

Integrated OCE (IOCE) CMS Specifications V17.2

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Summary of Quarterly Release Modifications

The modifications of the IOCE for the July 2016 v17.2 release are summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some IOCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

#	Type	Effective Date	Edits Affected	Modification
1	Logic	7/1/2016	24	Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. The earliest date included for this release is 10/1/2009.
2	Logic	7/1/2016	95, 96, 97	Implement new edits under the partial hospitalization program logic for weekly hours of service requirements: <ul style="list-style-type: none"> - Edit 95: Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service (RTP) <u>Criteria:</u> A PHP claim From and Through date spans 4 or more days, but less than 8 days, and there are less than 20 hours of services present. - Edit 96: Partial hospitalization interim claim From and Through dates must span more than 4 days (RTP) <u>Criteria:</u> An interim PHP claim (bill type 763 or 133 with condition code 41) From and Through date spans less than 5 days. - Edit 97: Partial hospitalization services are required to be billed weekly (RTP) <u>Criteria:</u> A PHP claim From and Through date spans more than 7 days. See special processing logic under OPPS (page 7), Appendix C-a (Weekly PHP flowchart) and Appendix F(a) (OPPS edits applied by bill type).
3	Logic	1/1/2016	98	Implement new edit 98: Claim with pass-through device, drug or biological lacks required procedure (RTP). <u>Criteria:</u> A pass-through device, drug or biological HCPCS code is present without an associated, required procedure. See special processing logic under OPPS (page 13), Appendix P (flowchart) and Appendix F(a).
4	Logic	1/1/2015		Add program logic to exclude certain blood products (packed red cells and whole blood) from packaging if reported on a comprehensive APC claim (see special processing logic under OPPS, page 9 and Appendix L).
5	Logic	4/5/2016	67	Apply mid-quarter FDA approval date for HCPCS code Q5102.
6	Logic	4/1/2016	94	Apply the edit if new biosimilar HCPCS code Q5102 is reported without the associated new modifier ZB.
7	Logic	7/1/2016	87	Updates to the skin substitute list (Appendix O: move Q4164 from low cost to high cost).
8	Logic	1/1/2016	92	Updates to the device and device procedure lists.
9	Logic and Field Definition	1/1/2016		Change the program logic to provide unique Payer Value Code QU when a condition for device credit is present, reported with condition code 49, 50 or 53 (see special processing logic under OPPS, page 9 and Table 5).
10	Documentation	1/1/2016		Update Appendix L (Comprehensive APC processing) under the inpatient procedure where the patient expired logic to note non-covered SI values are returned as excluded from packaging under comprehensive APCs, but any associated edits are not returned (documentation only, no change to program logic).
11	Documentation	1/1/2015	45	Update the reference on page 8 to indicate the change made for edit 45 to include SI = J1 procedures is retroactive to 1/1/2015 (documentation only, no change to program logic).
12	Documentation	7/1/2016		Update Table 2 with reference information for the reporting of modifiers.
13	Documentation	1/1/2016		Updated special processing logic on page 9 to include reference to the use of the complexity-adjusted comprehensive APC as the look-up for device credit amount when condition code 49, 50 or 53 are present (documentation only, no change to program logic).
14	Content	4/1/2016	22	Add modifier ZB (Pfizer/Hospira) to the list of valid modifiers.
15	Content	1/1/2015		Modify the valid revenue list for revenue code 940 (Other therapeutic services) to have SI value changed to N if reported with a blank HCPCS code.
16	Content	7/1/2016		Update the following lists for the release (see quarterly data files): <ul style="list-style-type: none"> - Questionable covered service list (edit 12) - Valid revenue code list - Revised files for pass-through offset conditions (edit 98) - Device and device-procedure lists (edit 92) - Skin substitute product lists (edit 87) - Non-covered procedure list (edit 9)
17	Content	7/1/2016		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
18	Content	7/1/2016	20, 40	Implement version 22.2 of the NCCI (as modified for applicable outpatient institutional providers).
19	Other	7/1/2016		Create 508-compliant versions of the Specifications and Summary of Data Changes documents for publication on the CMS web site. Provide MF and PC IOCE software and supporting quarterly data file reports for publication on the CMS web site.
20	Other	7/1/2016		Deliver quarterly software update and all related documentation and files to users via electronic means.

Introduction

This 'integrated' OCE (IOCE) 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 Medicare Administrative Contractor (MAC) identify the claim as 'OPPS' or 'Non-OPPS' by passing a flag to the IOCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

This version of the IOCE processes claims consisting of multiple days of service. The IOCE performs three major functions:

1. Edit the data to identify errors and return a series of edit flags.
2. 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.
3. 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 is represented by a collection of data, which consists of all necessary demographic (header) data, plus all services provided (line items). It is the user's responsibility to organize all applicable services into a single claim record, and pass them as a unit to the IOCE. The IOCE only functions on a single claim and does not have any cross claim capabilities. The IOCE accepts up to 450 line items per claim. The IOCE software is responsible for ordering line items by date of service.

