	Dx [1-5]	HCPC [6,13]	OPPS site of svc [14]	Non Mcare [28] Non OPPS [62]	Proc & Mod [18, 38, 43, 45, 47, 49, 71, 73, 75, 77[k], 78, 79, 82]	HCPCS Req'd [48[d]]	Modifier [16,17,22[b],37,74]	CCI [19,20,39,40]	[a] Line Item Date [23]	Units [15]	Rev Code [41,65]	Rev Code [44]	Age, Sex [25,26]	Partial Hosp [29-34, 80[m]]	APC [21,27,42]	MH [35,36, 63, 64, 81]	Bill Type [46]	APC buffer completed	Obs Logic [52,56,57], DirAdm [58], Spec Inpt [60], Manual Price [66, 70], FDA/NCD [67, 68, 83]; Trauma[76]	Opps Proc (55)	DME (61); Not FI/MAC (72)
1	12X or 14X w cond code 41	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No
2	12X or 14X w.o cond code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	No	Yes
3	13X w condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
4	13X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes
5	76X (CMHC)	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	Yes
6	34X[h](HHA) w Vaccine[e], Antigen, Splint or Cast	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	No
7	34X[h] (HHA) w.o Vaccine[e], Antigen, Splint or Cast	Yes	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	No
8	75X(CORF) w Vac(PPS)[v1-6.3]	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes
9	43X (RNHCI)	No	No	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	No	No	Yes	No	No	Yes	No
10	71X (RHC), 73X (FQHC)	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	Yes	No	No	No	No	No	No	No	Yes
11	Any bill type except 12x,13x, 14x, 34x, 43x, 71x, 73x, 76x, w CC 07, w Antigen, Splint or Cast	Yes[f]	Yes[f]	Yes	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	No
12	75X[h] (CORFs)	Yes	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
13	22X[hj], 23X[hj] (SNF), 24X[g]	Yes	Yes	Yes	No	Yes[J]	No	No	No	Yes	No	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
14	32X, 33X (HHA)	Yes[f]	Yes[f]	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	No
15	72X (ESRD)	Yes	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
16	74X[h] (OPTs)	Yes	Yes	Yes	No	No	No	Yes	No	Yes	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
17	81x (Hospice), 82x	Yes	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes

(*) FLOW CHART CELLS ARE IN HIERARCHICAL ORDER **Yes = edits apply, No = edits do not apply**

Edit 10, and Edits 23 and 24 for From/Through dates, are not dependent on AppxF

[a] **if edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates, and processing continues.**

[b] **Bypass edit 22 if Revenue code is 540** [c] **Edits 53 not applicable for bill type 13x** [K] Edits 77 not applicable to bill type 12x

[d] **Bypass edit 48 if Revenue code is 100x, 210x, 310x,0905, 0906, 0907; 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932; 0521, 0522, 0524, 0525, 0527, 0528;0948, 099x, 0637**

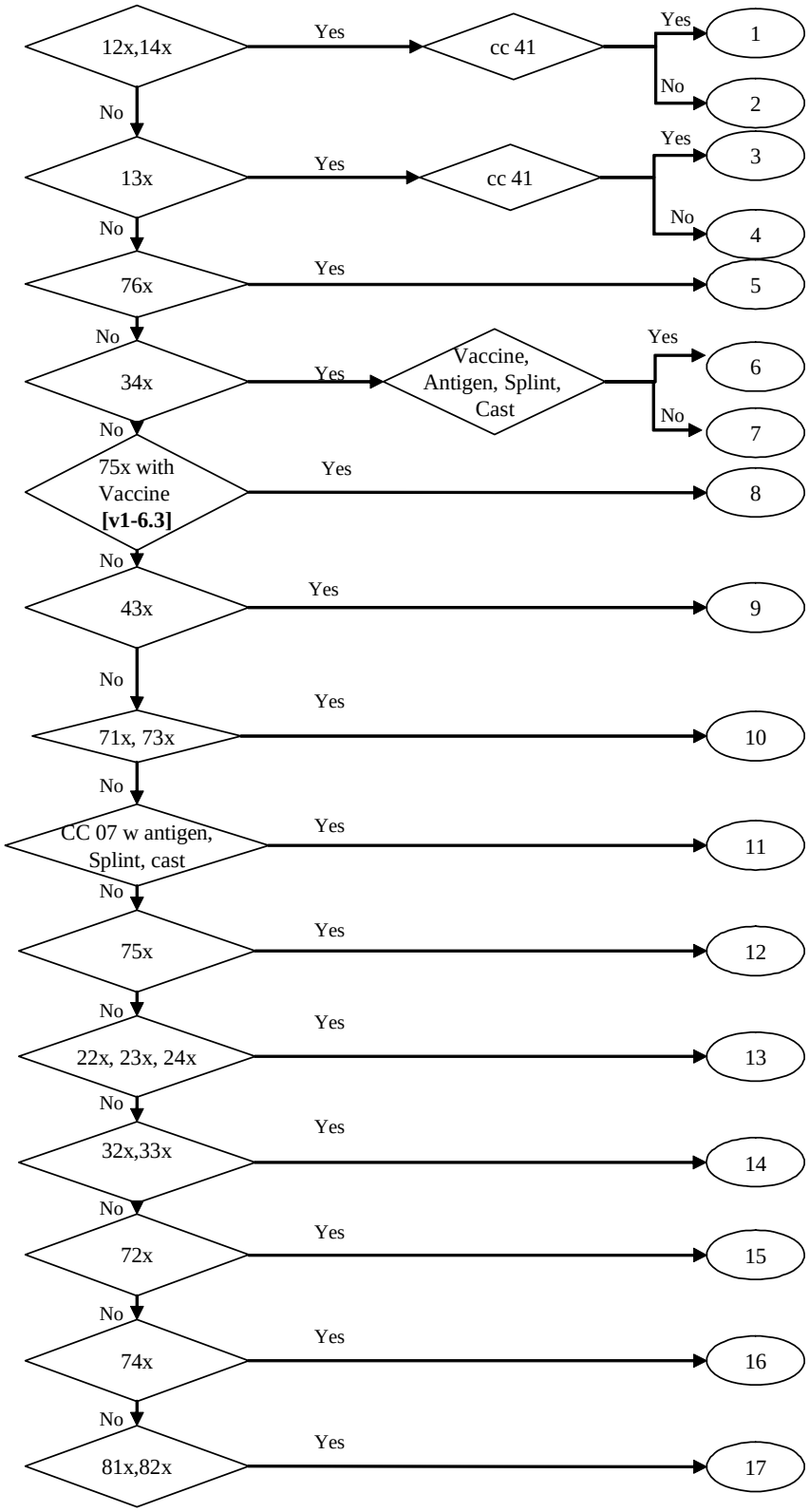
[e] **In V1.0 to V3.2,"vaccines" included all vaccines paid by APCs; from V4.0 onward, "vaccines" includes Hepatitis B vaccines only, plus Flu and PPV administration**

[f] **Bypass diagnosis edits (1-5) for bill types 32X and 33X (HHA) & 12X (inpt/B) if from date is <10/1/xx and Through date is >= 10/1/xx**

[g] **Delete TOB 24X effective 10/1/05** [h] **Apply CCI edits to TOB 22x, 23x, 34x, 74x and 75x, effective 1/1/06** [j] **Apply edit 28, effective 10/1/05**

[M] Edit 80 not applicable to TOB 76X (CMHC)

Appendix F(a) Flow Chart [OPPS flag = 1]



Appendix F(b) - OCE Edits Applied by Non-OPPS Hospital Bill Type [OPPS flag = 2]

Provider/Bill Types	Dx [1-3, 5]	Proc [8, 9, 11, 12, 30, 53 [c], 54, 69]	HCPC [6]	Non Mcare [28]	Proc & Modifier [18, 45, 49]	HCPC Req'd [48 [d]]	Modifier [17 [e], 22b]	CCI [19,20,39,40]	[a] Line Item Date [23]	Units [15]	Rev Code [41, 65]	Age, Sex [25,26]	Partial Hosp [29-34]	APC [21,27,42]	MH [35, 63, 64]	Bill Type [46]	APC/ASC buffer completed	FDA/NCD [67, 68, 83]	Opps Proc (55)	DME (61); Not FI/MAC (72)
12x&14x w cond code 41/OPPS flag =2	No	No	No		No	No	No	No	No	No	No	No		No	No	No	No	Yes	No	No	No	No
12x&14x w.o cond code 41/OPPS flag =2	Yes	Yes	Yes		Yes	No	No	Yes	No	Yes	Yes	Yes		Yes	No	No	No	No	No	Yes	No	Yes
13x w condition code 41/OPPS flag = 2	Yes	Yes	Yes		Yes	No	No	Yes	No	Yes	Yes	Yes		Yes	No	No	No	No	No	Yes	No	Yes
13x w.o cond code 41/OPPS flag = 2	Yes	Yes	Yes		Yes	No	No	Yes	No	Yes	Yes	Yes		Yes	No	No	No	No	No	Yes	No	Yes
85x/OPPs flag = 2	Yes	Yes	Yes		Yes	No	No	Yes	No	Yes	Yes	Yes		Yes	No	No	No	No	No	Yes	No	Yes [d]
83x/OPPs flag = 2**	Yes	Yes	Yes		Yes	No	No	Yes	No	Yes	Yes	Yes		Yes	No	No	No	No	Yes	Yes	No	Yes

(*) FLOW CHART CELLS ARE IN HIERARCHICAL ORDER

Yes = edits apply, No = edits do not apply

Edit 10, and Edits 23 and 24 for From/Through dates, are not dependent on AppxF

[a] if edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates, and processing continues.

[b] Bypass edit 22 if Revenue code is 540

[c] Edit 53 is not applicable to bill type 13x or 85x

[d] Bypass edit 72 if TOB is 85x and revenue code is 096x, 097x or 098x

[e] Bypass edit 17 if TOB is 85x

** Bill type invalid for IOCE effective for dates of service on or after 1/1/08 - v9.0

Appendix G [OPPS Only]

The payment adjustment flag for a line item is set based on the criteria in the following chart:

Criteria	**Payment Adjustment Flag Value**
Status indicator G	1
Status indicator H, U	2
Status indicator J [1]	3
Code is flagged as 'deductible not applicable'	4
Blood product with modifier BL on RC 38X line[2]	5
Blood product with modifier BL on RC 39X line[2]	6
Item provided without cost to provider	7
Item provided with partial credit to provider	8
First thru ninth composite APC present – prime & non-prime codes (v9.0 – v9.3)	91 – 99[3] (v9.0-v9.3)
All others	0

[1] Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)
[2] See Appendix J for assignment logic (v6.2)
[3]PAF 91-99 were replaced by the Composite Adjustment Flag, 1/1/09 (v10.0).

Appendix H [OPPS Only]

OCE Observation (v3.0 – v8.3) &
Extended Assessment & Management Composite Logic (v9.0)

OCE Observation Rules:

1. Code G0378 is used to identify all outpatient observations, regardless of the reason for observation (diagnosis) or the duration of the service.

2. Code G0379 is used to identify direct admission from a physician's office to observation care, regardless of the reason for observation.

3. Code G0378 has default Status Indicator "Q" and default APC 0
   - If the criteria are met for payable observation, the SI is changed to "S" and APC 339 is assigned.
   - If the criteria for payable observation are not met, the SI is changed to "N".

4. Code G0379 has default Status Indicator "Q" and default APC 0
   - If associated with a payable observation (payable G0378 present on the same day), the SI for G0379 is changed to "N".
   - If the observation on the same day is not payable, the SI is changed to "V" and APC 604 is assigned.
   - If there is no G0378 on the same day, the claim is returned to the provider.

5. Observation logic is performed only for claims with bill type 13x, with or without condition code 41.

6. Lines with G0378 and G0379 are rejected if the bill type is not 13x (or 85x).

7. If any of the criteria for separately payable observation is not met, the observation is packaged, or the claim or line is suspended or rejected according to the disposition of the observation edits.

8. In order to qualify for separate payment, each observation must be paired with a unique E/M or critical care (C/C) visit, or with code G0379 (Direct admission from physician's office).
   E/M or C/C visit is required the day before or day of observation; direct admission is required on the day of observation.

9. If an observation cannot be paired with an E/M or C/C visit or Direct admission, the observation is packaged.

10. E/M or C/C visit or Direct admission on the same day as observation takes precedence over E/M or C/C visit on the day before observation.

11. E/M, C/C visit or Direct admission that have been denied or rejected, either externally or by OCE edits, are ignored.

12. Both the associated E/M or C/C visit (APC 604-616, 617) and observation are paid separately if the criteria are met for separately payable observation.

13. If a "T" procedure occurs on the day of or the day before observation, the observation is packaged.

14. Multiple observations on a claim are paid separately if the required criteria are met for each one.

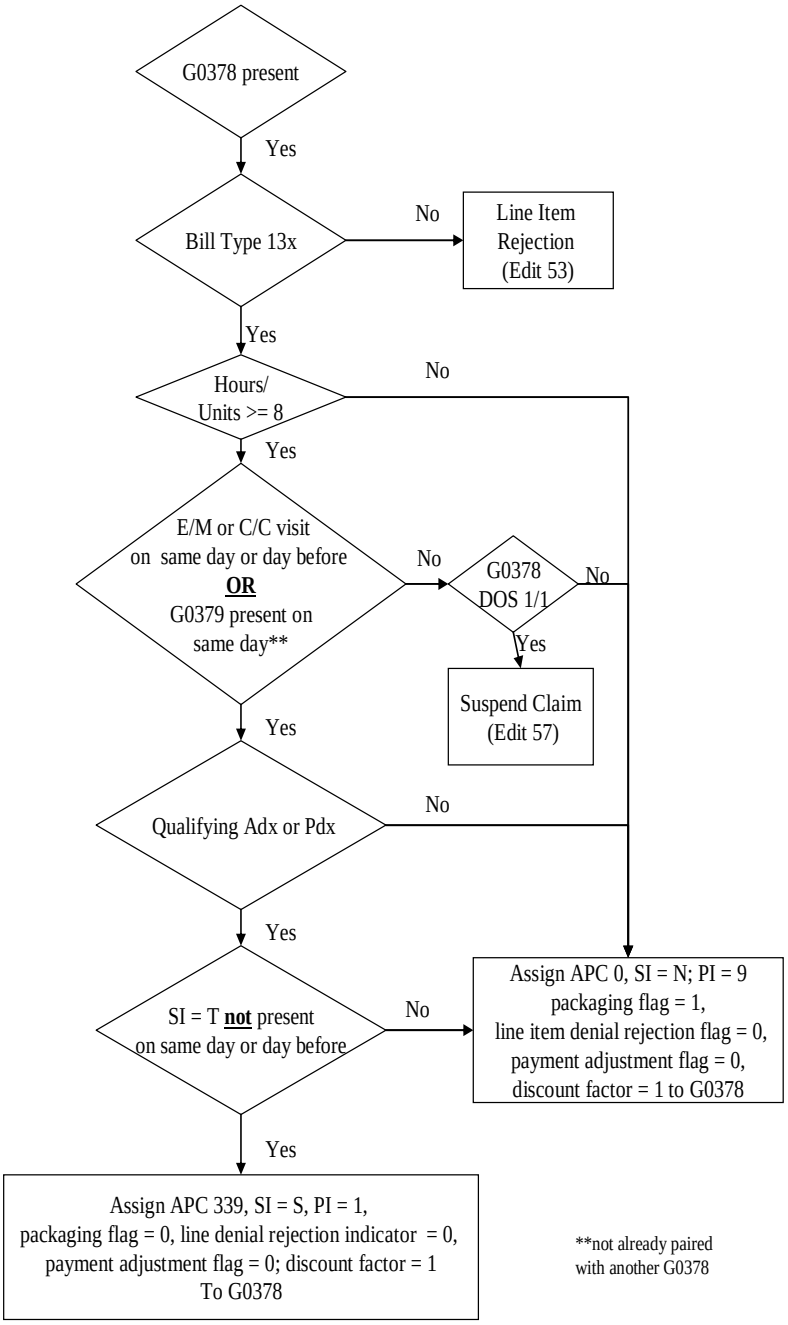
15. If there are multiple observations within the same time period and only one meets the criteria for separate APC payment, the observation with the most hours is considered to have met the criteria, and the other observations will be packaged.

16. Observation date is assumed to be the date admitted for observation
17. The diagnoses (patient's reason for visit or principal) required for the separately payable observation criteria are:

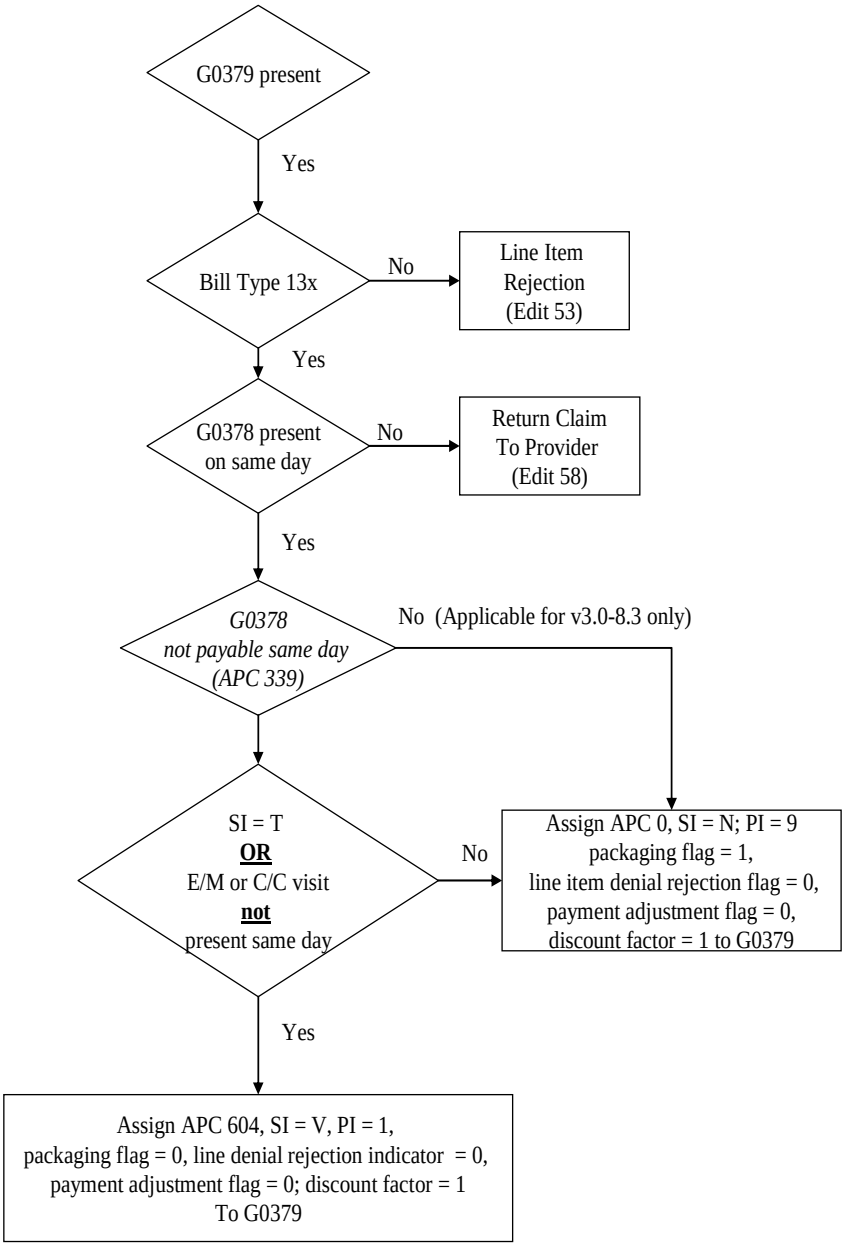
Chest Pain	Asthma	CHF
4110, 1, 81, 89	49301, 02, 11, 12, 21, 22, 91, 92	3918, 39891
4130, 1, 9		40201, 11, 91
78605, 50, 51, 52, 59		40401, 03, 11, 13, 91, 93
		4280, 1, 9, 20-23, 30-33, 40-43

18. The APCs required for the observation criteria to identify E/M or C/C visits are 604- 616, 617.

Appendix H-a
OCE Observation Criteria (v3.0 – v8.3)