The IOCE 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 IOCE 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 IOCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers and ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for historical claims with From Dates prior to 10/1/2015). Since these coding systems are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program reduces effort and reduces the chance of inconsistent processing.

The span of time that a claim represents is controlled by the **From** and **Through** dates that are part of the input header information. If the claim spans more than one calendar day, the IOCE subdivides 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.

The Control Block

Information is passed to the IOCE by means of a control block of pointers. Table 1 contains the structure of the IOCE control block. The shaded area separates input from return information. Multiple items are assumed to be in contiguous locations. The input for each line item contains the information described in Table 2.

Table 1: IOCE Control Block

Pointer Name	Pointer Description	UB-04 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for historical claims with From dates prior to 10/1/2015)	70 a-c (Pt's rvdx) 67 (pdx) 67A-Q (sdx)	Up to 28	8 (7 for code, 1 for POA flag)	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First three listed diagnoses are considered 'patient's reasons for visit dx', fourth diagnosis is considered 'principal dx'
Ndxptr	Count of the number of diagnoses pointed to by <i>Dxptr</i>		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 <i>Sgptr</i>		1	4	Binary fullword count
Flagptr	Line item action flag Flag set by 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 11	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 MAC use
NOccptr	Count of number of occurrence codes		1	4	Binary fullword count
CodeTypePtr	Code Type indicator	-	1	1	0=ICD10 Dx; 9=ICD9 Dx; blank or any other value uses <i>From</i> date to determine Dx code type. (Note: Deactivated as of 10/1/2015; the claim <i>From</i> Date is used to determine which diagnosis code set is applied.)
Dxeditptr	Diagnosis edit return buffer		Up to 28	Table 3	Count specified in <i>Ndxptr</i>
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Count specified in <i>Nsgptr</i>
Meditptr	Modifier edit return buffer		Up to 450	Table 3	Count specified in <i>Nsgptr</i>
Dteditptr	Date edit return buffer		Up to 450	Table 3	Count specified in <i>Nsgptr</i>
Rceditptr	Revenue code edit return buffer		Up to 450	Table 3	Count specified in <i>Nsgptr</i>
APCptr	APC/ASC return buffer		Up to 450	Table 7	Count specified in <i>Nsgptr</i>
Claimptr	Claim return buffer		1	Table 5	
Wkptr	Work area pointer		1	1.25 MB	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by <i>Wkptr</i>		1	4	Binary fullword

Table 2: Line item input information

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	May be blank; up to 5, 2-character modifiers allowed per single line item; validated in the order received
Service date	45	1	8	Required for all lines
Revenue code	42	1	4	Required for all lines
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

Edit Dispositions

For a list of the current edits returned in the IOCE, see Table 4 (Edit Descriptions). The occurrence of an edit can result in one of six different dispositions.

Disposition	Description
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 cannot 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 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 Denial	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 IOCE, many of the edits had a disposition of RTP in order to give providers time to adapt to OPPS. In subsequent releases of the IOCE, 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 (see Table 5).

Special processing conditions currently applied only to OPPTS 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 to N. 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.

Effective 1/1/2011, different PHP APCs, Level I and Level II, are assigned for hospital-based and for CMHC partial hospitalization programs.

If less than the minimum amount (number and type) 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 are denied, no PHP APC is assigned. Note: Any non-PHP services on the same day are processed according to the usual OPPTS 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 PHP claim (13x TOB with condition code 41 or TOB 76x), the claim is returned to the provider.

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

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

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

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

3. Through IOCE version 16.3, 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.

Effective January 1, 2016 (v17.0), if an inpatient-only procedure is present for a patient who expires (modifier CA on the inpatient procedure and patient status code = 20), the inpatient procedure is assigned under a comprehensive APC (SI = J1), and all other services reported on the claim are packaged (SI = N), except for those items excluded under comprehensive APC processing (see Appendix L).

4. Inpatient-only procedures that are on the separate-procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T, or effective 1/1/2015, if reported on a claim with a comprehensive APC procedure (SI = J1). The line(s) with the inpatient-separate procedure is rejected 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. [v6.1 – v15.3]

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

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

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), and effective 1/1/2016 (v17.0), may be used to assign the Comprehensive Observation APC (see Appendix L).

8. Direct referral from a physician in the community to a hospital for observation care may be used in the assignment of the Comprehensive Observation APC (effective v17.0), an extended assessment and management composite, packaged into T, V or critical care service procedure if present; otherwise, the direct referral is processed as a medical visit (see Appendix K-b). Direct referral for observation that is denied or rejected is not included in any subsequent special direct referral logic, and the default SI is retained as the final SI.

Exception: If LIAF = 1 has been assigned to the line, the denial/rejection is ignored, the line is included in subsequent direct referral logic, and that logic determines the final SI.

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).

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

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 IOCE changes the status indicator to A and removes 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 IOCE applies the appropriate payment adjustment flag (corresponding to the FB or FC modifier) to the procedure line. The IOCE also reduces the APC rate by the full offset amount (for FB), or by 50% of the offset amount (for FC) before determining the highest rate for multiple or terminated procedure discounting. If the modifier is used inappropriately (appended to procedure with SI other than S, T, X, V or Q3), the claim is returned to the provider [edit 75, v8.0 – 14.3]. If both the FB and FC modifiers are appended to the same line, the FB modifier takes precedence and the full offset reduction is applied [v10.0 - v14.3].

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

For a specified procedure pair (implantation of an implantable cardioverter defibrillator with pacing electrode (CRT-D)), 33249 and 33225 – the SIs for 33249 and 33225 is changed from Q3 to the specified SI/APC for standard OPPS processing when they do not appear on the same claim with the same date of service. When both procedures are submitted together on the same date of service, the primary procedure is assigned to the standard APC for payment and the secondary procedure is packaged. [v13.0 – v15.3]

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

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

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

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 payable code with status indicator of S, T, V or X (STVX-packaged, SI = Q1); other codes are packaged only in the presence of payable codes with status indicator T (T-packaged, SI = Q2). The OCE changes the SI from Q (#) to N for packaging, or to the 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 is paid. All other codes are packaged. Units of service = 1 is assigned to any line where an SI of Q1 or Q2 (S, T, V, X/T-packaged code) is changed to a separately payable SI and APC.

If any STVX-packaged or T-packaged independent bilateral or conditional bilateral code with modifier 50 is paid separately, the modifier is ignored in assigning the discount formula.

STVX/T-packaged codes (Q1, Q2) that are denied or rejected are not included in any subsequent special packaging logic. The default SI (Q1, Q2) is retained as the final SI.

Exception: If LIAF = 1 has been assigned to the line, the denial/rejection is ignored, the line is included in subsequent special packaging logic and that logic determines the final SI).

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 N), codes with SI of Q3 (composite candidates) are evaluated using the status indicator associated with their standard APC.

Effective 10/1/09, codes with SI of S, T, V or X that have been denied or rejected, are ignored in subsequent special S, T, V, X/T logic for packaging Q1 or Q2 codes. If no payable S, T, V or X code is present, the Q1 or Q2 code is processed for separate payment.

Effective 1/1/2015 (v16.0), SI of X is deactivated; codes previously assigned to SI of X are reassigned to SI of Q1 or S. For the purposes of executing this special conditional packaging logic, codes assigned to SI of Q1 are packaged in the presence of any payable code with SI of S, T or V (STV-packaged codes).

Effective 7/1/2015 (v16.2), Payment Adjustment Flag 11 is assigned when the OCE reduces the service units to one for conditionally packaged codes with SI = Q1 or Q2 that have the SI changed to a separately payable SI and 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 is 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 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 OPSS processing (see Appendix K). Some composites may 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 radiolabeled products. If any specified nuclear medicine procedure is submitted without a code for one of the specified radiolabeled products on the same claim, the claim is returned to the provider [v9.0 – v14.3].
16. OPSS claims for managed care beneficiaries, as identified by the MAC (Payer only condition code MA – Managed Care enrollee), are not subject to line level deductible.
17. In order to allow the MAC to process and pay for certain services on Hospice claims, any HCPCS code with status indicator M that is submitted with revenue code 657 on 81x or 82x bill types have the status indicator changed from M to A; the claim is not returned to the provider.

Effective 10/1/2014, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis on hospice claims. Hospice claims submitted with a manifestation code as principal diagnosis are returned to the provider (edit 86).

18. Certain ancillary services are packaged if submitted on the same date of service as the critical care E&M code (99291). If code 99291 is present with any of the specified ancillary procedure codes, the IOCE changes the SI of the ancillary procedure code from Q[#] to N for packaging. Exception: If code 99291 is present and modifier 59 is also present on any line with the same date of service, the specified ancillary codes are not packaged; the SI is changed to the standard SI and APC specified for the code. If 99291 is not present on the same date of service, the SI for the ancillary procedure is changed to the standard SI and APC specified for the code when separately payable.

Critical care-packaged codes 36600 and 94762 are not subject to the modifier 59 exception and always package when present with critical care code 99291. If reported in absence of 99291, 36600 (SI = Q1) and 94762 (SI = Q3) conditionally package with STV-procedures, or assign the standard APC and SI for separate payment.

Effective January 1, 2016 (v17.0), if critical care code 99291 is present and the claim meets the criteria for assignment under the Comprehensive Observation APC, the exception for the presence of modifier 59 does not occur; all ancillary, adjunctive services are packaged under the Comprehensive Observation APC.