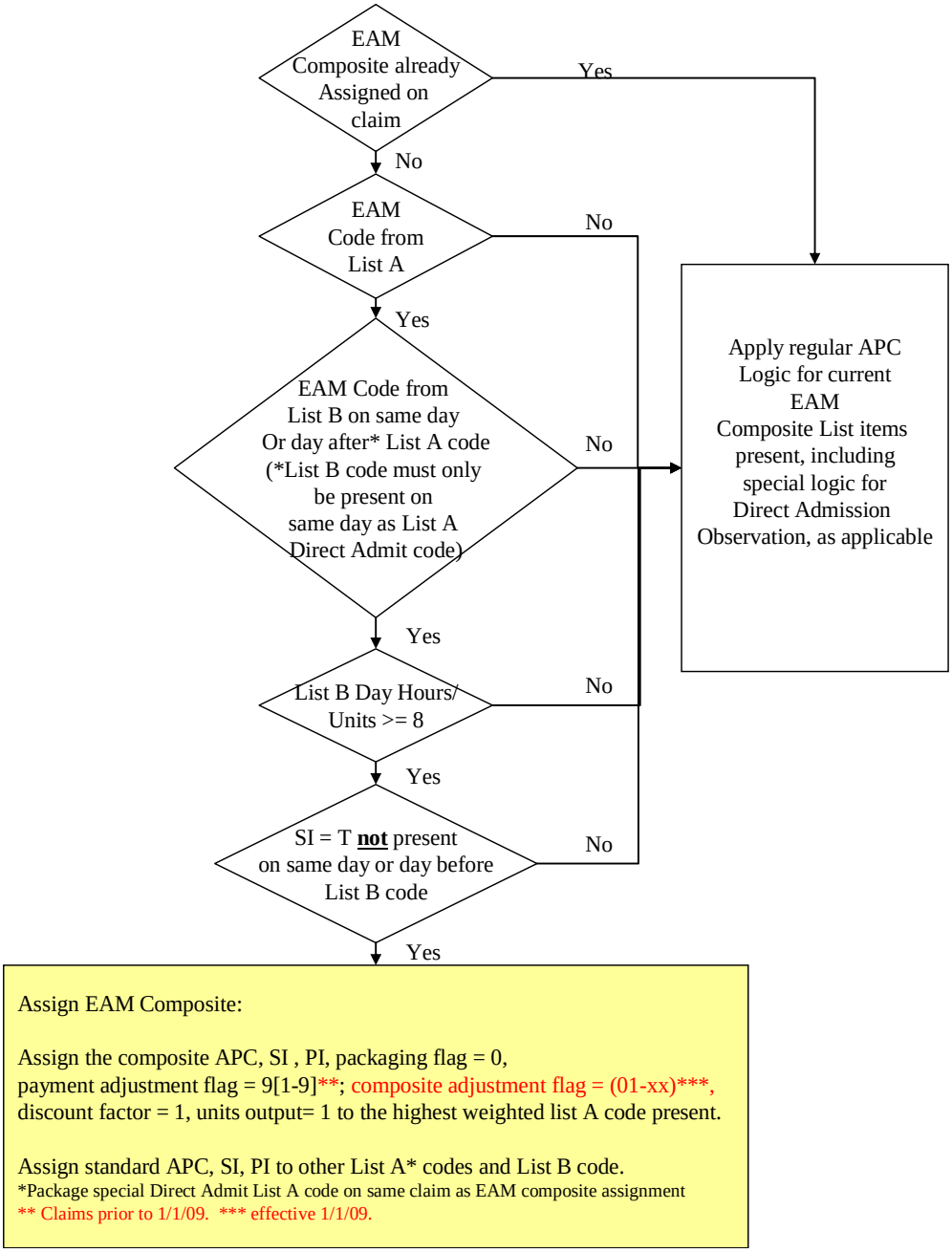


Appendix H-b
Direct Admission Logic



Appendix H-c
Extended Assessment & Management
Composite Criteria* [Effective v9.0]

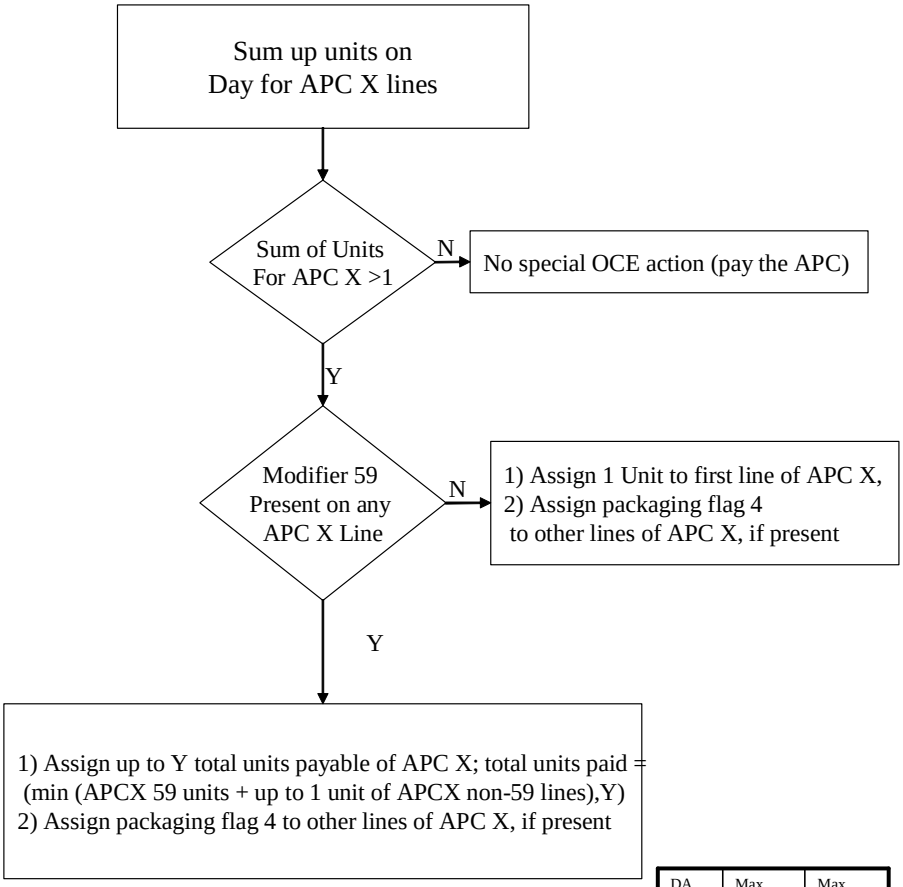
For each Extended Assessment and Management (EAM) Composite APC,
(Level II first, then Level I) do the following:



*See appendix K for general rules and code lists.

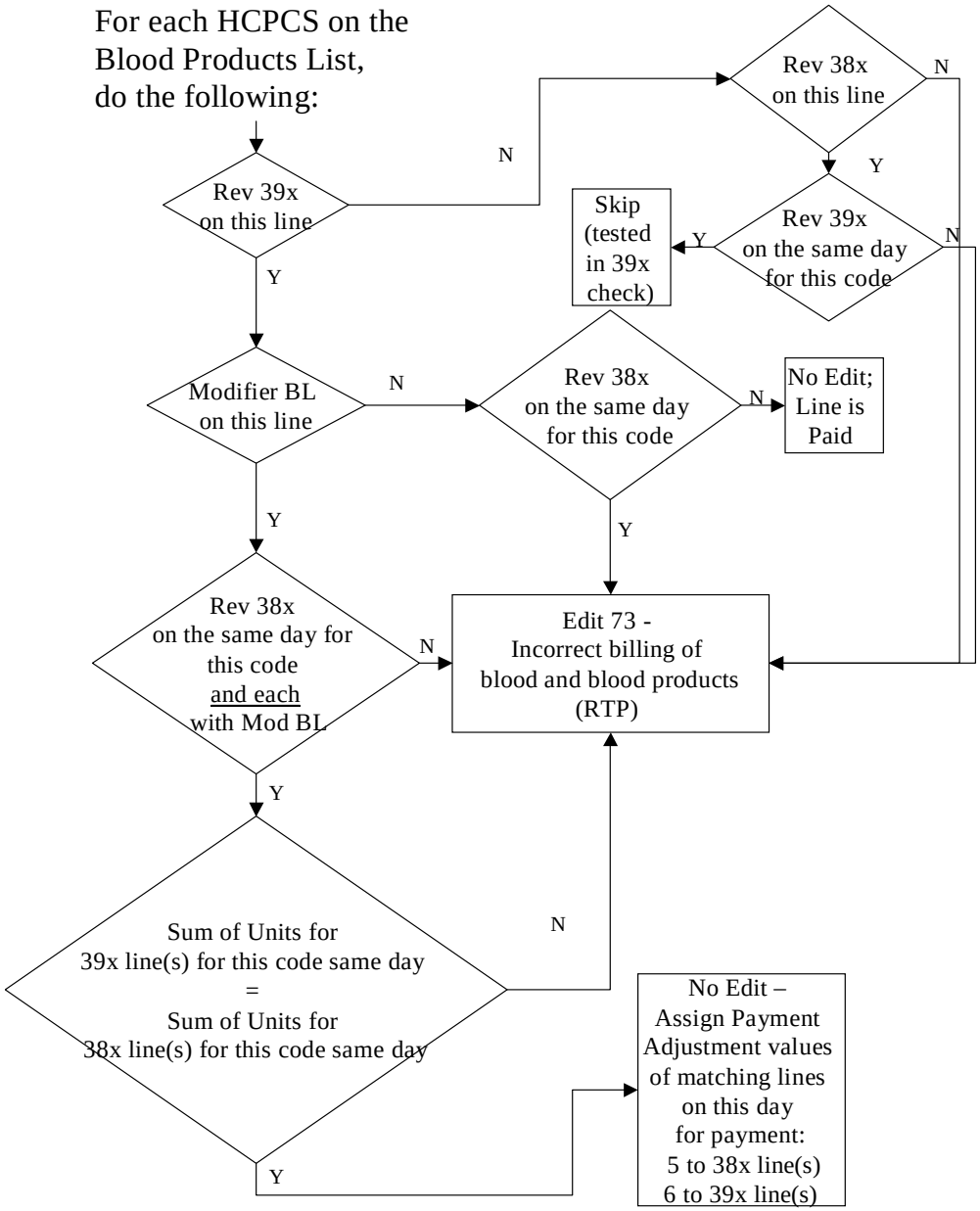
Appendix I [OPPS Only]
Drug Administration (v6.0 – v7.3 only)

For each APC X subjected to Y maximum allowed units
do the following (each day);



DA APC	Max APC units without modifier 59	Max APC units with modifier 59
116	1	2
117	1	2
120	1	4

Appendix J [OPPS Only]
Billing for blood/blood products



Note: If revenue code 381 is used with HCPCS other than packed red cells, or revenue code 382 with HCPCS other than whole blood, the claim will be returned to the provider (edit 79).

Appendix K
Composite APC Assignment Logic

LDR prostate brachytherapy and Electrophysiology/ablation composite APC assignment criteria:

a) 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

- 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 ~~payment~~ adjustment flag to the composite and all component codes present.

b) If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.

c) Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.

The component codes for the composite APC assignments are:

a) **LDR Prostate brachytherapy composite**

Prime/Group A code	Non-prime/Group B codes	Composite APC
55875	77778	8001

2. **Electrophysiology/ablation composite**

Prime/Group A codes	Non-prime/Group B codes	Composite APC
93619 93620	93650 93651 93652	8000

Appendix K (cont'd)

Composite APC Assignment Logic

Extended Assessment and Management Composite APC rules:

(See appendix H-c for flowchart):

a) If the criteria for the composite APC are met, the composite APC and its associated SI are assigned to the prime code (visit or critical care).

b) Only one extended assessment and management APC is assigned per claim.

c) If the criteria are met for a level I and a level II extended assessment and management APC, assignment of the level II composite takes precedence.

d) 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.

e) Visits not paid under an extended assessment and management composite are paid separately.

Exception: Code G0379 is always packaged if there is an extended assessment and management APC on the claim.

f) The SI for G0378 is always N.

g) Level I and II extended assessment and management composite APCs have SI = V if paid.

h) The logic for extended assessment and management is performed only for bill type 13x, with or without condition code 41.

i) Hours/units of service for observation (G0378) must be at least 8 or the composite APC is not assigned.

j) If a "T" procedure occurs on the day of or day before observation, the composite APC is not assigned.

k) Assign units of service = 1 to the line with the composite APC.

l) Assign the composite ~~payment~~ adjustment flag to the visit line with the composite APC and to the G0378.

m) If the composite APC assignment criteria are not met, apply regular APC logic for separately paid items, special logic for G0379 and the SI for G0378 = N.

Level II Extended Assessment and Management criteria:

a) If there is at least one of a specified list of critical care or emergency room visit codes on the day of or day before observation (G0378), assign the composite APC and related SI to the critical care or emergency visit code.

b) Additional emergency or critical care visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.

Prime/List A codes	Non-prime/List B code	Composite APC
99284, 99285, 99291, G0384	G0378	8003

Appendix K (cont'd)

Level I Extended Assessment and Management criteria:

a) If there is at least one of a specified list of prime 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 clinic visit or direct admission code.

b) Additional clinic visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.

c) Additional G0379, **on the same claim**, are assigned SI = N.

Prime /List A codes	Non-prime/List B code	Composite APC
99205, 99215, G0379	G0378	8002

Separate Direct Admit (G0379) Processing Logic

(See appendix H-b for flowchart):

a) Code G0378 must be present on the same day

b) No SI = T, E/M, or C/C visit on the same day

c) Code G0379 may be paid under the composite 8002, paid under APC 604, or packaged with SI = N.

Appendix K (cont'd)

Multiple Imaging Composite Assignment Rules & Criteria:

1. 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).
2. Within two of the imaging families, 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.
3. 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).
4. Multiple lines or multiple units of the same imaging procedure will count to assign the composite APC.
5. 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.
6. 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).

Family 1 – Ultrasound:

1. Ultrasound Composite (APC 8004)

76604	76776
76700	76831
76705	76856
76770	76857
76775	76870

Family 2 – CT/CTA with and without contrast*:

1. CT and CTA without Contrast Composite (APC 8005)

0067T	72128
70450	72131
70480	72192
70486	73200
70490	73700
71250	74150
72125	

2. CT and CTA with Contrast Composite (APC 8006)

70460	70496	72130	73206
70470	70498	72132	73701
70481	71260	72133	73702
70482	71270	72191	73706
70487	71275	72193	74160
70488	72126	72194	74170
70491	72127	73201	74175
70492	72129	73202	75635

Family 3 – MRI/MRA with and without contrast*:

1. MRI and MRA without Contrast Composite (APC 8007)

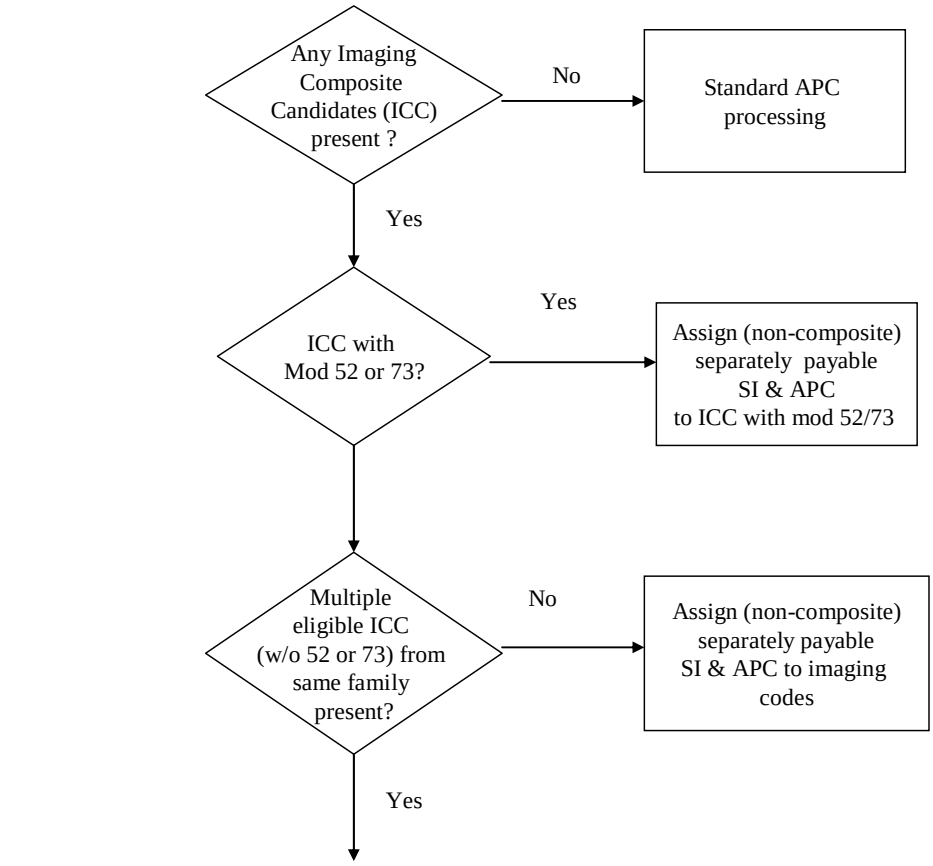
70336	72146	75557
70540	72148	75559
70544	72195	C8901
70547	73218	C8904
70551	73221	C8907
70554	73718	C8910
71550	73721	C8913
72141	74181	C8919

2. MRI and MRA with Contrast Composite (APC 8008)

70542	72147	73719	C8905
70543	72149	73720	C8906
70545	72156	73722	C8908
70546	72157	73723	C8909
70548	72158	74182	C8911
70549	72196	74183	C8912
70552	72197	75561	C8914
70553	73219	75563	C8918
71551	73220	C8900	C8920
71552	73222	C8902	
72142	73223	C8903	

*If a ‘without contrast’ procedure is performed on the same day as a ‘with contrast’ procedure from the same family, the ‘with contrast’ composite APC is assigned.

Appendix K-a
Multiple Imaging Composite Criteria
[Effective v10.0]



Assign Multiple Imaging Composite APC:
(see appendix K for the lists of eligible candidates for each imaging family/composite APC):

For the first code encountered in the composite family – assign the composite APC, SI , PI; packaging flag = 0, composite adjustment flag = (01- xx), discount factor = 1, units output= 1

For all other eligible codes from the same family present – change the SI from Q3 to N, assign packaging flag = 1, same composite adjustment flag.

Note: If there are a mix of eligible imaging candidates with & without contrast from the same imaging family, the 'with contrast' composite APC is assigned.

Appendix L
OCE overview

1. If claim from/through dates span more than one day, subdivide the line items on the claim into separate days based on the calendar day of the line item service date.

For claims with OPPS flag = "1":

2. Assign the default values to each line item in the APC/ASC return buffer.
   The default values for the APC return buffer for variables not transferred from input, or not pre-assigned, are as follows:

Payment APC/ASC	00000
HCPCS APC	00000
Status indicator	W
Payment indicator	3
Discounting formula number	1
Line item denial or rejection flag	0
Packaging flag	0
Payment adjustment flag	0
Payment method flag	Assigned in steps 8, 20 and 21
Composite adjustment flag	00

3. If no HCPCS code is on a line item and the revenue code is from one of four specific lists, then assign the following values to the line item in the APC return buffer.

	N-list	E-list	B-list	F-list
HCPCS APC	00000	00000	00000	00000
Payment APC:	00000	00000	00000	00000
Status Indicator:	N	E	B	F
Payment Indicator	9	3	3	4
Packaging flag:	1	0	0	0

If there is no HCPCS code on a line, and the revenue center is not on any of the specified lists, assign default values as follows:

HCPCS APC	00000
Payment APC:	00000
Status Indicator:	**Z**
Payment Indicator	3
Packaging flag:	0

If the HCPCS code is invalid, or the revenue code is invalid and the HCPCS is blank, assign default values as follows:

HCPCS APC	00000
Payment APC:	00000
Status Indicator:	**W**
Payment Indicator	3
Packaging flag:	0

4. If applicable based on Appendix F, assign HCPCS APC in the APC/ASC return buffer for each line item that contains an applicable HCPCS code.

Appendix L
OCE Overview (cont'd)

5. If procedure with status indicator “C” and modifier CA is present on a claim and patient status = 20, assign payment APC 375 to “C” procedure line and set the discounting factor to 1. Change SI to “N” and set the packaging flag to 1 for all other line items occurring on the same day as the line item with status indicator “C” and modifier CA. 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.

6. If edit 18 is present on a claim, generate edit 49 for all other line items occurring on the same day as the line item with edit 18, and set the line item denial or rejection flag to 1 for each of them. Go to step 19.

7. If all of the lines on the claim are incidental, and all of the line item action flags are zero, generate edit 27. Go to step 19.

8. If the line item action flag for a line item has a value of 2 or 3 then reset the values of the Payment APC and HCPCS APC to 00000, and set the payment method flag to 4. If the line item action flag for a line item has a value of 4, set the payment method flag to 0. Ignore line items with a line item action flag of 2, 3 or 4 in all subsequent steps.

9. Perform edits that are not based on the status indicator.

10. If bill type is 13x and condition code = 41, or type of bill = 76x, apply partial hospitalization logic from Appendix C. Go to step 11.

11. If bill type is 12x, 13x or 14x without condition code 41 apply mental health logic from Appendix C-b

12. Apply special packaging logic (T-packaged (SI = Q2) followed by STVX-packaged (SI = Q1)).

13. Apply general composite logic from appendix K (APC 8000, 8001).

14. Apply multiple imaging composite logic from appendix H-d & appendix K (APC 8004 - 8008).

15. If bill type is 13x, apply Extended Assessment and Management composite logic from appendix H-c and Direct Admission for Observation logic from Appendix H-b.

16. If code is on the “sometimes therapy” list, reassign the status indicator to A, APC 0 when there is a therapy revenue code or a therapy modifier on the line.

17. Perform all remaining edits that are driven by the status indicator

18. If the payment APC for a line item has not been assigned a value in step 9 thru 17, set payment APC in the APC return buffer for the line item equal to the HCPCS APC for the line item.

19. If edits 9, 13, 19, 20, 28, 39, 40, 45, 47, 49, 53, 64, 65, 67, 68, 69, 76, 83 are present in the edit return buffer for a line item, the line item denial or rejection flag for the line item is set to 1.

20. Compute the discounting formula number based on Appendix D for each line item that has a status indicator of "T", a modifier of 52, 73 or 50, or is a non-type "T" procedure with modifier 52 or 73.

    Note: If the SI or APC of a code is changed during claims processing, the newly assigned SI or APC is used in computing the discount formula. Line items that meet any of the following conditions are not included in the discounting logic.

    Line item action flag is 2, 3, or 4
    Line item rejection disposition or line item denial disposition in the APC/ASC return buffer is 1 and the line item action flag is not 1
    Packaging flag is not 0 or 3

21. If the packaging flag has not been assigned a value of 1 or 2 in previous steps and the status indicator is "N", then set the packaging flag for the line item to 1.

22. If the submitted charges for HCPCS surgical procedures (SI = T, or SI = S in code range 10000-69999) is less than $1.01 for any line with a packaging flag of 0, then reset the packaging flag for that line to 3 when there are other surgical procedures on the claim with charges greater than $1.00.

23. For all bill types where APCs are assigned, apply drug administration APC consolidation logic from appendix I. (v6.0 – v7.3 only)

24. Set the payment adjustment flag for a line item based on the criteria in Appendix G and Appendix J.

25. Set the payment method flag for a line item based on the criteria in Appendix E(a). If any payment method flag is set to a value that is greater than zero, reset the HCPCS and Payment APC values for that line to '00000'.

26. If the line item denial or rejection flag is 1 or 2 and the payment method flag has been set to 2 in the previous step, reset the payment method flag to 3.

For claims with OPPS flag = "2":

2. Set Non-OPPS bill type flag as applicable, based on the presence or absence of ASC procedures.

Appendix M

Summary of Modifications

The modifications of the OCE for the January 2009 release (V10.0) are summarized in the attached table.
Readers should also read through the specifications and note the highlighted sections, which also indicate change from the prior release of the software.

Some OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

	Mod. Type	Effective Date	Edit	
1.	Logic	1/1/09		Interface changes: a) Add new 2-byte field "Composite Adjustment Flag (CAF)" to the APC/ASC Return Buffer. - Assigned by the IOCE to identify individual composite APCs and their related components. - Two-byte, zero-filled, alpha-numeric characters - (Discontinue PAF 91-99, used for this purpose Jan1 – Dec 31. 2008). b) Expand the units field from 7 to 9 bytes for the input & output record (tables 2 & 7).
2.	Logic	1/1/09		Add new status indicators: R – Blood and blood products U – Brachytherapy sources Q1 – STVX-Packaged Codes Q2 – T-Packaged Codes Q3 – Codes that may be paid through a composite APC
3.	Logic	1/1/09	81	New edit 81 – Mental health service not payable outside the partial hospitalization program **(RTP)** Criteria: Mental health HCPCS codes that are not payable outside the partial hospital program submitted on TOB 12x, 13x or 14x without Condition Code 41 (list of codes).
4.	Logic	1/1/09	82	New edit 82 – Charge exceeds token charge ($1.01) (**RTP)**. Criteria: Apply to claims when code C9898 is billed with charges greater than $1.01
5.	Logic		83	New edit 83 – Service provided on or after effective date of NCD non-coverage (Line item denial)
6.	Logic	1/1/09		Implement new composite APC assignment logic for imaging procedures (appendix K)
7.	Logic	1/1/09	30, 32, 33, 34	Modify PHP logic (see appendix C-a) - Discontinue APC 33 - Implement two new PHP APCs (Level 1 = 3 qualifying services; level II = 4 or more services - Deny all PHP lines on any day with fewer than 3 qualifying services (edit 30) - Discontinue edits 32, 33 and 34
8.	Logic	1/1/09		Modify the logic to apply the modifier FB or FC reduction & the associated Payment adjustment flag to a procedure only if there is a device present on the claim that is on the matched list of qualifying full/partial credit reduction crosswalk for that procedure.
9.	Logic	1/1/09		Add code G0384 to the list of prime codes for composite APC 8003, Level II Extended Assessment and Management (appendix K).
10.	Logic	1/1/09	80	Update the list of codes approved for the partial hospitalization program
11.	Logic	1/1/09		Discontinue packaging flag value 2 (Packaged as part of PHP or Daily MH per diem); use new composite adjustment flag to identify PHP and Daily MH composite APCs (appendix C).
12.	Logic	1/1/09		Set the payment rate for the Daily Mental Health cap (APC 34) to equal the payment rate for the Level II PHP APC (APC 173).
13.	Logic	**10/1/07**		Add TOB 12x to the bypass for diagnosis edits (1-5) if claim From date is <10/1/xx and Through date is >= 10/1/xx (appendix F)
14	Logic	1/1/09	19, 20, 39, 40	Add modifier 27 to the list of 'CCI modifiers' used to overturn CCI edits when the modifier indicator on the code pair is "1".
15	Logic	1/1/09		Add code G0402 to the list of codes for PAF 4 – Deductible not applicable.
	Logic	**7/1/03**		Add code Q0091 to the list of codes for PAF 4 – Deductible not applicable.
16	Logic	1/1/09		Add Status Indicator 'U' (Brachytherapy sources) to the assignment criteria for PAF 2 (appendix G)
17	Logic	1/1/09		Add code 0183T to the 'Sometimes Therapy' logic (change SI to A if submitted with a therapy revenue code or therapy modifier).
18	Logic	1/1/09		SI assignment for APC 34 changed from 'P' to 'S' (appendix C-b)
19	Logic			Updated DMH list, added code G0177 (code has SI = N, will not contribute to MH cap but will be packaged into the MH composite (APC 34) if present).

1	Content			Make HCPCS/APC/SI changes as specified by CMS
2	Content		19, 20, 39, 40	Implement version **14.3** of the NCCI file, with no excluded code pairs.

				(Reinstate all Anesthesia, E&M and MH code pairs previously excluded from NCCI editing)
3	Content	**4/1/08**	67	Implement mid-Quarter FDA approval date of 6/24/08 for code 90696
4	Content	4/1/08	67	Implement mid-Quarter FDA approval date of 4/3/08 for code 90681
5	Content	9/29/08	83	Implement mid-Quarter non-coverage date for codes: 0062T, 0063T, 22526, 22527
6	Content	**1/1/03**	8	Remove code J1051 from the list of procedures for females only
7	Content	1/1/09	71, 77	Update procedure/device and device/procedure edit requirements
8	Content	1/1/09	78	Update radiolabeled products edit requirements
9	Content	1/1/09	22	Add new modifiers as follows: JC, JD, KE, RA, RB, RE
10	Content	1/1/09	22	Delete modifier RP – Replacement & repair (DMEPOS)
11				Update the IOCE Overview in appendix L to reflect necessary changes in processing order
12	Doc	1/1/09	9	Modify the description for edit 9 – Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion.
13	Doc	1/1/09	28	Modify the description for edit 28 – Code not recognized by Medicare for outpatient claims; alternate code for same service may be available.
14	Doc	1/1/09	50	Modify the description for edit 50 - Non-covered under any Medicare outpatient benefit, based on statutory exclusion.
15	Doc	1/1/09	78	Modify the description for edit 78 – Claim lacks required radiolabeled product
16	Doc	1/1/09		Modify the description for SI 'H' – Pass-through device categories, therapeutic radiopharmaceuticals
17	Doc	1/1/09		Modify the description for SI 'K' – Non pass-through drugs and biologicals
18	Data CD	1/1/09	8	Add column for identification of the sex to the HCPCS map file
19	User Manual	1/1/09		Change name of edit code list from "Required radiopharmaceuticals" to 'Required radiolabeled products'
20	User Manual	1/1/09		Change name of edit code lists for edits 9, 28 and 50 to reflect edit description changes
21	Doc			Create a 508 Compliant version of the document– for publication on CMS website

Appendix N

Code Lists Referenced in this Document

A. HCPCS Codes for Reporting Antigens, Vaccine Administration, Splints, and Casts

Category	Code
Antigens	95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, 95180, 95199
Vaccine Administration	90471, 90472, G0008, G0009
Splints	29105, 29125, 29126, 29130, 29131, 29505, 29515
Casts	29000, 29010, 29015, 29020, 29025, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29086, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29445, 29450, 29700, 29705, 29710, 29715, 29720, 29730, 29740, 29750, 29799

B. Partial Hospitalization Services

PHP List A	PHP List B
90818	90801
90819	90802
90821	90816
90822	90817
90826	90818
90827	90819
90828	90821
90829	90822
90845	90823
90846	90824
90847	90826
90865	90827
90880	90828
G0410	90829
G0411	90845
	90846
	90847
	90865
	90880
	96101
	96102
	96103
	96116
	96118
	96119
	96120
	G0129
	G0176
	G0177
	G0410
	G0411

Final

Summary of Data Changes

Integrated OCE v 10.0

Effective January 1, 2009

Table of Contents

DEFINITIONS

- A blank in a field indicates ‘no change’

- The “old” column describes the attribute prior to the change being made in the current update, which is indicated in the “new” column. If the effective date of the change is the same as the effective date of the new update, ‘old’ describes the attribute up to the last day of the previous quarter. If the effective date is retroactive, then ‘old’ describes the attribute for the same date in the previous release of the software.

- “Unassigned”, “Pre-defined” or “Placeholder” in APC or HCPCS descriptions indicates that the APC or HCPCS code is inactive. When the APC or HCPCS code is activated, it becomes valid for use in the OCE, and a new description appears in the “new description” column, with the appropriate effective date.

- Activation Date (ActivDate) indicates the mid-quarter date of FDA approval for a drug, or the mid-quarter date of a new or changed code resulting from a National Coverage Determination (NCD). The Activation Date is the date the code becomes valid for use in the OCE. If the Activation Date is blank, then the effective date takes precedence.

- Termination Date (TermDate) indicates the mid-quarter date when a code or change becomes inactive. A code is not valid for use in the OCE after its termination date.

- For codes with SI of “Q1, Q2, and Q3”, the APC assignment is the standard APC to which the code would be assigned if it is paid separately.

APC CHANGES

Added APCs

The following APC(s) were added to the IOCE, **effective 04-01-08**

APC	APCDesc	StatusIndicator
01219	Dtap-ipv vacc 4-6 yr im	K
01239	Rotavirus vacc 2 dose oral	K

The following APC(s) were added to the IOCE, **effective 01-01-09**

APC	APCDesc	StatusIndicator
00129	Level I Closed Treatment Fracture Finger/Toe/Trunk	T
00138	Level II Closed Treatment Fracture Finger/Toe/Trunk	T
00139	Level III Closed Treatment Fracture Finger/Toe/Trunk	T
00172	Level I Partial Hospitalization (3 services)	P
00173	Level II Partial Hospitalization (4 or more services)	P
00174	Level IV Laparoscopy	T
00626	Level 1 Type B Emergency Visits	V
00627	Level 2 Type B Emergency Visits	V
00628	Level 3 Type B Emergency Visits	V
00629	Level 4 Type B Emergency Visits	V
01186	Acetylcysteine injection	K
01189	Foscarnet sodium injection	K
01204	Cyclosporin parenteral	K
01206	Dimecaprol injection	K
01208	Factor VIII (porcine)	K
01209	Diethylstilbestrol injection	K
01211	Oxytetracycline injection	K
01212	Diphtheria antitoxin	K
01216	Lyme disease vaccine, im	K
01217	Penicillin g benzathine inj	K
01218	Trifluprom azine hcl inj	K
01220	Calcitonin salmon injection	K
01221	Dimethyl sulfoxide 50%	K
01222	Pentastarch 10% solution	K
01223	Pentobarbital sodium inj	K
01224	Sincalide injection	K
01225	Somatrem injection	K
01226	Inj streptokinase /250000 IU	K
01227	Urea injection	K
01228	Hyaluronidase recombinant	K
01230	Nabilone oral	K
01231	Plicamycin (mithramycin) inj	K
01232	Mitomycin 5 MG inj	K
01233	Mitomycin 20 MG inj	K
01234	Mitomycin 40 MG inj	K
01235	Valrubicin injection	K
01236	Levoleucovorin injection	K

APC	APCDesc	StatusIndicator
01237	Inj iron dextran	K
01238	Topotecan oral	K
01240	Apligraf skin sub	K
01241	Oasis wound matrix skin sub	K
01242	Oasis burn matrix skin sub	K
01243	Integra BMWD skin sub	K
01244	Integra DRT skin sub	K
01245	Dermagraft skin sub	K
01246	Graftjacket skin sub	K
01247	Integra matrix skin sub	K
01248	Primatrix skin sub	K
01249	Cymetra allograft	K
01250	Graftjacket express allograf	K
01251	Integra flowable wound matri	G
01252	Gammagraft skin sub	K
08004	Ultrasound Composite	S
08005	CT and CTA without Contrast Composite	S
08006	CT and CTA with Contrast Composite	S
08007	MRI and MRA without Contrast Composite	S
08008	MRI and MRA with Contrast Composite	S
09245	Injection, romiplostim	G
09246	Inj, gadoxetate disodium	G
09248	Inj, clevidipine butyrate	G

Deleted APCs

The following APC(s) were deleted from the IOCE, **effective 01-01-06**

APC	APCDesc
09144	Encephalitis vaccine, sc

The following APC(s) were deleted from the IOCE, **effective 01-01-09**

APC	APCDesc
00023	Exploration Penetrating Wound
00033	Partial Hospitalization
00043	Closed Treatment Fracture Finger/Toe/Trunk
00109	Removal/Repair of Implanted Devices
00125	Refilling of Infusion Pump
00212	Nervous System Injections
00236	Level II Posterior Segment Eye Procedures
00258	Tonsil and Adenoid Procedures
00335	Magnetic Resonance Imaging, Miscellaneous
00430	Drug Preadministration-Related Services
00441	Level VI Drug Administration
00625	Level IV Vascular Access Procedures
00663	Level I Electronic Analysis of Devices
00748	Bleomycin sulfate injection
00767	Enfuvirtide injection
00805	Mecasermin injection

APC	APCDesc
00806	Hyaluronidase recombinant
00808	Nabilone oral
00811	Carboplatin injection
00862	Mitomycin 5 MG inj
00880	Pentastarch 10% solution
00882	Melphalan oral
00911	Inj streptokinase /250000 IU
00912	Interferon alfacon-1
00930	Antithrombin iii injection
00941	Mitomycin 20 MG inj
00942	Mitomycin 40 MG inj
00998	Inj biperiden lactate/5 mg
01032	Aud osseo dev, int/ext comp
01041	Plicamycin (mithramycin) inj
01140	Integra matrix tissue
01141	Primatrix tissue
01165	Aripiprazole injection
01169	Neurawrap nerve protector,cm
01215	Inj iron dextran
01606	Injection anistreplase 30 u
01629	Nonmetabolic act d/e tissue
01632	Metabolic active D/E tissue
01821	Interspinous implant
02940	Somatrem injection
07028	Fosphenytoin
09051	Urea injection
09054	Metabolically active tissue
09141	Measles-rubella vaccine, sc
09156	Nonmetabolic active tissue
09167	Valrubicin, 200 mg
09222	Injectable human tissue
09350	Neuragen nerve guide, per cm
09351	Tissuemend tissue
09357	Flowable Wound Matrix, 1 cc

APC Description Changes

The following APC(s) had description changes, **effective 01-01-09**

APC	Old Description	New Description
00002	Level I Fine Needle Biopsy/Aspiration	Fine Needle Biopsy/Aspiration
00035	Arterial/Venous Puncture	Vascular Puncture and Minor Diagnostic Procedures
00040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	Percutaneous Implantation of Neurostimulator Electrodes
00048	Level I Arthroplasty with Prosthesis	Level I Arthroplasty or Implantation with Prosthesis
00061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr
00121	Level I Tube changes and Repositioning	Level I Tube or Catheter Changes or Repositioning
00209	Level II Extended EEG and Sleep Studies	Level II Extended EEG, Sleep, and Cardiovascular

APC	Old Description	New Description
		Studies
00213	Level I Extended EEG and Sleep Studies	Level I Extended EEG, Sleep, and Cardiovascular Studies
00237	Level III Posterior Segment Eye Procedures	Level II Posterior Segment Eye Procedures
00250	Nasal Cauterization/Packing	Level I ENT Procedures
00251	Level I ENT Procedures	Level II ENT Procedures
00252	Level II ENT Procedures	Level III ENT Procedures
00253	Level III ENT Procedures	Level IV ENT Procedures
00254	Level IV ENT Procedures	Level V ENT Procedures
00256	Level V ENT Procedures	Level VI ENT Procedures
00259	Level VI ENT Procedures	Level VII ENT Procedures
00337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast f
00425	Level II Arthroplasty with Prosthesis	Level II Arthroplasty or Implantation with Prosthesis
00427	Level II Tube Changes and Repositioning	Level II Tube or Catheter Changes or Repositioning
00609	Level 1 Emergency Visits	Level 1 Type A Emergency Visits
00613	Level 2 Emergency Visits	Level 2 Type A Emergency Visits
00614	Level 3 Emergency Visits	Level 3 Type A Emergency Visits
00615	Level 4 Emergency Visits	Level 4 Type A Emergency Visits
00672	Level IV Posterior Segment Eye Procedures	Level III Posterior Segment Eye Procedures
00689	Electronic Analysis of Cardioverter-defibrillators	Level II Electronic Analysis of Devices
00690	Electronic Analysis of Pacemakers and other Cardiac Devices	Level I Electronic Analysis of Devices
00691	Level III Electronic Analysis of Devices	Level IV Electronic Analysis of Devices
00692	Level II Electronic Analysis of Devices	Level III Electronic Analysis of Devices
00752	Dactinomycin actinomycin d	Dactinomycin injection
00760	Anadulafungin injection	Anidulafungin injection
00764	Granisetron HCl injection	Granisetron hcl injection
00765	Granisetron HCl 1 mg oral	Granisetron hcl 1 mg oral
00769	Ondansetron HCl 8mg oral	Ondansetron hcl 8 mg oral
00807	Aldesleukin/single use vial	Aldesleukin injection
00812	Carmus bischl nitro inj	Carmustine injection
00820	Daunorubicin	Daunorubicin injection
00821	Daunorubicin citrate liposom	Daunorubicin citrate inj
00823	Docetaxel	Docetaxel injection
00828	Gemcitabine HCl	Gemcitabine hcl injection
00843	Pegaspargase/singl dose vial	Pegaspargase injection
00849	Rituximab cancer treatment	Rituximab injection
00852	Topotecan	Topotecan injection
00855	Vinorelbine tartrate	Vinorelbine tartrate inj
00856	Porfimer sodium	Porfimer sodium injection
00946	HepaGam B IM injection	Hepagam b im injection
01084	Denileukin diftitox	Denileukin diftitox inj
01138	Hepagam B intravenous, inj	Hepagam b intravenous, inj
01139	Protein C concentrate	Protein c concentrate
01166	Cytarabine liposome	Cytarabine liposome inj
01213	VWF complex, not Humate-P	Antihemophilic viii/vwf comp
01214	Inj IVIG Privigen 500 mg	Inj IVIG privigen 500 mg
01613	Trastuzumab	Trastuzumab injection
09004	Gemtuzumab ozogamicin	Gemtuzumab ozogamicin inj