19. Deductible and co-insurance are waived for certain preventive services (see Appendix G for the specified payment adjustment flag values and Appendix O for the list of preventive services), and for any services submitted with modifier Q3 (Live kidney donor surgery and related services) on the line.

Deductible is waived for all services coded in the CPT range 10000 – 69999, on any day/date of service when modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) is also present on a valid code in the same range on the claim. The IOCE sets the specified payment adjustment flag on the line, except when any other payment adjustment flag is already applied to the same line (see Appendix G).

20. Certain claims are returned to the provider if a specified add-on code is submitted without a code for a required primary procedure on the same date of service (edit 84).
21. Claims are returned to the provider if the surgical procedure to insert the ocular telescope prosthesis is submitted without the code for the telescopic intraocular lens, or vice versa, on the same date of service (edit 85). Discontinued insertion procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing telescopic lens code [v13.0 – v14.3].
22. Certain skin substitute products are separately paid, based on their standard SI/APC assignment, only when billed with specified skin substitute application procedure codes. If one of the specified application procedure codes is not present on the same date of service as the skin substitute, the skin substitute product is packaged (has its SI changed to N) [v13.0 – v14.3].

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

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

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

Effective January 1, 2016 (v17.0), laboratory codes with SI = Q4 are subject to conditional packaging criteria in determining the final SI assignment, i.e., paid under the clinical lab fee schedule (SI = A), or packaged (SI = N):

- a. For claims with bill type 13x: if the laboratory code(s) with SI Q4 is reported with modifier L1 and is present with other payable OPPS services that have SI = S, T, V, Q1, Q2, or Q3 on the same claim, the SI is changed to A; otherwise the laboratory code(s) is packaged with SI = N. If there are only laboratory codes present, all laboratory codes with SI = Q4 are changed to SI = A.
- b. For claims with bill type 12x without condition code W2, and for claims with bill type 14x: if a laboratory code(s) is present with SI Q4, the SI is changed to A. Laboratory services on claims with bill type 12x that do contain condition code W2 remain packaged (SI = N).

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

24. Effective 1/1/2015 (v16.0), certain high cost procedures (SI = J1) are paid an all-inclusive rate to include all services submitted on the claim. Except for services excluded by statute (ambulance, brachytherapy sources, mammography, preventive care services, pass-through drugs and devices, and procedures paid under reasonable cost), all allowed, adjunctive services submitted on the claim are packaged into the “comprehensive” APC payment rate (i.e., the status indicator is changed to N). Multiple comprehensive procedures, if present on the claim in specified combinations, may be assigned to a higher-paying comprehensive APC representing a complexity adjustment. Services that are excluded from the all-inclusive payment retain their standard APC and SI for standard processing.

Effective January 1, 2016 (v17.0), claims for observation services (SI = J2) meeting specified criteria (see Appendix L) are paid under a single Comprehensive Observation C-APC payment rate, to include all services submitted on the claim. The same exception criteria for excluded services under high cost procedure comprehensive APCs (SI = J1) apply to the Comprehensive Observation APC, and all allowed adjunctive services submitted on the claim with the

Comprehensive Observation APC are packaged (SI is changed to N). If multiple visits are present for qualified Comprehensive Observation C-APC assignment, the visit code with the highest standard APC payment rate is assigned the Comprehensive Observation APC; all other visits are packaged.

Claims reporting an inpatient-only procedure with modifier CA for a patient who expired that also include a comprehensive APC procedure assign the specified inpatient procedure APC as the payable APC for the claim. The comprehensive APC procedure line is assigned to its comprehensive APC, however, the line is packaged with SI = N, along with all other lines on the claim [v15.0 – v16.3].

Effective January 1, 2016 (v17.0), claims reporting an inpatient-only procedure with modifier CA for a patient who expires (patient status = 20) are assigned a Comprehensive APC (SI = J1); all other services reported on the claim are packaged (SI = N), except for those items excluded under Comprehensive APC processing (see Appendix L). Other comprehensive APC services that may be present (SI = J1 or J2) on the same claim as an inpatient-only comprehensive APC procedure are packaged.

Effective January 1, 2016 (v17.0), if SRS (stereotactic radiosurgery) planning and preparation codes are reported on the same claim as the comprehensive APC for SRS, the SRS planning and preparation codes are excluded from packaging and are identified for separate payment.