APC	Old Description	New Description
09012	Arsenic trioxide	Arsenic trioxide injection
09210	Palonosetron HCl	Palonosetron hcl
09243	Injection, bendamustine hcl	Bendamustine injection
09244	Injection, regadenoson	Regadenoson injection
09356	TenoGlide Tendon Prot, cm2	TenoGlide tendon prot, cm2

APC Status Indicator Changes

The following APC(s) had Status Indicator changes, **effective 01-01-09**

APC	Old SI	New SI
00034	P	S
00035	T	X
00760	G	K
00949	K	R
00950	K	R
00952	K	R
00954	K	R
00955	K	R
00956	K	R
00957	K	R
00958	K	R
00959	K	R
00960	K	R
00966	K	R
00967	K	R
00968	K	R
00969	K	R
01009	K	R
01010	K	R
01011	K	R
01013	K	R
01016	K	R
01017	K	R
01018	K	R
01019	K	R
01020	K	R
01021	K	R
01022	K	R
01214	K	G
01716	H	U
01717	H	U
01719	H	U
02616	H	U
02632	H	U
02634	H	U
02635	H	U
02636	H	U
02638	H	U
02639	H	U

APC	Old SI	New SI
02640	H	U
02641	H	U
02642	H	U
02643	H	U
02698	H	U
02699	H	U
09126	G	K
09227	G	K
09228	G	K
09229	G	K
09230	G	K
09231	G	K
09232	G	K
09233	G	K
09235	G	K
09244	K	G
09500	K	R
09501	K	R
09502	K	R
09503	K	R
09504	K	R
09505	K	R
09506	K	R
09507	K	R
09508	K	R

HCPCS/CPT PROCEDURE CODE CHANGES

Added HCPCS/CPT Procedure Codes

The following new HCPCS/CPT code(s) were added to the IOCE, **effective 01-01-09**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
00211	Anesth, cran surg, hemotoma	C	00000			
0054T	Bone surgery using computer	N	00000			
0055T	Bone surgery using computer	N	00000			
00567	Anesth, cabg w/pump	C	00000			
0193T	Rf bladder neck microremodel	T	00165			
0194T	Procalcitonin (pct)	A	00000			
0195T	Arthrod presac interbody	C	00000			
0196T	Arthrod presac interbody eac	C	00000			
0197T	Intrafraction track motion	N	00000			
0198T	Ocular blood flow measure	S	00230			
0528F	Rcmnd flw-up 10 yrs docd	E	00000	28		
0529F	Intrvl 3+yrs pts clnscp docd	E	00000	28		
0535F	Dyspnea mngmnt plan docd	E	00000	28		
0540F	Gluco mngmnt plan docd	E	00000	28		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
0575F	HIV rna plan care docd	M	00000	72		
1150F	Doc pt rsk death w/in 1yr	E	00000	28		
1151F	Doc no pt rsk death w/in 1yr	E	00000	28		
1152F	Doc advncd dis comfort 1st	E	00000	28		
1153F	Doc advncd dis cmfrt not 1st	E	00000	28		
1157F	Advnc care plan in rcrd	E	00000	28		
1158F	Advnc care plan tlk docd	M	00000	72		
1159F	Med list docd in rcrd	E	00000	28		
1160F	Rvw meds by rx/dr in rcrd	E	00000	28		
1170F	Fxnl status assessed	E	00000	28		
1180F	Thromboemb risk assessed	E	00000	28		
1220F	Pt screened for depression	M	00000	72		
2050F	Wound char size etc docd	E	00000	28		
20696	Comp multiplane ext fixation	T	00050			
20697	Comp ext fixate strut change	T	00139			
22856	Cerv artific diskectomy	C	00000			
22861	Revise cerv artific disc	C	00000			
22864	Remove cerv artif disc	C	00000			
27027	Buttock fasciotomy	T	00049			
27057	Buttock fasciotomy w/dbrdmt	T	00049			
3016F	Pt scrnd unhlthy OH use	E	00000	28		
3018F	Pre-prxd rsk et al docd	E	00000	28		
3250F	Nonprim loc anat bx site tum	M	00000	72		
3321F	AJCC cncr 0/IA melan docd	E	00000	28		
3322F	Melan >AJCC stage 0 or IA	E	00000	28		
3370F	AJCC brst cncr stage 0 docd	M	00000	72		
3372F	AJCC brst cncr stage 1 +docd	M	00000	72		
3374F	AJCC brst cncr stage 1 +docd	M	00000	72		
3376F	AJCC brstcncr stage 2 docd	M	00000	72		
3378F	AJCC brstcncr stage 3 docd	M	00000	72		
3380F	AJCC brstcncr stage 4 docd	M	00000	72		
3382F	AJCC cln cncr stage 0 docd	M	00000	72		
3384F	AJCC cln cncr stage 1 docd	M	00000	72		
3386F	AJCC cln cncr stage 2 docd	M	00000	72		
3388F	AJCC cln cncr stage 3 docd	M	00000	72		
3390F	AJCC cln cncr stage 4 docd	M	00000	72		
3450F	Dyspnea scrnd, no-mild dysp	E	00000	28		
3451F	Dyspnea scrnd mod-high dysp	E	00000	28		
3452F	Dyspnea not screened	E	00000	28		
3455F	TB scrng done-interpd 6mon	E	00000	28		
3470F	RA disease activity, low	E	00000	28		
3471F	RA disease activity, mod	E	00000	28		
3472F	RA disease activity, high	E	00000	28		
3475F	Disease progn RA poor docd	E	00000	28		
3476F	Disease progn RA good docd	E	00000	28		
3490F	History - AIDS-defining cond	M	00000	72		
3491F	HIV unsure baby of HIV+moms	E	00000	28		
3492F	History CD4+cell count <350	M	00000	72		
3493F	No hist CD4+cell cnt <350	M	00000	72		
3494F	CD4+cell count <200cells/mm3	M	00000	72		
3495F	CD4+cell cnt 200-499 cells	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
3496F	CD4+ cell count >=500 cells	M	00000	72		
3497F	CD4+ cell percentage <15%	E	00000	28		
3498F	CD4+ cell percentage >=15%	E	00000	28		
3500F	CD4 +cell cnt/% docd as done	M	00000	72		
3502F	HIV rna vrl ld <lmts quantif	M	00000	72		
3503F	HIV rna vrl ldnot<lmts quntf	M	00000	72		
3510F	Doc tb scrng-rslts interpd	E	00000	28		
3511F	Chlmyd/gonrh tsts docd done	E	00000	28		
3512F	Syph scrng docd as done	E	00000	28		
3513F	Hep B scrng docd as done	E	00000	28		
3514F	Hep C scrng docd as done	E	00000	28		
3515F	Pt has docd immun to hep C	E	00000	28		
3550F	Low rsk thromboembolism	E	00000	28		
3551F	Intrmed rsk thromboembolism	E	00000	28		
3552F	Hgh risk for thromboembolism	E	00000	28		
35535	Artery bypass graft	C	00000			
3555F	Pt inr measurement performed	E	00000	28		
35570	Artery bypass graft	C	00000			
35632	Artery bypass graft	C	00000			
35633	Artery bypass graft	C	00000			
35634	Artery bypass graft	C	00000			
3570F	Rprt bone scint x-refw/x-ray	E	00000	28		
3572F	Pt consid poss risk fx	E	00000	28		
3573F	Pt not consid poss risk fx	E	00000	28		
4148F	Hep A vac injxn admin/recvd	E	00000	28		
4149F	Hep B vac injxn admin/recvd	E	00000	28		
41512	Tongue suspension	T	00252			
41530	Tongue base vol reduction	T	00253			
4192F	Pt not rcvng glucoco thxpy	E	00000	28		
4193F	Pt rcvng<10mg daily predniso	E	00000	28		
4194F	Pt rcvng>10mg daily predniso	E	00000	28		
4195F	Pt rcvng anti-rheum thxpy RA	E	00000	28		
4196F	Ptnot rcvng anti-rhm thxpyRA	E	00000	28		
4260F	Wound srfc culturetech used	E	00000	28		
4261F	Tech other than surfc cultr	E	00000	28		
4265F	Wet-dry dressings Rx-recmd	E	00000	28		
4266F	No wet-dry drssings Rx-recmd	E	00000	28		
4267F	Comprssion thxpy prescribed	E	00000	28		
4268F	Pt ed re comp thxpy rcvd	E	00000	28		
4269F	Appropos mthd offloading Rxd	E	00000	28		
4270F	Pt rcvng anti r-viral thxpy	M	00000	72		
4271F	Pt rcvng anti r-viral thxpy	M	00000	72		
4274F	Flu immuno admin'd rcvd	M	00000	72		
4275F	Hep B vac inj admin/rcvd	E	00000	28		
4276F	Potent antivir thxpy Rxd	M	00000	72		
4279F	PCP prophylaxis Rxd	M	00000	72		
4280F	PCP prophylax Rxd 3mon low %	M	00000	72		
4290F	Pt scrned for inj drug use	E	00000	28		
4293F	Pt scrnd - hgh-rsk sex behav	E	00000	28		
4300F	Pt rcvng warf thxpy	E	00000	28		
4301F	Pt not rcvng warf thxpy	E	00000	28		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
4305F	Pt ed re ft care inspct rcvd	E	00000	28		
4306F	Pt tlk psych & Rx opd addic	E	00000	28		
4320F	Pt talk psychsoc+rx oh dpnd	E	00000	28		
43273	Endoscopic pancreatoscopy	T	00151			
43279	Lap myotomy, heller	C	00000			
46930	Destroy internal hemorrhoids	T	00148			
49652	Lap vent/abd hernia repair	T	00130			
49653	Lap vent/abd hern proc comp	T	00130			
49654	Lap inc hernia repair	T	00130			
49655	Lap inc hern repair comp	T	00130			
49656	Lap inc hernia repair recur	T	00130			
49657	Lap inc hern recur comp	T	00130			
5100F	Rsk fx ref w/n 24 hrs x-ray	E	00000	28		
55706	Prostate saturation sampling	T	00184			
61796	Srs, cranial lesion simple	B	00000	62		
61797	Srs, cran les simple, addl	B	00000	62		
61798	Srs, cranial lesion complex	B	00000	62		
61799	Srs, cran les complex, addl	B	00000	62		
61800	Apply srs headframe add-on	B	00000	62		
62267	Interdiscal perq aspir, dx	T	00004			
63620	Srs, spinal lesion	B	00000	62		
63621	Srs, spinal lesion, addl	B	00000	62		
64455	N block inj, plantar digit	T	00204			
64632	N block inj, common digit	T	00204			
65756	Corneal trnspl, endothelial	T	00244			
65757	Prep corneal endo allograft	N	00000			
77785	Hdr brachytx, 1 channel	S	00313			
77786	Hdr brachytx, 2-12 channel	S	00313			
77787	Hdr brachytx over 12 chan	S	00313			
78808	Iv inj ra drug dx study	Q1	00392			
83876	Assay, myeloperoxidase	A	00000			
83951	Oncoprotein, dcp	A	00000			
85397	Clotting funct activity	A	00000			
87905	Sialidase enzyme assay	A	00000			
88720	Bilirubin total transcut	A	00000			
88740	Transcutaneous carboxyhb	A	00000			
88741	Transcutaneous methb	A	00000			
90951	Esrd serv, 4 visits p mo, <2	M	00000	72		
90952	Esrd serv, 2-3 vsts p mo, <2	M	00000	72		
90953	Esrd serv, 1 visit p mo, <2	M	00000	72		
90954	Esrd serv, 4 vsts p mo, 2-11	M	00000	72		
90955	Esrd srv 2-3 vsts p mo, 2-11	M	00000	72		
90956	Esrd srv, 1 visit p mo, 2-11	M	00000	72		
90957	Esrd srv, 4 vsts p mo, 12-19	M	00000	72		
90958	Esrd srv 2-3 vsts p mo 12-19	M	00000	72		
90959	Esrd serv, 1 vst p mo, 12-19	M	00000	72		
90960	Esrd srv, 4 visits p mo, 20+	M	00000	72		
90961	Esrd srv, 2-3 vsts p mo, 20+	M	00000	72		
90962	Esrd serv, 1 visit p mo, 20+	M	00000	72		
90963	Esrd home pt, serv p mo, <2	M	00000	72		
90964	Esrd home pt serv p mo, 2-11	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
90965	Esrd home pt serv p mo 12-19	M	00000	72		
90966	Esrd home pt, serv p mo, 20+	M	00000	72		
90967	Esrd home pt serv p day, <2	M	00000	72		
90968	Esrd home pt srv p day, 2-11	M	00000	72		
90969	Esrd home pt srv p day 12-19	M	00000	72		
90970	Esrd home pt serv p day, 20+	M	00000	72		
93228	Remote 30 day ecg rev/report	M	00000	72		
93229	Remote 30 day ecg tech supp	S	00209			
93279	Pm device progr eval, sngl	S	00690			
93280	Pm device progr eval, dual	S	00690			
93281	Pm device progr eval, multi	S	00690			
93282	Icd device prog eval, 1 sngl	S	00689			
93283	Icd device progr eval, dual	S	00689			
93284	Icd device progr eval, mult	S	00689			
93285	Ilr device eval progr	S	00690			
93286	Pre-op pm device eval	N	00000			
93287	Pre-op icd device eval	N	00000			
93288	Pm device eval in person	S	00690			
93289	Icd device interrogate	S	00689			
93290	Icm device eval	S	00690			
93291	Ilr device interrogate	S	00690			
93292	Wcd device interrogate	S	00689			
93293	Pm phone r-strip device eval	S	00689			
93294	Pm device interrogate remote	M	00000	72		
93295	Icd device interrogat remote	M	00000	72		
93296	Pm/icd remote tech serv	S	00689			
93297	Icm device interrogat remote	M	00000	72		
93298	Ilr device interrogat remote	M	00000	72		
93299	Icm/ilr remote tech serv	S	00209			
93306	Tte w/doppler, complete	S	00269			
93351	Stress tte complete	S	00269			
93352	Admin ecg contrast agent	M	00000	72		
95803	Actigraphy testing	S	00218			
95992	Canalith repositioning proc	A	00000			
96360	Hydration iv infusion, init	S	00438			
96361	Hydrate iv infusion, add-on	S	00436			
96365	Ther/proph/diag iv inf, init	S	00439			
96366	Ther/proph/diag iv inf addon	S	00436			
96367	Tx/proph/dg addl seq iv inf	S	00437			
96368	Ther/diag concurrent inf	N	00000			
96369	Sc ther infusion, up to 1 hr	S	00438			
96370	Sc ther infusion, addl hr	S	00437			
96371	Sc ther infusion, reset pump	S	00436			
96372	Ther/proph/diag inj, sc/im	S	00436			
96373	Ther/proph/diag inj, ia	S	00437			
96374	Ther/proph/diag inj, iv push	S	00437			
96375	Tx/pro/dx inj new drug addon	S	00437			
96376	Tx/pro/dx inj new drug adon	N	00000			
96379	Ther/prop/diag inj/inf proc	S	00436			
99460	Init nb em per day, hosp	V	00605			
99461	Init nb em per day, non-fac	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
99462	Sbsq nb em per day, hosp	C	00000			
99463	Same day nb discharge	V	00605			
99464	Attendance at delivery	N	00000			
99465	Nb resuscitation	S	00094			
99466	Ped crit care transport	N	00000			
99467	Ped crit care transport addl	N	00000			
99468	Neonate crit care, initial	C	00000			
99469	Neonate crit care, subsq	C	00000			
99471	Ped critical care, initial	C	00000			
99472	Ped critical care, subsq	C	00000			
99475	Ped crit care age 2-5, init	C	00000			
99476	Ped crit care age 2-5, subsq	C	00000			
99478	Ic, lbw inf < 1500 gm subsq	C	00000			
99479	Ic lbw inf 1500-2500 g subsq	C	00000			
99480	Ic inf pbw 2501-5000 g subsq	C	00000			
A6545	Grad comp non-elastic BK	A	00000			
A9284	Non-electronic spirometer	N	00000			
A9580	Sodium fluoride F-18	N	00000			
C8929	TTE w or wo fol wcon,Doppler	S	00128	55		
C8930	TTE w or w/o contr, cont ECG	S	00128	55		
C9245	Injection, romiplostim	G	09245	55		
C9246	Inj, gadoxetate disodium	G	09246	55		
C9247	Inj, iobenguane, I-123, dx	N	00000	55		
C9248	Inj, clevidipine butyrate	G	09248	55		
C9899	Inpt implant pros dev,no cov	A	00000	55		
D0417	Collect & prep saliva sample	E	00000	28		
D0418	Analysis of saliva sample	E	00000	28		
D3222	Part pulp for apexogenesis	E	00000	50		
D5991	Topical medicament carrier	E	00000	50		
E0487	Electronic spirometer	N	00000			
E0656	Segmental pneumatic trunk	Y	00000	61		
E0657	Segmental pneumatic chest	Y	00000	61		
E0770	Functional electric stim NOS	Y	00000	61		
E1354	Wheeled cart, port cyl/conc	Y	00000	61		
E1356	Batt pack/cart, port conc	Y	00000	61		
E1357	Battery charger, port conc	Y	00000	61		
E1358	DC power adapter, port conc	Y	00000	61		
E2230	Manual standing system	E	00000	28		
E2231	Solid seat support base	Y	00000	61		
E2295	Ped dynamic seating frame	Y	00000	61		
G0402	Initial preventive exam	V	00605			
G0403	EKG for initial prevent exam	M	00000	72		
G0404	EKG tracing for initial prev	S	00099			
G0405	EKG interpret & report preve	B	00000	62		
G0406	Telhealth inpt consult 15min	M	00000	72		
G0407	Telheath inpt consult 25min	M	00000	72		
G0408	Telhealth inpt consult 35min	M	00000	72		
G0409	CORF related serv 15 mins ea	M	00000	72		
G0410	Grp psych partial hosp 45-50	P	00000			
G0411	Inter active grp psych parti	P	00000			
G0412	Open tx iliac spine uni/bil	C	00000			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
G0413	Pelvic ring fracture uni/bil	T	00050			
G0414	Pelvic ring fx treat int fix	C	00000			
G0415	Open tx post pelvic fxcture	C	00000			
G0416	Sat biopsy prostate 1-20 spc	S	01505			
G0417	Sat biopsy prostate 21-40	S	01507			
G0418	Sat biopsy prostate 41-60	S	01511			
G0419	Sat biopsy prostate: >60	S	01513			
G8489	CAD measures grp	M	00000	72		
G8490	RA measures grp	M	00000	72		
G8491	HIV/AIDS measures grp	M	00000	72		
G8492	Prev Care measures grp	M	00000	72		
G8493	Back pain measures grp	M	00000	72		
G8494	DM meas qual act perform	M	00000	72		
G8495	CKD meas qual act perform	M	00000	72		
G8496	PC meas qual act perform	M	00000	72		
G8497	CABG meas qual act perform	M	00000	72		
G8498	CAD meas qual act perform	M	00000	72		
G8499	RA meas qual act perform	M	00000	72		
G8500	HIV meas qual act perform	M	00000	72		
G8501	Perio meas qual act perform	M	00000	72		
G8502	BP meas qual act perform	M	00000	72		
G8503	Doc proph antibx w/in 1 hr	M	00000	72		
G8504	Doc ord pro antbx w/in 1 hr	M	00000	72		
G8505	No doc proph antibx w/in 1hr	M	00000	72		
G8506	Pt rec ACE/ARB	M	00000	72		
G8507	Pt inelig pt verif meds	M	00000	72		
G8508	Pt inelig; pain asses no f/u	M	00000	72		
G8509	Pain assess no f/u pln doc	M	00000	72		
G8510	Pt inelig neg scrn depres	M	00000	72		
G8511	Clin depres scrn no f/u doc	M	00000	72		
G8512	Pain sev quant present	M	00000	72		
G8513	ABI meas & doc	M	00000	72		
G8514	PT inelig; ABI measure	M	00000	72		
G8515	No ABI measurement	M	00000	72		
G8516	Scrn fal rsk >2 fal or w/inj	M	00000	72		
G8517	Scrn fall rsk; <2 falls	M	00000	72		
G8518	Clin stg b/f lun/eso ca surg	M	00000	72		
G8519	Pt in; clin ca stg b/f surg	M	00000	72		
G8520	Clin stg b/f surg not doc	M	00000	72		
G8521	Antplt recd 48 hrs & disch	M	00000	72		
G8522	Pt inelig; antiplt therapy	M	00000	72		
G8523	Antplt not recd reas no spec	M	00000	72		
G8524	Patch closure conv CEA	M	00000	72		
G8525	No patch closure CEA	M	00000	72		
G8526	No patch closure conv CEA	M	00000	72		
G8527	Doc ord antimic prophy	M	00000	72		
G8528	Pt inelig; proph antibiot	M	00000	72		
G8529	No doc ord antimic prophy	M	00000	72		
G8530	Auto AV fistula recd	M	00000	72		
G8531	Pt inelig; auto AV fistula	M	00000	72		
G8532	No auto AV fistula; no reas	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
G8533	Partic in clin data base reg	M	00000	72		
G8534	Doc elder mal scrn f/u plan	M	00000	72		
G8535	Pt inelig no eld mal scrn	M	00000	72		
G8536	No doc elder mal scrn	M	00000	72		
G8537	Pt inelig eldmal scrn no f/u	M	00000	72		
G8538	Eld mal scrn no f/u pln	M	00000	72		
G8539	Cur funct assess & care pln	M	00000	72		
G8540	Pt inelig funct assess	M	00000	72		
G8541	No doc cur funct assess	M	00000	72		
G8542	Pt inelig func asses no pln	M	00000	72		
G8543	Cur funct asses; no care pln	M	00000	72		
G8544	CABG measures grp	M	00000	72		
J0641	Levoleucovorin injection	K	01236			
J1267	Doripenem injection	G	09241			
J1453	Fosaprepitant injection	G	09242			
J1459	Inj IVIG privigen 500 mg	G	01214			
J1750	Inj iron dextran	K	01237			
J1930	Lanreotide injection	K	09237			
J1953	Levetiracetam injection	G	09238			
J2785	Regadenoson injection	G	09244			
J3101	Tenecteplase injection	K	09002			
J3300	Triamcinolone A inj PRS-free	N	00000			
J7186	Antihemophilic viii/vwf comp	K	01213			
J7606	Formoterol fumarate, inh	M	00000	72		
J8705	Topotecan oral	K	01238			
J9033	Bendamustine injection	G	09243			
J9207	Ixabepilone injection	G	09240			
J9330	Temsirolimus injection	G	01168			
L0113	Cranial cervical torticollis	A	00000			
L6711	Ped term dev, hook, vol open	A	00000			
L6712	Ped term dev, hook, vol clos	A	00000			
L6713	Ped term dev, hand, vol open	A	00000			
L6714	Ped term dev, hand, vol clos	A	00000			
L6721	Hook/hand, hvy dty, vol open	A	00000			
L6722	Hook/hand, hvy dty, vol clos	A	00000			
L8604	Dextranomer/hyaluronic acid	N	00000			
Q4100	Skin substitute, NOS	N	00000			
Q4101	Apligraf skin sub	K	01240			
Q4102	Oasis wound matrix skin sub	K	01241			
Q4103	Oasis burn matrix skin sub	K	01242			
Q4104	Integra BMWD skin sub	K	01243			
Q4105	Integra DRT skin sub	K	01244			
Q4106	Dermagraft skin sub	K	01245			
Q4107	Graftjacket skin sub	K	01246			
Q4108	Integra matrix skin sub	K	01247			
Q4109	Tissuemend skin sub	N	00000			
Q4110	Primatrix skin sub	K	01248			
Q4111	Gammagraft skin sub	K	01252			
Q4112	Cymetra allograft	K	01249			
Q4113	Graftjacket express allograf	K	01250			
Q4114	Integra flowable wound matri	G	01251			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
S3711	Circulating tumor cell test	E	00000	28		
S9433	Medical food oral 100% nutr	E	00000	28		