25. Effective January 1, 2016 (v17.0), Advance Care Planning services (code 99497) reported with the Medicare annual wellness visit (initial or subsequent) are paid under the Medicare Physician Fee Schedule (SI = A); otherwise, advance care planning is subject to conditional packaging (SI = Q1). If advance care planning is reported with no other payable OPPS services, it is paid by APC with SI = V; if reported with other OPPS payable services (SI = S, T, V, J1, J2, Q1, Q2, Q3), it is packaged (SI = N).
26. Effective January 1, 2016 (v17.0), if corneal tissue processing is present (HCPCS V2785) without a cornea transplant procedure, the line reporting corneal tissue processing is rejected (edit 93).
27. Claims with pass-through device HCPCS codes (SI = H) furnished with certain device-intensive procedures require a payment offset to the APC payment rate for the procedure. Effective January 1, 2016 (v17.0), the IOCE shall identify the offset condition for the pass-through device HCPCS and associated device-intensive procedure by providing a unique claim level Payer Value Code (QN), with Value Code amount representing the APC payment offset in the claim return buffer (Table 5). A payment adjustment flag is returned to identify the pass-through device HCPCS line(s) associated with the payment offset; multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through device HCPCS lines present that are associated with the same device-intensive procedure(s) APC. An additional claim level Payer Value Code (QO) and payment adjustment flag value may be returned if there is an additional condition present for a separate device offset on the same claim (see Appendix G).

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

An exception is made for claims containing the comprehensive APC for an inpatient-only procedure reported with modifier CA for a patient who expires that also contain conditions for pass-through device payment offset; the pass-through device payment offset is provided.
28. Effective January 1, 2016 (v17.0), if modifier CT is reported for certain imaging codes for CT scans performed on equipment not meeting NEMA standards, a payment adjustment flag is passed to OPPS Pricer indicating the line is subject to payment reduction. CT scan codes from the specified list that are reported with modifier CT and are packaged (SI = N) due to multiple imaging composite APC assignment or comprehensive APC assignment, do not receive payment adjustment. The first code assigned to a multiple imaging composite APC receives the payment adjustment flag if there are CT scan codes reported with modifier CT that are constituents of the composite APC (i.e., the composite APC line may or may not have modifier CT reported) (see Appendix G and K for additional reference).
29. Effective January 1, 2016 (v17.0), OPPS and non-OPPS claims containing biosimilar HCPCS codes without a corresponding modifier representing the biosimilar manufacturer, are returned to the provider (edit 94).

30. Effective April 1, 2016 (v17.1), claims containing specified pass-through drugs or biologicals furnished with an associated procedure require pass-through payment offset. If conditions exist for pass-through drug or biological payment offset, the IOCE shall provide a unique Payer Value Code with Value Code amount representing the amount of the payment offset. A payment adjustment flag is assigned to the pass-through drug or biological to identify which line(s) is associated with the corresponding Payer Value Code and Value Code amount; multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through drugs or biologicals present that are associated with the same offset condition. Claims that may contain multiple conditions eligible for pass-through drug or biological offset return additional Payer Value Codes and payment adjustment flag values for each condition (see Table 5 and Table 7).

There are four categories of pass-through drug and biological conditions eligible for payment offset: radiopharmaceuticals, skin substitute products, contrast agents and stress agents. Conditions for payment offset for pass-through radiopharmaceuticals reported with an associated nuclear medicine procedure are considered across the claim; otherwise conditions for payment offset for other pass-through drug and biological categories reported with an associated procedure are performed for the same service date. Claims containing pass-through drugs and biologicals that do not report the required, associated procedure are returned to the provider (edit 98).

Special processing conditions for FQHC claims under PPS:

Effective for claims with From Dates on or after October 1, 2014, claims submitted through the IOCE with bill type 77x for Federally Qualified Health Centers (FQHC) shall be processed under the FQHC PPS. FQHC claims shall be paid under a per encounter basis for qualified clinic visits. Any supporting ancillary services provided on the day of the FQHC visit shall be packaged into the encounter payment. If the FQHC claim contains multiple dates of service, each day is processed separately through the IOCE. Special output flag values shall be assigned during FQHC processing under the IOCE to facilitate identification of FQHC payment processing by the Pricer program. (See Table 7: APC Return Buffer and Appendix M: FQHC Criteria and Logic Flowchart for additional details).

The following criteria are used for processing FQHC PPS claims through the IOCE:

1. FQHC encounters require the reporting of both a unique FQHC payment HCPCS code (G0466, G0467, G0468, G0469 or G0470) indicating the type of visit (New or established medical visit, new or established mental health visit, or Initial Preventive Physical Exam/Annual Wellness Visit), and a qualifying visit HCPCS related to the services performed. FQHC claims that do not contain a required FQHC payment code shall be returned to the provider (edit 88). The FQHC payment code must be reported with revenue code 519, 52x or 900. FQHC payment codes reporting revenue codes other than those listed shall be returned to the provider (edit 90). FQHC claims that do not contain both the FQHC payment code and a qualifying visit code are also returned to the provider (edit 89). The FQHC payment code identifies the line where the Pricer program applies the FQHC encounter payment.

FQHC encounters for new patient visits or for the IPPE/AWV are identified by the IOCE for additional payment adjustment by the Pricer program. Only one FQHC payment code per day is identified for the new patient/IPPE/AWV payment adjustment, if the appropriate FQHC visit criteria is met for the new patient or IPPE/AWV FQHC visit, i.e., appropriate FQHC payment HCPCS codes are present and qualifying visit HCPCS codes are present.