Deleted HCPCS/CPT Procedure Codes

The following HCPCS/CPT code(s) were deleted from the IOCE, **effective 01-01-09**

HCPCS	CodeDesc
0026T	Measure remnant lipoproteins
0027T	Endoscopic epidural lysis
0028T	Dexa body composition study
0029T	Magnetic tx for incontinence
0031T	Speculoscopy
0032T	Speculoscopy w/direct sample
0041T	Detect ur infect agnt w/cpas
0043T	Co expired gas analysis
0046T	Cath lavage, mammary duct(s)
0047T	Cath lavage, mammary duct(s)
0049T	External circulation assist
0058T	Cryopreservation, ovary tiss
0059T	Cryopreservation, oocyte
0060T	Electrical impedance scan
0061T	Destruction of tumor, breast
0088T	Rf tongue base vol reduxn
0089T	Actigraphy testing, 3-day
0090T	Cervical artific disc
0093T	Cervical artific diskectomy
0096T	Rev cervical artific disc
0137T	Prostate saturation sampling
0162T	Anal program gast neurostim
20986	Cptr-asst dir ms px io img
20987	Cptr-asst dir ms px pre img
3302F	AJCC stage 0 docd
3303F	AJCC stage IA docd
3304F	AJCC stage IB docd
3305F	AJCC stage IC docd
3306F	AJCC stage IIA docd
3307F	AJCC stage IIB docd
3308F	AJCC stage IIC docd
3309F	AJCC stage IIIA docd
3310F	AJCC stage IIIB docd
3311F	AJCC stage IIIC docd
3312F	AJCC stage IV docd
3313F	AJCC stage IVB docd
3314F	AJCC stage IVC docd
4152F	Docd pegintf/rib thxy consd
4154F	Hep A vac series recommended
4156F	Hep B vac series recommended
46934	Destruction of hemorrhoids
46935	Destruction of hemorrhoids

HCPCS	CodeDesc
46936	Destruction of hemorrhoids
52606	Control postop bleeding
52612	Prostatectomy, first stage
52614	Prostatectomy, second stage
52620	Remove residual prostate
53853	Prostatic water thermother
61793	Focus radiation beam
77781	High intensity brachytherapy
77782	High intensity brachytherapy
77783	High intensity brachytherapy
77784	High intensity brachytherapy
78890	Nuclear medicine data proc
78891	Nuclear med data proc
88400	Bilirubin total transcut
90760	Hydration iv infusion, init
90761	Hydrate iv infusion, add-on
90765	Ther/proph/diag iv inf, init
90766	Ther/proph/dg iv inf, add-on
90767	Tx/proph/dg addl seq iv inf
90768	Ther/diag concurrent inf
90769	Sc ther infusion, up to 1 hr
90770	Sc ther infusion, addl hr
90771	Sc ther infusion, reset pump
90772	Ther/proph/diag inj, sc/im
90773	Ther/proph/diag inj, ia
90774	Ther/proph/diag inj, iv push
90775	Tx/pro/dx inj new drug addon
90776	Tx/pro/dx inj same drug adon
90779	Ther/prop/diag inj/inf proc
90918	ESRD related services, month
90919	ESRD related services, month
90920	ESRD related services, month
90921	ESRD related services, month
90922	ESRD related services, day
90923	Esrd related services, day
90924	Esrd related services, day
90925	Esrd related services, day
91100	Pass intestine bleeding tube
93727	Analyze ilr system
93731	Analyze pacemaker system
93732	Analyze pacemaker system
93733	Telephone analy, pacemaker
93734	Analyze pacemaker system
93735	Analyze pacemaker system
93736	Telephonic analy, pacemaker
93741	Analyze ht pace device sngl
93742	Analyze ht pace device sngl
93743	Analyze ht pace device dual
93744	Analyze ht pace device dual
93760	Cephalic thermogram
93762	Peripheral thermogram

HCPCS	CodeDesc
99289	Ped crit care transport
99290	Ped crit care transport addl
99293	Ped critical care, initial
99294	Ped critical care, subseq
99295	Neonate crit care, initial
99296	Neonate critical care subseq
99298	Ic for lbw infant < 1500 gm
99299	Ic, lbw infant 1500-2500 gm
99300	Ic, infant pbw 2501-5000 gm
99431	Initial care, normal newborn
99432	Newborn care, not in hosp
99433	Normal newborn care/hospital
99435	Newborn discharge day hosp
99436	Attendance, birth
99440	Newborn resuscitation
C9003	Palivizumab, per 50 mg
C9237	Inj, lanreotide acetate
C9238	Inj, levetiracetam
C9239	Inj, temsirolimus
C9240	Injection, ixabepilone
C9241	Injection, doripenem
C9242	Injection, fosaprepitant
C9243	Injection, bendamustine hcl
C9244	Injection, regadenoson
C9357	Flowable Wound Matrix, 1 cc
C9723	Dyn IR Perf Img
G0308	ESRD related svc 4+mo < 2yrs
G0309	ESRD related svc 2-3mo <2yrs
G0310	ESRD related svc 1 vst <2yrs
G0311	ESRD related svs 4+mo 2-11yr
G0312	ESRD relate svs 2-3 mo 2-11y
G0313	ESRD related svs 1 mon 2-11y
G0314	ESRD related svs 4+ mo 12-19
G0315	ESRD related svs 2-3mo/12-19
G0316	ESRD related svs 1vis/12-19y
G0317	ESRD related svs 4+mo 20+yrs
G0318	ESRD related svs 2-3 mo 20+y
G0319	ESRD related svs 1visit 20+y
G0320	ESD related svs home undr 2
G0321	ESRDrelatedsvs home mo 2-11y
G0322	ESRD related svs hom mo12-19
G0323	ESRD related svs home mo 20+
G0324	ESRD relate svs home/dy <2yr
G0325	ESRD relate home/day/ 2-11yr
G0326	ESRD relate home/dy 12-19yr
G0327	ESRD relate home/dy 20+yrs
G0332	Preadmin IV immunoglobulin
G0344	Initial preventive exam
G0366	EKG for initial prevent exam
G0367	EKG tracing for initial prev
G0368	EKG interpret & report preve

HCPCS	CodeDesc
G0394	Blood occult test,colorectal
J1751	Iron dextran 165 injection
J1752	Iron dextran 267 injection
J3100	Tenecteplase injection
J7340	Metabolic active D/E tissue
J7341	Non-human, metabolic tissue
J7342	Metabolically active tissue
J7343	Nonmetabolic act d/e tissue
J7344	Nonmetabolic active tissue
J7346	Injectable human tissue
J7347	Integra matrix tissue
J7348	Tissuemend tissue
J7349	Primatrix tissue
J7602	Albuterol inh non-comp con
J7603	Albuterol inh non-comp u d
J9182	Etoposide 100 MG inj
L2860	Torsion mechanism knee/ankle
L3890	Torsion mechanism wrist/elbo
L5993	Heavy duty feature, foot
L5994	Heavy duty feature, knee
L5995	Lower ext pros heavyduty fea
L7611	Ped term dev, hook, vol open
L7612	Ped term dev, hook, vol clos
L7613	Ped term dev, hand, vol open
L7614	Ped term dev, hand, vol clos
L7621	Hook/hand, hvy dty, vol open
L7622	Hook/hand, hvy dty, vol clos
Q4096	VWF complex, not Humate-P
Q4097	Inj IVIG Privigen 500 mg
Q4098	Inj iron dextran
Q4099	Formoterol fumarate, inh
S0143	Aztreonam, inh sol gram
S2075	Lap inc/vent hernia repair
S2076	Lap umbilical hernia repair
S2077	Lap mesh implant hern rep
S2135	Neurolysis interspace foot
S9092	Canolith repositioning

HCPCS Description Changes

The following code descriptions were changed, **effective 04-01-08**

HCPCS	Old Description	New Description
90681	Rotovirus vacc 2 dose oral	Rotavirus vacc 2 dose oral

The following code descriptions were changed, **effective 10-01-08**

HCPCS	Old Description	New Description
S3860	genet test cardiac ion-comp	Genet test cardiac ion-comp
S3861	genetic test Brugada	Genetic test Brugada

HCPCS	Old Description	New Description
S3862	genet test cardiac ion-spec	Genet test cardiac ion-spec

The following code descriptions were changed, **effective 01-01-09**

HCPCS	Old Description	New Description
00210	Anesth, open head surgery	Anesth, cranial surg nos
00562	Anesth, heart surg w/pump	Anesth hrt surg w/pmp age 1+
0513F	Elev BP plan of care docd	Elev bp plan of care docd
0514F	Care plan Hgb docd ESA pt	Care plan hgb docd esa pt
0520F	Tissue dose done w/in 5 days	Rad dos limts b/4 3d rad
1040F	DSM-IV info MDD docd	Dsm-iv info mdd doc'd
1060F	Doc perm/cont/parox atr fib	Doc perm/cont/parox atr. fib
1100F	Ptfalls assess-docd ge2+/yr	Ptfalls assess-doc'd ge2+/yr
1101F	Pt falls assess-docd le1/yr	Pt falls assess-doc'd le1/yr
1119F	Init Eval for condition	Init eval for condition
1121F	Subs Eval for condition	Subs eval for condition
1123F	ACP discuss/dscn mkr docd	Acp discuss/dscn mkr docd
1124F	ACP discuss-no dscnmkr docd	Acp discuss-no dscnmkr docd
1125F	Amnt Pain noted pain prsnt	Amnt pain noted pain prsnt
1126F	Amnt Pain noted none prsnt	Amnt pain noted none prsnt
12031	Layer closure of wound(s)	Intmd wnd repair s/tr/ext
12032	Layer closure of wound(s)	Intmd wnd repair s/tr/ext
12034	Layer closure of wound(s)	Intmd wnd repair s/tr/ext
12035	Layer closure of wound(s)	Intmd wnd repair s/tr/ext
12036	Layer closure of wound(s)	Intmd wnd repair s/tr/ext
12037	Layer closure of wound(s)	Intmd wnd repair s/tr/ext
12041	Layer closure of wound(s)	Intmd wnd repair n-hf/genit
12042	Layer closure of wound(s)	Intmd wnd repair n-hg/genit
12044	Layer closure of wound(s)	Intmd wnd repair n-hg/genit
12045	Layer closure of wound(s)	Intmd wnd repair n-hg/genit
12046	Layer closure of wound(s)	Intmd wnd repair n-hg/genit
12047	Layer closure of wound(s)	Intmd wnd repair n-hg/genit
12051	Layer closure of wound(s)	Intmd wnd repair face/mm
12052	Layer closure of wound(s)	Intmd wnd repair face/mm
12053	Layer closure of wound(s)	Intmd wnd repair face/mm
12054	Layer closure of wound(s)	Intmd wnd repair, face/mm
12055	Layer closure of wound(s)	Intmd wnd repair face/mm
12056	Layer closure of wound(s)	Intmd wnd repair face/mm
12057	Layer closure of wound(s)	Intmd wnd repair face/mm
15002	Wnd prep, ch/inf, trk/arm/lg	Wound prep, trk/arm/leg
15003	Wnd prep, ch/inf addl 100 cm	Wound prep, addl 100 cm
15004	Wnd prep ch/inf, f/n/hf/g	Wound prep, f/n/hf/g
2001F	Weight recorded	Weight record
2030F	H2O stat docd, normal	H2O stat doc'd, normal
2031F	H2O stat docd, dehydrated	H2O stat doc'd, dehydrated
3022F	Lvef >=40% systolic	Lvef =40% systolic
3027F	Spirom fev/fvc>=70%/w/o copd	Spirom fev/fvc=70%/ w/o copd
3035F	O2 saturation<=88% /pao<=55	O2 saturation =88% /pa0 =55
3037F	O2 saturation >88% /pao>55	O2 saturation> 88% /pao>55
3042F	Fev>= 40% predicted value	Fev= 40% predicted value
3045F	HG a1c level 7.0-9.0%	Hg a1c level 7.0-9.0%
3050F	Ldl-c >= 130 mg/dl	Ldl-c = 130 mg/dl

HCPCS	Old Description	New Description
3073F	Pre-surg eye measures docd	Pre-surg eye measures doc'd
3077F	Syst bp >= 140 mm hg6 it	Syst bp = 140 mm hg6 it
3080F	Diast bp >= 90 mm hg	Diast bp = 90 mm hg
3082F	Kt/v lt 1.2	Kt/v lt1.2
3093F	Doc new diag 1st/addl mdd	Doc new diag 1st/addl. mdd
3095F	Central dexa results docd	Central dexa results doc'd
3110F	Pres/absn hmrhg/lesion docd	Pres/absn hmrhg/lesion doc'd
3112F	Ct/mri brain done gt 24 hrs	Ct/mri brain done gt24 hrs
3132F	Doc ref upper gi endoscopy	Doc ref. upper gi endoscopy
3215F	Pt immunity to hep A docd	Pt immunity to hep a docd
3216F	Pt immunity to hep B docd	Pt immunity to hep b docd
3218F	Rna tstng hep c docd-done	RNA tstng hep C doc'd-done
3220F	Hep C quant rna tstng docd	Hep c quant rna tstng docd
3265F	RNA tstng HepC vir ord/docd	Rna tstng hepc vir ord/docd
3266F	HepC gn tstng docd b/4txmnt	Hepc gn tstng docd b/4txmnt
3268F	PSA/T/GlSc docd b/4 txmnt	Psa/t/glsc docd b/4 txmnt
3279F	Hgb lvl >/=13 g/dL	Hgb lvl >/= 13 g/dl
3281F	Hgb lvl <11 g/dL	Hgb lvl <11 g/dl
3288F	Fall risk assessment docd	Fall risk assessment doc'd
3291F	Pt=D(Rh)+or sensitized	Pt=d(rh)+ or sensitized
3292F	HIV tstng asked/docd/revwd	Hiv tstng asked/docd/revwd
3301F	Cancer stage docd, metast	Cancer stage docd metast
3315F	ER +or PR +breast cancer	Er+ or pr+ breast cancer
3319F	X-ray/CT/Ultrsnd et al ordd	X-ray/ct/ultrsnd et al ord
3320F	No Xray/CT/ et al ordd	No xray/ct/ et al ordd
3330F	Imaging study ordered (BkP)	Imaging study ordered (bkp)
3344F	Mammo assess susp docd	Mammo assess susp, docd
37765	Phleb veins extrem 10-20	Phleb veins - extrem - to 20
37766	Phleb veins extrem 20+	Phleb veins - extrem 20+
4005F	Pharm thx for op rxd	Pharm thx for op rx'd
4055F	Pt rcvng periton dialysis	Pt. rcvng periton dialysis
4056F	Approp oral rehyd recommd	Approp. oral rehyd. recomm'd
4062F	Pt referral psych docd	Pt referral psych doc'd
4067F	Pt referral for ECT docd	Pt referral for ECT doc'd
4070F	Dvt prophylx recvd day 2	Dvt prophylx recv'd day 2
4084F	Aspirin recvd w/in 24 hrs	Aspirin recv'd w/in 24 hrs
4100F	Biphos thxpy vein ord/recvd	Biphos thxpy vein ord/rec'vd
4110F	Int mam art used for cabg	Int. mam art used for cabg
4120F	Antibiot rxd/given	Antibiot rx'd/given
4124F	Antibiot not rxd/given	Antibiot not rx'd/given
4130F	Topical prep rx AOE	Topical prep rx aoe
4158F	Pt edu re: alcoh drnkng done	Pt edu re alcoh drnkng done
4163F	Pt couns. 4 txmnt opt, prost	Pt couns 4 txmnt opt prost
4164F	Adjv hrmnl thxpy Rxd	Adjv hrmnl thxpy rxd
4165F	3D-CRT/IMRT received	3d-crt/imrt received
4167F	Hd Bed tilted 1st day vent	Hd bed tilted 1st day vent
4168F	Pt care ICU&vent w/in 24hrs	Pt care icu&vent w/in 24hrs
4171F	Pt rcvng ESA thxpy	Pt rcvng esa thxpy
4172F	Pt not rcvng ESA thxpy	Pt. not rcvng esa thxpy
4174F	Couns potent Glauc impct	Couns potent glauc impct
4175F	Vis of >=20/40 w/in 90 days	Vis of >= 20/40 w/in 90 days

HCPCS	Old Description	New Description
4176F	Talk re UV light pt/crgvr	Talk re uv light pt/crgvr
4177F	Talk pt/crgvr re AREDS prev	Talk pt/crgvr re areds prev
4178F	AntiD glbln rcvd w/in 26wks	Antid glbln rcvd w/in 26wks
4180F	Adjv thxpyRxd/rcvd Stg3A-C	Adjv thxpyrxd/rcvd stg3a-c
4181F	Conformal radn thxpy rcvd	Conformal rad'n thxpy rcv'd
4185F	Continuous PPI or H2RA rcvd	Continuous ppi or h2ra rcvd
4186F	No Cont. PPI or H2RA rcvd	No cont ppi or h2ra rcvd
4187F	Anti rheum DrugthxpyRxd/gvn	Anti rheum drugthxpyrxd/gvn
4189F	Approp dogoxin tstng done	Approp digoxin tstng done
4245F	Pt instr resume nrml lifest	Pt instr nrml lifest
49650	Laparo hernia repair initial	Lap ing hernia repair init
49651	Laparo hernia repair recur	Lap ing hernia repair recur
5062F	Doc f2fmammo fndng in 3 days	Doc f2fmammo fndng in 5 days
52649	2Prostate laser enucleation	Prostate laser enucleation
58740	Revise fallopian tube(s)	Adhesiolysis tube, ovary
58760	Remove tubal obstruction	Fimbrioplasty
82375	Assay, blood carbon monoxide	Assay, carboxyhb, quant
82376	Test for carbon monoxide	Assay, carboxyhb, qual
82805	Blood gases w/o2 saturation	Blood gases w/02 saturation
90649	H papilloma vacc 3 dose im	Hpv vaccine 4 valent, im
90650	Hpv typ bival 3 dose im	Hpv vaccine 2 valent, im
93307	Echo exam of heart	Tte w/o doppler, complete
93308	Echo exam of heart	Tte, f-up or lmtd
93350	Echo transthoracic	Stress tte only
99407	Behav chng smoking < 10 min	Behav chng smoking > 10 min
C9356	TenoGlide Tendon Prot, cm2	TenoGlide tendon prot, cm2
D1203	Topical fluor w/o prophy chi	Topical app fluoride child
D1204	Topical fluor w/o prophy adu	Topical app fluoride adult
D3310	Anterior	End thxpy, anterior tooth
D3320	Root canal therapy 2 canals	End thxpy, bicuspid tooth
D3330	Root canal therapy 3 canals	End thxpy, molar
G8372	Chemother rec stg 3 colon ca	Chemother rec stg3 colon ca
G8373	Chemo plan docum prior chemo	Chemo plan documen prior che
G8378	MD doc pt inelig rad therapy	MD doc pt inelig radiation
G8379	Radiat tx recom doc12mo ov	Doc radiat tx recom 12mo ov
G8380	Pt w stgIC-3Brst ca w/o tam	Pt w stgIC-3Brst ca not rec
G8383	Radiation rec not doc 12 mo	No doc radiation rec 12mo ov
G8384	MDS pt w/o base cytogen test	Base cytogen test MDS notper
G8385	Diab pt w nodoc Hgb A1c 12m	Diabet pt no do Hgb A1c 12m
G8386	Diab pt w nodoc LDL 12m	Diabet pt nodoc LDLiprotei
G8388	ESRD pt w URR/Ktv not doc el	ESRD pt w URR/Ktv notdoc eli
G8389	MDS pt no doc Fe prior EPO	MDS pt no doc FE st prio EPO
G8417	BMI >=30 calcuate w/followup	Calc BMI abv up param f/u
G8418	BMI < 22 calcuate w/followup	Calc BMI blw low param f/u
G8419	BMI>=30or<22 cal no followup	Calc BMI out nrm param nof/u
G8420	BMI<30 and >=22 calc & docu	Calc BMI norm parameters
G8431	Clin depression screen doc	Pos clin depres scrn f/u doc
G8433	Pt inelig for depression scr	Pt inelig; scrn clin dep
G8437	Tx plan develop & document	Care plan develop & document
G8438	Tx plan develop & not docum	Pt inelig for devlp care pln
G8439	Pt inelig for co-develp tx p	Care plan develp & not docum

HCPCS	Old Description	New Description
G8440	Pain assessment document	Pain assess f/u pln document
G8446	Some prescrib handwritten or	Some prescrib print or call
G8447	Pt visit doc using CCHIT cer	Pt vis doc use CCHIT cer EHR
G8448	Pt visit docum w/non-CCHIT c	Pt vis doc w/non-CCHIT EHR
G8457	Tobacco non-user	Cur tobacco non-user
G8485	Report Diabetes measures	Report, Diabetes measures
G8486	Report prev care measures	Report, Prev Care Measures
G8487	Report CKD measures	Report CKD Measures
G8488	Report ESRD measures	Report ESRD Measures
J0348	Anadulafungin injection	Anidulafungin injection
J0395	Arbutamine HCl injection	Arbutamine hcl injection
J1571	HepaGam B IM injection	Hepagam b im injection
J1573	Hepagam B intravenous, inj	Hepagam b intravenous, inj
J1626	Granisetron HCl injection	Granisetron hcl injection
J2469	Palonosetron HCl	Palonosetron hcl
J2724	Protein C concentrate	Protein c concentrate
J3301	Triamcinolone acetonide inj	Triamcinolone acet inj NOS
J7639	Dornase alpha non-comp unit	Dornase alfa non-comp unit
J9000	Doxorubic hcl 10 MG vl chemo	Doxorubicin hcl injection
J9015	Aldesleukin/single use vial	Aldesleukin injection
J9017	Arsenic trioxide	Arsenic trioxide injection
J9050	Carmus bischl nitro inj	Carmustine injection
J9098	Cytarabine liposome	Cytarabine liposome inj
J9120	Dactinomycin actinomycin d	Dactinomycin injection
J9150	Daunorubicin	Daunorubicin injection
J9151	Daunorubicin citrate liposom	Daunorubicin citrate inj
J9160	Denileukin diftitox, 300 mcg	Denileukin diftitox inj
J9170	Docetaxel	Docetaxel injection
J9181	Etoposide 10 MG inj	Etoposide injection
J9201	Gemcitabine HCl	Gemcitabine hcl injection
J9212	Interferon alfacon-1	Interferon alfacon-1 inj
J9266	Pegaspargase/singl dose vial	Pegaspargase injection
J9300	Gemtuzumab ozogamicin	Gemtuzumab ozogamicin inj
J9310	Rituximab cancer treatment	Rituximab injection
J9350	Topotecan	Topotecan injection
J9355	Trastuzumab	Trastuzumab injection
J9357	Valrubicin, 200 mg	Valrubicin injection
J9390	Vinorelbine tartrate/10 mg	Vinorelbine tartrate inj
J9600	Porfimer sodium	Porfimer sodium injection
K0672	Remove soft interface, repl	Removable soft interface LE
Q0166	Granisetron HCl 1 mg oral	Granisetron hcl 1 mg oral
Q0179	Ondansetron HCl 8mg oral	Ondansetron hcl 8 mg oral

HCPCS Changes- APC, Status Indicator and/or Edit Assignments

The following code(s) had an APC and/or SI and/or edit change, **effective 08-01-00** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90735	Encephalitis vaccine, sc	00357	00000	X	E	N/A	50

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-01** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90735	Encephalitis vaccine, sc	00356	00000	K	E	N/A	50

The following code(s) had an APC and/or SI and/or edit change, **effective 04-01-02** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
E1902	AAC non-electronic board			A	Y	N/A	61

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-03** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90735	Encephalitis vaccine, sc			N	E	N/A	50

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-05** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
93000	Electrocardiogram, complete			B	M	13	72
93790	Review/report BP recording			B	M	14	72

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90735	Encephalitis vaccine, sc	09144	00000	K	E	N/A	50
93000	Electrocardiogram, complete			B	M	62	72
93790	Review/report BP recording			B	M	62	72

The following code(s) had an APC and/or SI and/or edit change, **effective 04-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
S0345	Home ecg monitrng global 24h					9	28
S0346	Home ecg monitrng tech 24hr					9	28
S0347	Home ecg monitrng prof 24hr					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 07-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
S5523	HIP midline cath insert kit					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 10-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
S0147	Alglucosidase alfa 20 mg					9	28
S0316	Follow-up/reassessment					9	28
S2325	Hip core decompression					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 04-01-07** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
S0180	Etonogestrel implant system					9	28
S0270	Home std case rate 30 days					9	28
S0271	Home hospice case 30 days					9	28
S0272	Home episodic case 30 days					9	28
S0273	MD home visit outside cap					9	28
S0274	Nurse practr visit outs cap					9	28
S3618	Free beta HCG					9	28
S9351	HIT cont antiemetic diem					9	28
T1503	Med admin, not oral/inject					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 07-01-07** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
S2066	Breast GAP flap reconst					9	28
S2067	Breast "stacked" DIEP/GAP					9	28
S2068	Breast DIEP or SIEA flap					9	28
S3800	Genetic testing ALS					9	28
S3905	Auto handheld diag nerv test					9	28
S9152	Speech therapy, re-eval					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 04-01-08** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90681	Rotavirus vacc 2 dose oral	00000	01239	E	K	9	N/A
90696	Dtap-ipv vacc 4-6 yr im	00000	01219	E	K	9	N/A
S3628	PAMG-1 rapid assay for ROM					50	28

The following code(s) had an APC and/or SI and/or edit change, **effective 10-01-08** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0062T	Rep intradisc annulus;1 lev	00050	00000	T	E	N/A	28
0063T	Rep intradisc annulus;>1lev	00050	00000	T	E	N/A	28
22526	Idet, single level	00050	00000	T	E	N/A	28
22527	Idet, 1 or more levels	00050	00000	T	E	N/A	28
S2118	Total hip resurfacing					9	28
S2270	Insertion vaginal cylinder					9	28

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
S3860	Genet test cardiac ion-comp					9	28
S3861	Genetic test Brugada					9	28
S3862	Genet test cardiac ion-spec					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-09** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0067T	Ct colonography;dx			S	Q3		
0126T	Chd risk imt study			Q	Q1		
0171T	Lumbar spine proces distract	00050	00052				
0172T	Lumbar spine process addl	00050	00052				
0186T	Suprachoroidal drug delivery	00236	00237				
0192T	Insert ant segment drain ext	00234	00673				
10120	Remove foreign body	00006	00016				
11000	Debride infected skin	00013	00015				
11057	Trim skin lesions, over 4	00015	00013				
11100	Biopsy, skin lesion	00013	00015				
11201	Remove skin tags add-on	00015	00013				
11623	Exc h-f-nk-sp mlg+marg 2.1-3	00020	00021				
11640	Exc face-mm malig+marg 0.5 <	00019	00020				
11641	Exc face-mm malig+marg 0.6-1	00019	00020				
11765	Excision of nail fold, toe	00015	00013				
12021	Closure of split wound	00135	00134				
12031	Intmd wnd repair s/tr/ext	00134	00133				
12034	Intmd wnd repair s/tr/ext	00134	00133				
12035	Intmd wnd repair s/tr/ext	00134	00133				
12041	Intmd wnd repair n-hf/genit	00134	00133				
12042	Intmd wnd repair n-hg/genit	00134	00133				
12044	Intmd wnd repair n-hg/genit	00134	00133				
12051	Intmd wnd repair face/mm	00134	00133				
12052	Intmd wnd repair face/mm	00134	00133				
12053	Intmd wnd repair face/mm	00134	00133				
12054	Intmd wnd repair, face/mm	00134	00133				
13121	Repair of wound or lesion	00135	00134				
13131	Repair of wound or lesion	00135	00134				
13132	Repair of wound or lesion	00135	00134				
13133	Repair wound/lesion add-on	00135	00134				
16025	Dress/debrid p-thick burn, m	00016	00015				
16030	Dress/debrid p-thick burn, l	00016	00015				
16035	Incision of burn scab, initi	00016	00015				
20100	Explore wound, neck	00023	00252				
20103	Explore wound, extremity	00023	00136				
20225	Bone biopsy, trocar/needle	00020	00021				
20500	Injection of sinus tract	00251	00252				
20660	Apply, rem fixation device	00000	00138	C	T		
21089	Prepare face/oral prosthesis	00251	00250				
21172	Reconstruct orbit/forehead	00000	00256	C	T		
21299	Cranio/maxillofacial surgery	00251	00250				
21310	Treatment of nose fracture	00251	00250				
21315	Treatment of nose fracture	00251	00253				
21386	Treat eye socket fracture	00000	00256	C	T		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
21387	Treat eye socket fracture	00000	00256	C	T		
21480	Reset dislocated jaw	00251	00250				
21499	Head surgery procedure	00251	00250				
21550	Biopsy of neck/chest	00020	00021				
21800	Treatment of rib fracture	00043	00129				
21820	Treat sternum fracture	00043	00129				
21899	Neck/chest surgery procedure	00251	00250				
22305	Treat spine process fracture	00043	00129				
22310	Treat spine fracture	00043	00138				
22315	Treat spine fracture	00043	00139				
23500	Treat clavicle fracture	00043	00129				
23505	Treat clavicle fracture	00043	00139				
23520	Treat clavicle dislocation	00043	00138				
23525	Treat clavicle dislocation	00043	00138				
23540	Treat clavicle dislocation	00043	00129				
23545	Treat clavicle dislocation	00043	00138				
23570	Treat shoulder blade fx	00043	00129				
23575	Treat shoulder blade fx	00043	00138				
23600	Treat humerus fracture	00043	00129				
23605	Treat humerus fracture	00043	00139				
23620	Treat humerus fracture	00043	00129				
23625	Treat humerus fracture	00043	00139				
23650	Treat shoulder dislocation	00043	00129				
23665	Treat dislocation/fracture	00043	00138				
23675	Treat dislocation/fracture	00043	00129				
23929	Shoulder surgery procedure	00043	00129				
24500	Treat humerus fracture	00043	00129				
24505	Treat humerus fracture	00043	00129				
24530	Treat humerus fracture	00043	00129				
24535	Treat humerus fracture	00043	00138				
24560	Treat humerus fracture	00043	00129				
24565	Treat humerus fracture	00043	00129				
24576	Treat humerus fracture	00043	00129				
24577	Treat humerus fracture	00043	00138				
24600	Treat elbow dislocation	00043	00129				
24620	Treat elbow fracture	00043	00139				
24640	Treat elbow dislocation	00043	00129				
24650	Treat radius fracture	00043	00129				
24655	Treat radius fracture	00043	00138				
24670	Treat ulnar fracture	00043	00129				
24675	Treat ulnar fracture	00043	00129				
24999	Upper arm/elbow surgery	00043	00129				
25111	Remove wrist tendon lesion	00053	00049				
25112	Reremove wrist tendon lesion	00053	00049				
25210	Removal of wrist bone	00054	00050				
25215	Removal of wrist bones	00054	00050				
25259	Manipulate wrist w/anesthes	00043	00139				
25394	Repair carpal bone, shorten	00053	00051				
25400	Repair radius or ulna	00052	00051				
25430	Vasc graft into carpal bone	00054	00051				
25431	Repair nonunion carpal bone	00054	00051				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
25500	Treat fracture of radius	00043	00129				
25505	Treat fracture of radius	00043	00138				
25520	Treat fracture of radius	00043	00138				
25530	Treat fracture of ulna	00043	00129				
25535	Treat fracture of ulna	00043	00129				
25560	Treat fracture radius & ulna	00043	00129				
25565	Treat fracture radius & ulna	00043	00138				
25600	Treat fracture radius/ulna	00043	00129				
25605	Treat fracture radius/ulna	00043	00138				
25622	Treat wrist bone fracture	00043	00129				
25624	Treat wrist bone fracture	00043	00138				
25630	Treat wrist bone fracture	00043	00129				
25635	Treat wrist bone fracture	00043	00138				
25650	Treat wrist bone fracture	00043	00129				
25660	Treat wrist dislocation	00043	00129				
25675	Treat wrist dislocation	00043	00129				
25680	Treat wrist fracture	00043	00129				
25690	Treat wrist dislocation	00043	00139				
25820	Fusion of hand bones	00053	00051				
25999	Forearm or wrist surgery	00043	00129				
26340	Manipulate finger w/anesth	00043	00138				
26600	Treat metacarpal fracture	00043	00129				
26605	Treat metacarpal fracture	00043	00129				
26607	Treat metacarpal fracture	00043	00139				
26641	Treat thumb dislocation	00043	00129				
26645	Treat thumb fracture	00043	00138				
26670	Treat hand dislocation	00043	00129				
26675	Treat hand dislocation	00043	00138				
26700	Treat knuckle dislocation	00043	00129				
26705	Treat knuckle dislocation	00043	00129				
26706	Pin knuckle dislocation	00043	00139				
26720	Treat finger fracture, each	00043	00129				
26725	Treat finger fracture, each	00043	00129				
26740	Treat finger fracture, each	00043	00129				
26742	Treat finger fracture, each	00043	00129				
26750	Treat finger fracture, each	00043	00129				
26755	Treat finger fracture, each	00043	00129				
26770	Treat finger dislocation	00043	00129				
26989	Hand/finger surgery	00043	00129				
27193	Treat pelvic ring fracture	00043	00129				
27200	Treat tail bone fracture	00043	00129				
27215	Treat pelvic fracture(s)			C	E	N/A	28
27216	Treat pelvic ring fracture	00050	00000	T	E	N/A	28
27217	Treat pelvic ring fracture			C	E	N/A	28
27218	Treat pelvic ring fracture			C	E	N/A	28
27220	Treat hip socket fracture	00043	00129				
27230	Treat thigh fracture	00043	00129				
27238	Treat thigh fracture	00043	00138				
27246	Treat thigh fracture	00043	00138				
27250	Treat hip dislocation	00043	00129				
27256	Treat hip dislocation	00043	00129				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
27265	Treat hip dislocation	00043	00129				
27267	Cltx thigh fx	00043	00129				
27299	Pelvis/hip joint surgery	00043	00129				
27412	Autochondrocyte implant knee	00042	00052				
27415	Osteochondral knee allograft	00042	00052				
27479	Surgery to stop leg growth	00000	00050	C	T		
27500	Treatment of thigh fracture	00043	00138				
27501	Treatment of thigh fracture	00043	00129				
27502	Treatment of thigh fracture	00043	00139				
27503	Treatment of thigh fracture	00043	00129				
27508	Treatment of thigh fracture	00043	00129				
27510	Treatment of thigh fracture	00043	00138				
27516	Treat thigh fx growth plate	00043	00129				
27517	Treat thigh fx growth plate	00043	00129				
27520	Treat kneecap fracture	00043	00129				
27530	Treat knee fracture	00043	00129				
27532	Treat knee fracture	00043	00139				
27538	Treat knee fracture(s)	00043	00129				
27550	Treat knee dislocation	00043	00129				
27560	Treat kneecap dislocation	00043	00129				
27599	Leg surgery procedure	00043	00129				
27750	Treatment of tibia fracture	00043	00129				
27752	Treatment of tibia fracture	00043	00139				
27760	Cltx medial ankle fx	00043	00129				
27762	Cltx med ankle fx w/mnpj	00043	00139				
27767	Cltx post ankle fx	00043	00129				
27768	Cltx post ankle fx w/mnpj	00043	00129				
27780	Treatment of fibula fracture	00043	00129				
27781	Treatment of fibula fracture	00043	00139				
27786	Treatment of ankle fracture	00043	00129				
27788	Treatment of ankle fracture	00043	00129				
27808	Treatment of ankle fracture	00043	00129				
27810	Treatment of ankle fracture	00043	00138				
27816	Treatment of ankle fracture	00043	00129				
27818	Treatment of ankle fracture	00043	00138				
27824	Treat lower leg fracture	00043	00129				
27825	Treat lower leg fracture	00043	00139				
27830	Treat lower leg dislocation	00043	00129				
27831	Treat lower leg dislocation	00043	00139				
27840	Treat ankle dislocation	00043	00138				
27899	Leg/ankle surgery procedure	00043	00129				
28190	Removal of foot foreign body	00019	00020				
28400	Treatment of heel fracture	00043	00129				
28405	Treatment of heel fracture	00043	00139				
28430	Treatment of ankle fracture	00043	00129				
28435	Treatment of ankle fracture	00043	00129				
28450	Treat midfoot fracture, each	00043	00129				
28455	Treat midfoot fracture, each	00043	00129				
28470	Treat metatarsal fracture	00043	00129				
28475	Treat metatarsal fracture	00043	00129				
28490	Treat big toe fracture	00043	00129				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
28495	Treat big toe fracture	00043	00129				
28510	Treatment of toe fracture	00043	00129				
28515	Treatment of toe fracture	00043	00129				
28530	Treat sesamoid bone fracture	00043	00129				
28540	Treat foot dislocation	00043	00129				
28570	Treat foot dislocation	00043	00138				
28575	Treat foot dislocation	00043	00139				
28600	Treat foot dislocation	00043	00129				
28605	Treat foot dislocation	00043	00129				
28630	Treat toe dislocation	00043	00129				
28660	Treat toe dislocation	00043	00129				
28899	Foot/toes surgery procedure	00043	00129				
30999	Nasal surgery procedure	00251	00250				
31299	Sinus surgery procedure	00251	00250				
31599	Larynx surgery procedure	00251	00250				
31615	Visualization of windpipe	00076	00252				
35761	Exploration of artery/vein	00115	00093				
35903	Excision, graft, extremity	00115	00093				
36420	Vein access cutdown < 1 yr			T	X		
36425	Vein access cutdown > 1 yr			T	X		
36566	Insert tunneled cv cath	00625	00623				
36575	Repair tunneled cv cath	00109	00121				
36589	Removal tunneled cv cath	00109	00121				
36591	Draw blood off venous device			Q	Q1		
36592	Collect blood from picc	00000	00624	N	Q1		
36600	Withdrawal of arterial blood			Q	Q1		
38792	Identify sentinel node			Q	Q1		
40799	Lip surgery procedure	00251	00250				
40899	Mouth surgery procedure	00251	00250				
41250	Repair tongue laceration	00251	00250				
41599	Tongue and mouth surgery	00251	00250				
41899	Dental surgery procedure	00251	00250				
42299	Palate/uvula surgery	00251	00250				
42699	Salivary surgery procedure	00251	00250				
42800	Biopsy of throat	00252	00253				
42820	Remove tonsils and adenoids	00258	00254				
42821	Remove tonsils and adenoids	00258	00254				
42825	Removal of tonsils	00258	00254				
42826	Removal of tonsils	00258	00254				
42830	Removal of adenoids	00258	00254				
42831	Removal of adenoids	00258	00254				
42835	Removal of adenoids	00258	00254				
42836	Removal of adenoids	00258	00254				
42860	Excision of tonsil tags	00258	00254				
42870	Excision of lingual tonsil	00258	00254				
42999	Throat surgery procedure	00251	00250				
43420	Repair esophagus opening	00000	00254	C	T		
46505	Chemodenervation anal musc	00148	00155				
47370	Laparo ablate liver tumor rf	00132	00174				
49465	Fluoro exam of g/colon tube			Q	Q1		
5020F	Txmnts 2 main Dr by 1 mon			M	E	72	28