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

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

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

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

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

2. Effective January 1, 2016 (v17.0), Grandfathered Tribal FQHC providers are identified by the presence of payer only condition code MG passed to the IOCE on a claim for FQHC PPS services. Claims submitted for Grandfathered Tribal FQHC providers have different encounter requirements than other FQHC PPS providers. Only one visit is payable per day; if multiple visits are present for the same day, the first medical visit (or first mental health visit if no medical visits are reported) is identified to OPSS Pricer for payment; all other visits are packaged (see Appendix M).
3. Preventive services under the FQHC PPS shall be packaged into the FQHC encounter payment; however, line items reporting preventive services are subject to a waiver of coinsurance payment. The IOCE shall identify to the Pricer program the FQHC packaged preventive services by way of a specific packaging flag value 6 (Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment).

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

4. Influenza and pneumococcal vaccines and associated vaccine administration services continue to be paid under reasonable cost through the cost report, and are not packaged into the FQHC encounter payment. If influenza and/or pneumococcal vaccine and vaccine administration is reported on the FQHC claim, the services are identified for the Pricer program as non-packaged services that are excluded from the FQHC encounter payment.
5. Telehealth facility fees continue to be paid by the Medicare physician fee schedule, and are not packaged into the FQHC encounter payment. If telehealth facility fees are reported on the FQHC claim, the service is processed through the IOCE and identified as a non-packaged service for the Pricer program in order to be processed for fee schedule payment. Effective July 1, 2015 (v16.2), Telehealth facility fees reported without a FQHC payment code and qualifying visit code are not returned to the provider.
6. Items or services that are not covered under the FQHC PPS shall be assigned a line item action flag value of 5 by the IOCE, and are excluded from FQHC encounter payment. Line items where the IOCE assigns line item action flag 5 are line item rejected (edit 91). Line items may also be passed into the IOCE with non-covered line item charges with line item action flag 5 previously assigned; these lines are not subject to edit 91.

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

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

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

7. Effective January 1, 2016 (v17.0), Chronic Care Management (CCM) services reported with code 99490 for FQHC PPS claims are paid under the Medicare Physician Fee Schedule and are not packaged into the FQHC encounter. If CCM services are reported, the service is processed through the IOCE and identified as a non-packaged service for the Pricer program in order to be processed for fee schedule payment. CCM services reported without a FQHC payment code and qualifying visit code are not returned to the provider.

Special processing conditions applied 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 assigns 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. (Note: Effective 1/1/08, ASC procedures are no longer identified in the IOCE; in the absence of ASC procedures, all non-OPPS claims are flagged as 'should not be 83x').

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 HHAs 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 O for the specific list of HCPCS codes for reporting antigens, vaccine administration, splints and casts).

National Correct Coding Initiative (NCCI) Edits

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

Effective January 1, 2006, these NCCI edits also apply to ALL services billed under bill types 22X, 23X, 34X, 74X, and 75X, by the following providers: Skilled Nursing Facilities (SNFs), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs), CORFs, and Home Health Agencies (HHAs).

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

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

See Appendix F (a) and F (b) "OCE Edits Applied by Bill Type" for bill types that the IOCE subjects to these and other IOCE edits.

All institutional outpatient claims, regardless of facility type, process through the Integrated Outpatient Code Editor (IOCE)*; however, not all edits are performed for all sites of service or types of claim. Appendix F (a) contains IOCE 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 1/1/2008 (v9.0), claims for 83x bill type are not processed through the IOCE.

Standard APC Processing

The OPPTS 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 indicator 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 IOCE as a means of allowing the MAC to override a line item denial or rejection (used by MAC to override IOCE and have PRICER compute payment ignoring the line item rejection or denial) or allowing the MAC to indicate that the line item should be denied or rejected even if there are no IOCE 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 OPPTS.

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 OPPTS (See Appendix E). OPPTS 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 N summarizes the process of filling in the APC return buffer.

If a claim spans more than one day, the IOCE 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 IOCE 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 OPPTS 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 (NCCI or other edits) are not be included in the composite criteria.

Edits that use status indicator (SI) in their criteria 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 is carried through to the end of processing and is returned as the final SI.

Exception: If LIAF "1" is appended to a line with SI Q(#), the line item denial or rejection is ignored, the line is included in IOCE logic and the IOCE logic determines 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 IOCE to be used, the From date on the header information is used.

Edit and Claim Return Buffers (Tables 3 – 7)

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.

Table 3: Edit Return Buffers

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	0, 1-5, 29, 86	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 28 diagnoses.
Procedure edit return buffer	3	30	0, 6, 8-9, 11-18, 20-21, 28, 30, 35, 37-38, 40, 42-45, 47, 49-50, 52-58, 60-64, 66-74, 76-85, 87, 88, 89, 91, 92, 93, 94, 95, 96, 97, 98	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 <u>line item</u> dates.	There is one 4x3 buffer for each of up to 450 line items.
Revenue center edit return buffer	3	5	0, 9, 41, 48, 50, 65, 90	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 Notes:

1. Revenue center edits: Edit 9: Revenue codes 099x with SI of E when submitted without a HCPCS code (OPPS only); Edit 50: Revenue code 0637 with SI of E when submitted without a HCPCS code (OPPS & Non-OPPS)

Each of the edit 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.

Some of the IOCE edits are inactive for the current version of the program. Each edit is assigned a number and a description of the edits is contained in Table 4.

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

Table 6, a complex table which summarizes the edit return buffers, claim disposition and claim reasons, is removed; this information is available in Tables 3, 4 and 5.

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(#)), the HCPCS APC and the payment APC are always the same. The APC/ASC return buffer contains the information that is 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 4: Edit Descriptions

Edit #	Description	Non OPPS Hosp.	Disposition
1	Invalid diagnosis code	Y	RTP
2	Diagnosis and age conflict	Y	RTP
3	Diagnosis and sex conflict	Y	RTP
4	Medicare secondary payer alert (v1.0-v1.1)		Suspend
5	External cause of morbidity 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 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 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 reject
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 (Disabled – v9.2)	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		Line item denial
19	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (combined with edit 20; # deleted v13.2, retroactive to earliest non-archived version)		Line item reject
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present		Line item reject
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		Claim rejection
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available (See Appendix C for logic for edits 29-36, and 63-64)	Y	Line item reject
29	Partial hospitalization service for non-mental health diagnosis		RTP
30	Insufficient services on day of partial hospitalization		Line item denial
31	Partial hospitalization on same day as ECT or type T procedure (v1.0 – v6.3)		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 (combined with edit 40; # deleted v13.2, retroactive to earliest non-archived version)		Line item reject
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present		Line item reject
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 reject
46	Partial hospitalization condition code 41 not approved for type of bill	Y*	RTP
47	Service is not separately payable		Line item reject
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

Edit #	Description	Non OPPS Hosp.	Disposition
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 reject
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	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 (Edit deleted in v11.2, retroactive to date of establishment or earliest non-archived version).		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) (v1.0 – v13.3)		RTP
64	AT service not payable outside the partial hospitalization program (See Appendix C) (v1.0 – v13.3)		Line item reject
65	Revenue code not recognized by Medicare	Y	Line item reject
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 (v6.1 – v15.3)		RTP
72	Service not billable to the 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	Y*	RTP
75	Incorrect billing of modifier FB or FC (v8.0 – v15.3)		RTP
76	Trauma response critical care code without revenue code 068x and CPT 99291		Line item reject
77	Claim lacks allowed procedure code (v8.1 – v15.3)		RTP
78	Claim lacks required radiolabeled product (v9.0 – v14.3)		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
84	Claim lacks required primary code		RTP
85	Claim lacks required device code or required procedure code (v13.0 – v14.3)		RTP
86	Manifestation code not allowed as principal diagnosis		RTP
87	Skin substitute application procedure without appropriate skin substitute product code		RTP
88	FQHC payment code not reported for FQHC claim		RTP
89	FQHC claim lacks required qualifying visit code		RTP
90	Incorrect revenue code reported for FQHC payment code		RTP
91	Item or service not covered under FQHC PPS or for RHC		Line item reject
92	Device-dependent procedure reported without device code		RTP
93	Corneal tissue processing reported without cornea transplant procedure		LIR
94	Biosimilar HCPCS reported without biosimilar modifier	Y*	RTP
95	Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service		RTP
96	Partial hospitalization interim claim from and through dates must span more than 4 days		RTP
97	Partial hospitalization services are required to be billed weekly		RTP
98	Claim with pass-through device, drug or biological lacks required procedure		RTP

Table 4 Notes:

- 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 exceed the code's limit, 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.
- 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.
- If Edit 27 is triggered, no other edits are performed on the claim.
- Edits 4 and 5 are not applicable for patient's reason for visit diagnosis.
- Edits 3 and 8 (sex conflict edits) are bypassed if condition code 45 is present on the claim.
- Edit 9 is not applied/is bypassed for code G0428 with S1 = E.
- The 'Non-OPPS Hosp.' column is for non-OPPS hospital bill types allowed for the edit condition; Y* = edits apply to Non-OPPS hospital claims.