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
50542	Laparo ablate renal mass	00132	00174				
50727	Revise ureter	00000	00165	C	T		
51720	Treatment of bladder lesion	00164	00156				
51845	Repair bladder neck	00000	00202	C	T		
51860	Repair of bladder wound	00000	00162	C	T		
52327	Cystoscopy, inject material	00162	00163				
54050	Destruction, penis lesion(s)	00015	00013				
54332	Revise penis/urethra	00000	00181	C	T		
54336	Revise penis/urethra	00000	00181	C	T		
54535	Extensive testis surgery	00000	00181	C	T		
55875	Transperi needle place, pros			Q	Q3		
55876	Place rt device/marker, pros	00156	00310	T	X		
58541	Lsh, uterus 250 g or less	00131	00132				
58542	Lsh w/t/o ut 250 g or less	00131	00132				
58543	Lsh uterus above 250 g	00131	00132				
58544	Lsh w/t/o uterus above 250 g	00131	00132				
59897	Fetal invas px w/us	00189	00191				
61000	Remove cranial cavity fluid	00212	00207				
61001	Remove cranial cavity fluid	00212	00207				
61020	Remove brain cavity fluid	00212	00207				
61026	Injection into brain canal	00212	00207				
61050	Remove brain canal fluid	00212	00207				
61055	Injection into brain canal	00212	00207				
62194	Replace/irrigate catheter	00212	00207				
62263	Epidural lysis mult sessions	00203	00207				
62268	Drain spinal cord cyst	00212	00207				
62292	Injection into disk lesion	00212	00207				
62294	Injection into spinal artery	00212	00207				
62367	Analyze spine infusion pump	00691	00692				
63746	Removal of spinal shunt	00109	00203				
64421	N block inj, intercost, mlt	00206	00207				
64553	Implant neuroelectrodes	00225	00040				
64613	Destroy nerve, neck muscle	00204	00206				
64614	Destroy nerve, extrem musc	00204	00206				
64910	Nerve repair w/allograft	00220	00221				
64911	Neurorraphy w/vein autograft	00220	00221				
65125	Revise ocular implant	00240	00241				
65260	Remove foreign body from eye	00236	00235				
65280	Repair of eye wound	00236	00237				
66625	Removal of iris	00232	00233				
67015	Release of eye fluid	00237	00672				
67028	Injection eye drug	00231	00238	S	T		
67030	Incise inner eye strands	00236	00237				
67101	Repair detached retina	00236	00235				
67110	Repair detached retina	00236	00237				
67115	Release encircling material	00236	00237				
67120	Remove eye implant material	00236	00237				
67208	Treatment of retinal lesion	00236	00235				
67218	Treatment of retinal lesion	00236	00237				
67400	Explore/biopsy eye socket	00241	00240				
67412	Explore/treat eye socket	00241	00240				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
67900	Repair brow defect	00240	00241				
67902	Repair eyelid defect	00240	00241				
67971	Reconstruction of eyelid	00241	00240				
67974	Reconstruction of eyelid	00241	00240				
68020	Incise/drain eyelid lining	00240	00238				
68320	Revise/graft eyelid lining	00240	00241				
68326	Revise/graft eyelid lining	00241	00240				
68530	Clearance of tear duct	00240	00238				
68540	Remove tear gland lesion	00241	00240				
68700	Repair tear ducts	00241	00240				
68760	Close tear duct opening	00231	00238	S	T		
68761	Close tear duct opening	00231	00238	S	T		
68770	Close tear system fistula	00240	00241				
69399	Outer ear surgery procedure	00251	00250				
69714	Implant temple bone w/stimul	00256	00425				
69715	Temple bne implnt w/stimulat	00256	00425				
69717	Temple bone implant revision	00256	00425				
69718	Revise temple bone implant	00256	00425				
69799	Middle ear surgery procedure	00251	00250				
69949	Inner ear surgery procedure	00251	00250				
69979	Temporal bone surgery	00251	00250				
70010	Contrast x-ray of brain			Q	Q2		
70015	Contrast x-ray of brain			Q	Q2		
70170	X-ray exam of tear duct	00317	00263	Q	Q2		
70332	X-ray exam of jaw joint			Q	Q2		
70336	Magnetic image, jaw joint	00335	00336	S	Q3		
70373	Contrast x-ray of larynx			Q	Q2		
70390	X-ray exam of salivary duct			Q	Q2		
70450	Ct head/brain w/o dye			S	Q3		
70460	Ct head/brain w/dye			S	Q3		
70470	Ct head/brain w/o & w/dye			S	Q3		
70480	Ct orbit/ear/fossa w/o dye			S	Q3		
70481	Ct orbit/ear/fossa w/dye			S	Q3		
70482	Ct orbit/ear/fossa w/o&w/dye			S	Q3		
70486	Ct maxillofacial w/o dye			S	Q3		
70487	Ct maxillofacial w/dye			S	Q3		
70488	Ct maxillofacial w/o & w/dye			S	Q3		
70490	Ct soft tissue neck w/o dye			S	Q3		
70491	Ct soft tissue neck w/dye			S	Q3		
70492	Ct sft tsue nck w/o & w/dye			S	Q3		
70496	Ct angiography, head			S	Q3		
70498	Ct angiography, neck			S	Q3		
70540	Mri orbit/face/neck w/o dye			S	Q3		
70542	Mri orbit/face/neck w/dye			S	Q3		
70543	Mri orbt/fac/nck w/o & w/dye			S	Q3		
70544	Mr angiography head w/o dye			S	Q3		
70545	Mr angiography head w/dye			S	Q3		
70546	Mr angiograph head w/o&w/dye			S	Q3		
70547	Mr angiography neck w/o dye			S	Q3		
70548	Mr angiography neck w/dye			S	Q3		
70549	Mr angiograph neck w/o&w/dye			S	Q3		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
70551	Mri brain w/o dye			S	Q3		
70552	Mri brain w/dye			S	Q3		
70553	Mri brain w/o & w/dye			S	Q3		
70554	Fmri brain by tech			S	Q3		
71040	Contrast x-ray of bronchi			Q	Q2		
71060	Contrast x-ray of bronchi	00317	00263	Q	Q2		
71250	Ct thorax w/o dye			S	Q3		
71260	Ct thorax w/dye			S	Q3		
71270	Ct thorax w/o & w/dye			S	Q3		
71275	Ct angiography, chest			S	Q3		
71550	Mri chest w/o dye			S	Q3		
71551	Mri chest w/dye			S	Q3		
71552	Mri chest w/o & w/dye			S	Q3		
72010	X-ray exam of spine	00260	00261				
72125	Ct neck spine w/o dye			S	Q3		
72126	Ct neck spine w/dye			S	Q3		
72127	Ct neck spine w/o & w/dye			S	Q3		
72128	Ct chest spine w/o dye			S	Q3		
72129	Ct chest spine w/dye			S	Q3		
72130	Ct chest spine w/o & w/dye			S	Q3		
72131	Ct lumbar spine w/o dye			S	Q3		
72132	Ct lumbar spine w/dye			S	Q3		
72133	Ct lumbar spine w/o & w/dye			S	Q3		
72141	Mri neck spine w/o dye			S	Q3		
72142	Mri neck spine w/dye			S	Q3		
72146	Mri chest spine w/o dye			S	Q3		
72147	Mri chest spine w/dye			S	Q3		
72148	Mri lumbar spine w/o dye			S	Q3		
72149	Mri lumbar spine w/dye			S	Q3		
72156	Mri neck spine w/o & w/dye			S	Q3		
72157	Mri chest spine w/o & w/dye			S	Q3		
72158	Mri lumbar spine w/o & w/dye			S	Q3		
72191	Ct angiograph pelv w/o&w/dye			S	Q3		
72192	Ct pelvis w/o dye			S	Q3		
72193	Ct pelvis w/dye			S	Q3		
72194	Ct pelvis w/o & w/dye			S	Q3		
72195	Mri pelvis w/o dye			S	Q3		
72196	Mri pelvis w/dye			S	Q3		
72197	Mri pelvis w/o & w/dye			S	Q3		
72240	Contrast x-ray of neck spine			Q	Q2		
72255	Contrast x-ray, thorax spine			Q	Q2		
72265	Contrast x-ray, lower spine			Q	Q2		
72270	Contrast x-ray, spine			Q	Q2		
72285	X-ray c/t spine disk			Q	Q2		
72295	X-ray of lower spine disk			Q	Q2		
73040	Contrast x-ray of shoulder			Q	Q2		
73085	Contrast x-ray of elbow			Q	Q2		
73115	Contrast x-ray of wrist			Q	Q2		
73200	Ct upper extremity w/o dye			S	Q3		
73201	Ct upper extremity w/dye			S	Q3		
73202	Ct uppr extremity w/o&w/dye			S	Q3		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
73206	Ct angio upr extrm w/o&w/dye			S	Q3		
73218	Mri upper extremity w/o dye			S	Q3		
73219	Mri upper extremity w/dye			S	Q3		
73220	Mri uppr extremity w/o&w/dye			S	Q3		
73221	Mri joint upr extrem w/o dye			S	Q3		
73222	Mri joint upr extrem w/dye			S	Q3		
73223	Mri joint upr extr w/o&w/dye			S	Q3		
73525	Contrast x-ray of hip			Q	Q2		
73542	X-ray exam, sacroiliac joint			Q	Q2		
73580	Contrast x-ray of knee joint			Q	Q2		
73615	Contrast x-ray of ankle			Q	Q2		
73700	Ct lower extremity w/o dye			S	Q3		
73701	Ct lower extremity w/dye			S	Q3		
73702	Ct lwr extremity w/o&w/dye			S	Q3		
73706	Ct angio lwr extr w/o&w/dye			S	Q3		
73718	Mri lower extremity w/o dye			S	Q3		
73719	Mri lower extremity w/dye			S	Q3		
73720	Mri lwr extremity w/o&w/dye			S	Q3		
73721	Mri jnt of lwr extre w/o dye			S	Q3		
73722	Mri joint of lwr extr w/dye			S	Q3		
73723	Mri joint lwr extr w/o&w/dye			S	Q3		
74150	Ct abdomen w/o dye			S	Q3		
74160	Ct abdomen w/dye			S	Q3		
74170	Ct abdomen w/o & w/dye			S	Q3		
74175	Ct angio abdom w/o & w/dye			S	Q3		
74181	Mri abdomen w/o dye			S	Q3		
74182	Mri abdomen w/dye			S	Q3		
74183	Mri abdomen w/o & w/dye			S	Q3		
74190	X-ray exam of peritoneum	00317	00263	Q	Q2		
74305	X-ray bile ducts/pancreas	00000	00263	N	Q2		
74320	Contrast x-ray of bile ducts			Q	Q2		
74425	Contrst x-ray, urinary tract			Q	Q2		
74430	Contrast x-ray, bladder			Q	Q2		
74440	X-ray, male genital tract			Q	Q2		
74445	X-ray exam of penis			Q	Q2		
74450	X-ray, urethra/bladder			Q	Q2		
74455	X-ray, urethra/bladder			Q	Q2		
74470	X-ray exam of kidney lesion			Q	Q2		
74475	X-ray control, cath insert			Q	Q2		
74480	X-ray control, cath insert			Q	Q2		
74485	X-ray guide, GU dilation			Q	Q2		
74740	X-ray, female genital tract			Q	Q2		
75557	Cardiac mri for morph			S	Q3		
75559	Cardiac mri w/stress img			S	Q3		
75561	Cardiac mri for morph w/dye			S	Q3		
75563	Card mri w/stress img & dye			S	Q3		
75600	Contrast x-ray exam of aorta			Q	Q2		
75605	Contrast x-ray exam of aorta			Q	Q2		
75625	Contrast x-ray exam of aorta			Q	Q2		
75630	X-ray aorta, leg arteries			Q	Q2		
75635	Ct angio abdominal arteries			Q	Q2		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
75650	Artery x-rays, head & neck			Q	Q2		
75658	Artery x-rays, arm			Q	Q2		
75660	Artery x-rays, head & neck			Q	Q2		
75662	Artery x-rays, head & neck			Q	Q2		
75665	Artery x-rays, head & neck			Q	Q2		
75671	Artery x-rays, head & neck			Q	Q2		
75676	Artery x-rays, neck			Q	Q2		
75680	Artery x-rays, neck			Q	Q2		
75685	Artery x-rays, spine			Q	Q2		
75705	Artery x-rays, spine			Q	Q2		
75710	Artery x-rays, arm/leg			Q	Q2		
75716	Artery x-rays, arms/legs			Q	Q2		
75722	Artery x-rays, kidney			Q	Q2		
75724	Artery x-rays, kidneys			Q	Q2		
75726	Artery x-rays, abdomen			Q	Q2		
75731	Artery x-rays, adrenal gland			Q	Q2		
75733	Artery x-rays, adrenals			Q	Q2		
75736	Artery x-rays, pelvis			Q	Q2		
75741	Artery x-rays, lung			Q	Q2		
75743	Artery x-rays, lungs			Q	Q2		
75746	Artery x-rays, lung			Q	Q2		
75756	Artery x-rays, chest			Q	Q2		
75790	Visualize A-V shunt			Q	Q2		
75801	Lymph vessel x-ray, arm/leg			Q	Q2		
75803	Lymph vessel x-ray,arms/legs			Q	Q2		
75805	Lymph vessel x-ray, trunk			Q	Q2		
75807	Lymph vessel x-ray, trunk			Q	Q2		
75809	Nonvascular shunt, x-ray	00263	00261	Q	Q2		
75810	Vein x-ray, spleen/liver			Q	Q2		
75820	Vein x-ray, arm/leg			Q	Q2		
75822	Vein x-ray, arms/legs			Q	Q2		
75825	Vein x-ray, trunk			Q	Q2		
75827	Vein x-ray, chest			Q	Q2		
75831	Vein x-ray, kidney			Q	Q2		
75833	Vein x-ray, kidneys			Q	Q2		
75840	Vein x-ray, adrenal gland			Q	Q2		
75842	Vein x-ray, adrenal glands			Q	Q2		
75860	Vein x-ray, neck			Q	Q2		
75870	Vein x-ray, skull			Q	Q2		
75872	Vein x-ray, skull			Q	Q2		
75880	Vein x-ray, eye socket			Q	Q2		
75885	Vein x-ray, liver			Q	Q2		
75887	Vein x-ray, liver			Q	Q2		
75889	Vein x-ray, liver			Q	Q2		
75891	Vein x-ray, liver			Q	Q2		
75893	Venous sampling by catheter			Q	Q2		
75898	Follow-up angiography			Q	Q1		
75945	Intravascular us			Q	Q2		
75962	Repair arterial blockage			Q	Q2		
75966	Repair arterial blockage			Q	Q2		
75978	Repair venous blockage			Q	Q2		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
76000	Fluoroscope examination			Q	Q1		
76080	X-ray exam of fistula			Q	Q2		
76098	X-ray exam, breast specimen	00260	00317				
76498	Mri procedure	00335	00336				
76514	Echo exam of eye, thickness	00230	00035	S	X		
76604	Us exam, chest			S	Q3		
76700	Us exam, abdom, complete			S	Q3		
76705	Echo exam of abdomen			S	Q3		
76770	Us exam abdo back wall, comp			S	Q3		
76775	Us exam abdo back wall, lim			S	Q3		
76776	Us exam k transpl w/doppler			S	Q3		
76813	Ob us nuchal meas, 1 gest	00266	00265				
76825	Echo exam of fetal heart	00266	00269				
76826	Echo exam of fetal heart	00265	00697				
76831	Echo exam, uterus			S	Q3		
76856	Us exam, pelvic, complete			S	Q3		
76857	Us exam, pelvic, limited			S	Q3		
76870	Us exam, scrotum			S	Q3		
76936	Echo guide for artery repair	00000	00096	N	S		
76975	GI endoscopic ultrasound			Q	Q2		
77053	X-ray of mammary duct			Q	Q2		
77054	X-ray of mammary ducts			Q	Q2		
77076	X-rays, bone survey, infant	00260	00261				
77084	Magnetic image, bone marrow	00335	00336				
77310	Teletx isodose plan intermed	00305	00304				
77406	Radiation treatment delivery	00300	00301				
77778	Apply interstit radiat compl			Q	Q3		
78801	Tumor imaging, mult areas	00406	00414				
86486	Skin test, nos antigen	00000	00341	A	X		
86891	Autologous blood, op salvage	00346	00345				
86904	Blood typing, patient serum	00346	00345				
86920	Compatibility test, spin	00346	00345				
86972	RBC pretreatment	00346	00345				
86977	RBC pretreatment, serum	00346	00347				
88108	Cytopath, concentrate tech	00343	00433				
88162	Cytopath smear, other source	00343	00433				
88187	Flowcytometry/read, 2-8	00433	00342				
88188	Flowcytometry/read, 9-15	00433	00343				
88311	Decalcify tissue	00433	00342				
88319	Enzyme histochemistry	00433	00344				
88333	Intraop cyto path consult, 1	00343	00433				
88358	Analysis, tumor	00344	00343				
88361	Tumor immunohistochem/comput	00344	00343				
89049	Chct for mal hyperthermia	00343	00342				
89220	Sputum specimen collection	00343	00433				
90296	Diphtheria antitoxin	00000	01212	N	K		
90378	Rsv ig, im, 50mg	00000	09003	E	K	28	N/A
90471	Immunization admin	00437	00436				
90665	Lyme disease vaccine, im	00000	01216	N	K		
90708	Measles-rubella vaccine, sc	09141	00000	K	N		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90801	Psy dx interview			Q	Q3		
90802	Intac psy dx interview			Q	Q3		
90804	Psytx, office, 20-30 min			Q	Q3		
90805	Psytx, off, 20-30 min w/e&m			Q	Q3		
90806	Psytx, off, 45-50 min			Q	Q3		
90807	Psytx, off, 45-50 min w/e&m			Q	Q3		
90808	Psytx, office, 75-80 min			Q	Q3		
90809	Psytx, off, 75-80, w/e&m			Q	Q3		
90810	Intac psytx, off, 20-30 min			Q	Q3		
90811	Intac psytx, 20-30, w/e&m			Q	Q3		
90812	Intac psytx, off, 45-50 min			Q	Q3		
90813	Intac psytx, 45-50 min w/e&m			Q	Q3		
90814	Intac psytx, off, 75-80 min			Q	Q3		
90815	Intac psytx, 75-80 w/e&m			Q	Q3		
90816	Psytx, hosp, 20-30 min	00322	00000	Q	P		
90817	Psytx, hosp, 20-30 min w/e&m	00322	00000	Q	P		
90818	Psytx, hosp, 45-50 min	00323	00000	Q	P		
90819	Psytx, hosp, 45-50 min w/e&m	00323	00000	Q	P		
90821	Psytx, hosp, 75-80 min	00323	00000	Q	P		
90822	Psytx, hosp, 75-80 min w/e&m	00323	00000	Q	P		
90823	Intac psytx, hosp, 20-30 min	00322	00000	Q	P		
90824	Intac psytx, hsp 20-30 w/e&m	00322	00000	Q	P		
90826	Intac psytx, hosp, 45-50 min	00323	00000	Q	P		
90827	Intac psytx, hsp 45-50 w/e&m	00323	00000	Q	P		
90828	Intac psytx, hosp, 75-80 min	00323	00000	Q	P		
90829	Intac psytx, hsp 75-80 w/e&m	00323	00000	Q	P		
90845	Psychoanalysis			Q	Q3		
90846	Family psytx w/o patient			Q	Q3		
90847	Family psytx w/patient			Q	Q3		
90849	Multiple family group psytx			Q	Q3		
90853	Group psychotherapy			Q	Q3		
90857	Intac group psytx			Q	Q3		
90862	Medication management			Q	Q3		
90865	Narcosynthesis			Q	Q3		
90880	Hypnotherapy			Q	Q3		
90899	Psychiatric service/therapy			Q	Q3		
90945	Dialysis, one evaluation	00170	00607	S	V		
91122	Anal pressure record	00164	00156				
92626	Eval aud rehab status	00365	00366				
93041	Rhythm ECG, tracing	00099	00035	S	X		
93224	ECG monitor/report, 24 hrs			B	M	62	72
93227	ECG monitor/review, 24 hrs			B	M	62	72
93230	ECG monitor/report, 24 hrs			B	M	62	72
93233	ECG monitor/review, 24 hrs			B	M	62	72
93235	ECG monitor/report, 24 hrs			B	M	62	72
93237	ECG monitor/review, 24 hrs			B	M	62	72
93268	ECG record/review			B	M	62	72
93271	Ecg/monitoring and analysis	00663	00692				
93272	Ecg/review, interpret only			B	M	62	72
93307	Tte w/o doppler, complete	00269	00697				
93619	Electrophysiology evaluation			Q	Q3		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
93620	Electrophysiology evaluation			Q	Q3		
93650	Ablate heart dysrhythm focus			Q	Q3		
93651	Ablate heart dysrhythm focus			Q	Q3		
93652	Ablate heart dysrhythm focus			Q	Q3		
94060	Evaluation of wheezing	00368	00078	X	S		
94250	Expired gas collection	00367	00368				
94453	Hast w/oxygen titrate	00367	00368				
94644	Cbt, 1st hour	00078	00340	S	X		
94645	Cbt, each addl hour	00078	00340	S	X		
94750	Pulmonary compliance study	00368	00367				
94762	Measure blood oxygen level			Q	Q1		
95117	Immunotherapy injections	00437	00436				
95145	Antigen therapy services	00437	00436				
95146	Antigen therapy services	00437	00438				
95147	Antigen therapy services	00437	00438				
95149	Antigen therapy services	00437	00439				
95165	Antigen therapy services	00437	00436				
95170	Antigen therapy services	00437	00436				
95869	Muscle test, thor paraspinal	00218	00215				
95921	Autonomic nerv function test	00218	00215				
95922	Autonomic nerv function test	00218	00215				
95972	Analyze neurostim, complex	00663	00692				
95973	Analyze neurostim, complex	00663	00692				
95974	Cranial neurostim, complex	00663	00692				
95979	Analyz neurostim brain addon	00663	00692				
95990	Spin/brain pump refil & main	00125	00440	T	S		
95991	Spin/brain pump refil & main	00125	00440	T	S		
96101	Psycho testing by psych/phys			Q	Q3		
96102	Psycho testing by technician			Q	Q3		
96103	Psycho testing admin by comp			Q	Q3		
96110	Developmental test, lim			Q	Q3		
96111	Developmental test, extend			Q	Q3		
96116	Neurobehavioral status exam			Q	Q3		
96118	Neuropsych tst by psych/phys			Q	Q3		
96119	Neuropsych testing by tec			Q	Q3		
96120	Neuropsych tst admin w/comp			Q	Q3		
96150	Assess hlth/behave, init			Q	Q3		
96151	Assess hlth/behave, subseq			Q	Q3		
96152	Intervene hlth/behave, indiv			Q	Q3		
96153	Intervene hlth/behave, group			Q	Q3		
96154	Interv hlth/behav, fam w/pt			Q	Q3		
96401	Chemo, anti-neopl, sq/im	00438	00437				
96402	Chemo hormon antineopl sq/im	00438	00437				
96405	Chemo intralesional, up to 7	00438	00437				
96411	Chemo, iv push, addl drug	00439	00438				
96413	Chemo, iv infusion, 1 hr	00441	00440				
96415	Chemo, iv infusion, addl hr	00438	00437				
96416	Chemo prolong infuse w/pump	00441	00440				
96422	Chemo ia infusion up to 1 hr	00441	00440				
96425	Chemotherapy,infusion method	00441	00440				
96440	Chemotherapy, intracavitary	00441	00440				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
96445	Chemotherapy, intracavitary	00441	00440				
96450	Chemotherapy, into CNS	00441	00440				
96522	Refill/maint pump/resvr syst	00440	00439				
96523	Irrig drug delivery device			Q	Q1		
96542	Chemotherapy injection	00438	00439				
97602	Wound(s) care non-selective	00015	00013				
97606	Neg press wound tx, > 50 cm	00015	00013				
99205	Office/outpatient visit, new			Q	Q3		
99215	Office/outpatient visit, est			Q	Q3		
99251	Inpatient consultation			C	M	N/A	72
99252	Inpatient consultation			C	M	N/A	72
99253	Inpatient consultation			C	M	N/A	72
99254	Inpatient consultation			C	M	N/A	72
99255	Inpatient consultation			C	M	N/A	72
99284	Emergency dept visit			Q	Q3		
99285	Emergency dept visit			Q	Q3		
99291	Critical care, first hour			Q	Q3		
A9527	Iodine I-125 sodium iodide			H	U		
C1716	Brachytx, non-str, Gold-198			H	U		
C1717	Brachytx, non-str,HDR Ir-192			H	U		
C1719	Brachytx, NS, Non-HDRIr-192			H	U		
C1821	Interspinous implant	01821	00000	H	N		
C2616	Brachytx, non-str,Yttrium-90			H	U		
C2634	Brachytx, non-str, HA, I-125			H	U		
C2635	Brachytx, non-str, HA, P-103			H	U		
C2636	Brachy linear, non-str,P-103			H	U		
C2638	Brachytx, stranded, I-125			H	U		
C2639	Brachytx, non-stranded,I-125			H	U		
C2640	Brachytx, stranded, P-103			H	U		
C2641	Brachytx, non-stranded,P-103			H	U		
C2642	Brachytx, stranded, C-131			H	U		
C2643	Brachytx, non-stranded,C-131			H	U		
C2698	Brachytx, stranded, NOS			H	U		
C2699	Brachytx, non-stranded, NOS			H	U		
C8900	MRA w/cont, abd			S	Q3		
C8901	MRA w/o cont, abd			S	Q3		
C8902	MRA w/o fol w/cont, abd			S	Q3		
C8903	MRI w/cont, breast, uni			S	Q3		
C8904	MRI w/o cont, breast, uni			S	Q3		
C8905	MRI w/o fol w/cont, brst, un			S	Q3		
C8906	MRI w/cont, breast, bi			S	Q3		
C8907	MRI w/o cont, breast, bi			S	Q3		
C8908	MRI w/o fol w/cont, breast,			S	Q3		
C8909	MRA w/cont, chest			S	Q3		
C8910	MRA w/o cont, chest			S	Q3		
C8911	MRA w/o fol w/cont, chest			S	Q3		
C8912	MRA w/cont, lwr ext			S	Q3		
C8913	MRA w/o cont, lwr ext			S	Q3		
C8914	MRA w/o fol w/cont, lwr ext			S	Q3		
C8918	MRA w/cont, pelvis			S	Q3		
C8919	MRA w/o cont, pelvis			S	Q3		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
C8920	MRA w/o fol w/cont, pelvis			S	Q3		
C8957	Prolonged IV inf, req pump	00441	00440				
C9352	Neuragen nerve guide, per cm	09350	00000	G	N		
C9353	Neurawrap nerve protector,cm	01169	00000	G	N		
C9725	Place endorectal app	01507	00148	S	T		
C9726	Rxt breast appl place/remov	01508	00028	S	T		
C9727	Insert palate implants	01510	00252	S	T		
C9728	Place device/marker, non pro	00156	00310	T	X		
G0175	OPPS Service,sched team conf	00608	00606				
G0364	Bone marrow aspirate &biopsy	00002	00340	T	X		
G0379	Direct admit hospital observ			Q	Q3		
G0380	Lev 1 hosp type B ED visit	00604	00626				
G0381	Lev 2 hosp type B ED visit	00605	00627				
G0382	Lev 3 hosp type B ED visit	00606	00628				
G0383	Lev 4 hosp type B ED visit	00607	00629				
G0384	Lev 5 hosp type B ED visit	00608	00616	V	Q3		
J0129	Abatacept injection			G	K		
J0132	Acetylcysteine injection	00000	01186	N	K		
J0190	Inj biperiden lactate/5 mg	00998	00000	K	N		
J0348	Anidulafungin injection			G	K		
J0350	Injection anistreplase 30 u	01606	00000	K	N		
J0400	Aripiprazole injection	01165	00000	K	N		
J0470	Dimecaprol injection	00000	01206	N	K		
J0550	Penicillin g benzathine inj	00000	01217	N	K		
J0630	Calcitonin salmon injection	00000	01220	N	K		
J0894	Decitabine injection			G	K		
J1212	Dimethyl sulfoxide 50% 50 ML	00000	01221	N	K		
J1324	Enfuvirtide injection	00767	00000	K	N		
J1455	Foscarnet sodium injection	00000	01189	N	K		
J1740	Ibandronate sodium injection			G	K		
J1743	Idursulfase injection			G	K		
J2170	Mecasermin injection	00805	00000	K	N		
J2248	Micafungin sodium injection			G	K		
J2323	Natalizumab injection			G	K		
J2460	Oxytetracycline injection	00000	01211	N	K		
J2513	Pentastarch 10% solution	00880	01222				
J2515	Pentobarbital sodium inj	00000	01223	N	K		
J2778	Ranibizumab injection			G	K		
J2805	Sincalide injection	00000	01224	N	K		
J2940	Somatrem injection	02940	01225				
J2995	Inj streptokinase /250000 IU	00911	01226				
J3243	Tigecycline injection			G	K		
J3350	Urea injection	09051	01227				
J3400	Triflupromazine hcl inj	00000	01218	N	K		
J3473	Hyaluronidase recombinant	00806	01228	G	K		
J7191	Factor VIII (porcine)	00000	01208	N	K		
J7197	Antithrombin iii injection	00930	00000	K	N		
J7516	Cyclosporin parenteral 250mg	00000	01204	N	K		
J8600	Melphalan oral 2 MG	00882	00000	K	N		
J8650	Nabilone oral	00808	01230				
J9040	Bleomycin sulfate injection	00748	00000	K	N		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
J9045	Carboplatin injection	00811	00000	K	N		
J9165	Diethylstilbestrol injection	00000	01209	N	K		
J9212	Interferon alfacon-1 inj	00912	00000	K	N		
J9270	Plicamycin (mithramycin) inj	01041	01231				
J9280	Mitomycin 5 MG inj	00862	01232				
J9290	Mitomycin 20 MG inj	00941	01233				
J9291	Mitomycin 40 MG inj	00942	01234				
J9303	Panitumumab injection			G	K		
J9357	Valrubicin injection	09167	01235				
L8685	Implt nrostm pls gen sng rec			B	N	62	N/A
L8686	Implt nrostm pls gen sng non			B	N	62	N/A
L8687	Implt nrostm pls gen dua rec			B	N	62	N/A
L8688	Implt nrostm pls gen dua non			B	N	62	N/A
L8690	Aud osseo dev, int/ext comp	01032	00000	H	N		
M0064	Visit for drug monitoring			Q	Q3		
P9010	Whole blood for transfusion			K	R		
P9011	Blood split unit			K	R		
P9012	Cryoprecipitate each unit			K	R		
P9016	RBC leukocytes reduced			K	R		
P9017	Plasma 1 donor frz w/in 8 hr			K	R		
P9019	Platelets, each unit			K	R		
P9020	Plaelet rich plasma unit			K	R		
P9021	Red blood cells unit			K	R		
P9022	Washed red blood cells unit			K	R		
P9023	Frozen plasma, pooled, sd			K	R		
P9031	Platelets leukocytes reduced			K	R		
P9032	Platelets, irradiated			K	R		
P9033	Platelets leukoreduced irrad			K	R		
P9034	Platelets, pheresis			K	R		
P9035	Platelet pheres leukoreduced			K	R		
P9036	Platelet pheresis irradiated			K	R		
P9037	Plate pheres leukoredu irrad			K	R		
P9038	RBC irradiated			K	R		
P9039	RBC deglycerolized			K	R		
P9040	RBC leukoreduced irradiated			K	R		
P9043	Plasma protein fract,5%,50ml			K	R		
P9044	Cryoprecipitatereducedplasma			K	R		
P9048	Plasmaprotein fract,5%,250ml			K	R		
P9050	Granulocytes, pheresis unit			K	R		
P9051	Blood, l/r, cmv-neg			K	R		
P9052	Platelets, hla-m, l/r, unit			K	R		
P9053	Plt, pher, l/r cmv-neg, irr			K	R		
P9054	Blood, l/r, froz/degly/wash			K	R		
P9055	Plt, aph/pher, l/r, cmv-neg			K	R		
P9056	Blood, l/r, irradiated			K	R		
P9057	RBC, frz/deg/wsh, l/r, irrad			K	R		
P9058	RBC, l/r, cmv-neg, irrad			K	R		
P9059	Plasma, frz between 8-24hour			K	R		
P9060	Fr frz plasma donor retested			K	R		
Q0165	Prochlorperazine maleate10mg			B	N	62	N/A
Q0168	Dronabinol 5mg oral			B	N	62	N/A

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
Q0170	Promethazine HCl 25 mg oral			B	N	62	N/A
Q0172	Chlorpromazine HCl 25mg oral			B	N	62	N/A
Q0176	Perphenazine 8mg oral			B	N	62	N/A
Q0178	Hydroxyzine pamoate 50mg			B	N	62	N/A
Q2009	Fosphenytoin, 50 mg	07028	00000	K	N		

Hcpcs Edit Changes

The following code(s) were added to the list of male procedures, **effective 01-01-09**

Hcpcs
55706
G0416
G0417
G0418
G0419

The following code(s) were removed from the list of female procedures, **effective 01-01-08**

Hcpcs
J1051

HCPCS Approval and/or Termination Date Changes

The following code(s) had approval and /or termination date changes

HCPCS	Old ApprovalDt	New ApprovalDt	Old TerminationDt	New TerminationDt
90681	0	20080403		
90696	0	20080624		
0062T			0	20080928
0063T			0	20080928
22526			0	20080928
22527			0	20080928

Edit Assignments

The following code(s) were added to edit 67, 68, 69 or 83 **effective 04-01-08**

HCPCS	Edit#	ActivDate	TermDate
90681	67	20080403	
90696	67	20080624	

The following code(s) were added to edit 67, 68, 69 or 83 **effective 07-01-08**

HCPCS	Edit#	ActivDate	TermDate
0062T	83		20080928
0063T	83		20080928

HCPCS	Edit#	ActivDate	TermDate
22526	83		20080928
22527	83		20080928

The following code(s) were added to Deductible n/a, **effective 07-01-03**

HCPCS
Q0091

The following code(s) were added to Deductible n/a, **effective 01-01-09**

HCPCS
G0402

The following code(s) were added to the conditional bilateral list, **effective 01-01-09**

HCPCS
15878
15879

The following code(s) were removed from the independent bilateral list, **effective 01-01-08**

HCPCS
76645

The following code(s) were added to the inherently bilateral list, **effective 01-01-08**

HCPCS
76645

Radiolabeled product Changes

The following code(s) were added to the radiolabeled product list, **effective 01-01-09**

HCPCS
A9580
C9247

Edit Assignments

The following code(s) were added to the lab/pathology list, **effective 01-01-09**

HCPCS
83876
83951
85397
87905
88720
88740

HCPCS
88741

Mental Health Changes

The following code(s) were added to the mental health list that are not approved for the partial hospitalization program, **effective 01-01-09**

HCPCS
90849
90853
90857
90899

The following code(s) were added to the mental health list that are not payable outside the partial hospitalization program, **effective 01-01-09**

HCPCS
90816
90817
90818
90819
90821
90822
90823
90824
90826
90827
90828
90829
G0410
G0411

Procedure/ Device Pair Changes

The following procedure/device code pair requirements were added, **effective 01-01-09**

Proc	Device1
51715	L8604
61885	L8685
61885	L8686
61886	L8688
63685	L8685
63685	L8686
63685	L8687
63685	L8688
64590	L8685
64590	L8686
64590	L8687

Proc	Device1
64590	L8688
69714	L8690
69715	L8690
69717	L8690
69718	L8690

Device/Procedure Pair Changes

The following device/procedure code pair requirements were added, **effective 01-01-09**

Device	Proc
L8685	61885
L8685	63685
L8685	64590
L8686	61885
L8686	63685
L8686	64590
L8687	63685
L8687	64590
L8688	61886
L8688	63685
L8688	64590
L8690	69714
L8690	69715
L8690	69717
L8690	69718

MODIFIERS

Added Modifiers

The following modifier(s) were added to the list of valid modifiers, **effective 01-01-09**

modif	ACTIVATIONDATE
JC	0
JD	0
KE	0
RA	0
RB	0
RE	0

Deleted Modifiers

The following modifier(s) were deleted from the list of valid modifiers, **effective 01-01-09**

modif	ACTIVATIONDATE
RP	0

REVENUE CODES

Revenue Code Status Indicator Changes

The following revenue code(s) had Status Indicator changes, **effective 01-01-09**

RevenueCode	Old SI	New SI
0583	Z	B
0832	Z	B
0834	Z	B
0835	Z	B
0842	Z	B
0843	Z	B
0844	Z	B
0845	Z	B
0852	Z	B
0853	Z	B
0854	Z	B
0855	Z	B
0882	Z	B