Table 5: Claim Return Buffer

Item	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*, 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 cannot run - the environment cannot be set up as needed; exit immediately. * Edit 46 terminates processing only for those bill types where no other edits are applied (See Appendix F).
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 4) 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 4) 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, 21-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 50, 52, 54-56, 58, 60-63, 70-75, 77-82, 84- 90, 92, 94, 95, 96, 97, 98	Three-digit code specifying edits (see Table 4) that caused the 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 4).
Line item rejection reasons	3	12	13, 20, 28, 40, 45, 47, 53, 64, 65, 76, 91, 93	Three-digit code specifying the edits that caused the line item to be rejected (See Table 4).
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 4).
APC/ASC return buffer flag	1	1	0-1	0 - No services paid under OPPTS. APC/ASC return buffer filled in with default values and ASC group number (See App F). 1 - One or more services paid under OPPTS. 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 IOCE 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
Payer Value Code and Payer Value Code Amount	11	10	2-character value code (QN-QW) followed by amount (nnnnnnn.nn*)	Assigned by IOCE based on criteria for APC payment offset. *Decimal in Payer Value Code amount is implied. QN – First APC device offset QO – Second APC device offset QP – Reserved for future use QQ - Terminated procedure with pass-through device QR – First APC pass-through drug or biological offset QS – Second APC pass-through drug or biological offset QT – Third APC pass-through drug or biological offset QU – Condition for device credit present QV – QW (Reserved for future use) Note: If offset conditions do not exist, the value code label (QN-QW) is blank; the amount is zero-filled.

Table 7: APC/ASC Return Buffer

Name	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 and 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 [v8.2 – v8.3 only].
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status Indicator**	2	Alpha	A – Services not paid under OPSS; paid under fee schedule or other payment system. B – Non-allowed item or service for OPSS 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 J – New drug or new biological pass-through J1 – Hospital Part B services paid through a comprehensive APC J2 – Hospital Part B services that may be paid through a comprehensive APC K – Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals L – Flu/PPV vaccines M – Service not billable to the MAC N – Items and Services packaged into APC rates P – Partial hospitalization service Q – Packaged services subject to separate payment based on payment criteria Q1 – STV-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC Q4 – Conditionally packaged laboratory services R – Blood and blood products S – Procedure or service, not discounted when multiple T – Procedure or service, multiple reduction applies U – Brachytherapy sources V – Clinic or emergency department visit W – Invalid HCPCS or Invalid revenue code with blank HCPCS X – Ancillary service Y – Non-implantable DME Z – Valid revenue code with blank HCPCS and no other SI assigned
Payment Indicator**	2	Numeric (1-9)	1 – Paid standard hospital OPSS amount (status indicators J1, J2, K, R, S, T, U, V, X) 2 – Services not paid under OPSS; paid under fee schedule or other payment system (status indicator A) 3 – Not paid (Q, Q1, Q2, Q3, Q4, M, W, Y, E), or not paid under OPSS (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) 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, G0177 or G0129) 10 – Paid FQHC encounter payment 11 – Not paid or not included under FQHC encounter payment 12 – No additional payment, included in payment for FQHC encounter 13 – Paid FQHC encounter payment for New patient or IPPE/AWV 14 – Grandfathered tribal FQHC encounter payment
Discounting Formula Number**	1	1-9	(See Appendix D for formula values)
Line Item Denial or Rejection Flag**	1	0-2	0 - Line item not denied or rejected 1 - Line item denied or rejected (procedure edit return buffer for line item contains a 9, 13, 18, 20, 28, 30, 40, 45, 47, 49, 53, 64, 65, 67, 68, 69, 76, 83, 91, 93) 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)
Packaging Flag**	1	0-6	0 – Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of PH per diem or daily mental health service per diem (v1.0-v9.3 only) 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) 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment

Name	Size (bytes)	Values	Description
Payment Adjustment Flag**	2	0-nn [Right justified, blank filled]	0 – No payment adjustment 1 – Paid standard amount for pass-through drug or biological 2 – Payment based on charge adjusted to cost 3 – Additional payment for new drug or new biological applies to APC 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 9 – Deductible/co-insurance not applicable 10 – Co-insurance not applicable 11 – Multiple service units reduced to one by OCE processing; payment based on single payment rate 12 – Offset for first device pass-through 13 – Offset for second device pass-through 14 – PAMA Section 218 reduction on CT scan 15 – <i>Reserved for future use</i> 16 – Terminated procedure with pass-through device 17 – Condition for device credit present 18 – Offset for first pass-through drug or biological 19 – Offset for second pass-through drug or biological 20 – Offset for third pass-through drug or biological 91 – 99 Each composite APC present, same value for prime and non-prime codes (v 9.0 – v9.3 only)
Payment Method Flag**	1	0-5	0 – OPPS Pricer determines payment for service 1 – Service not paid based on coverage or billing rules 2 – Service is not subject to OPPS 3 – Service is not subject to OPPS, and has an OCE line item denial or rejection 4 – Line item is denied or rejected by MAC; OCE not applied to line item 5 – Payment for service determined under FQHC PPS
Service Units	9	1-x	Transferred from input, for Pricer. For line items assigned to APCs for daily mental health, PHP, composite APC or comprehensive APC, the service units are assigned a value of one by the IOCE even if the input service units were greater than one, and payment adjustment flag 11 is provided (v16.1). Service units are also assigned to one for payable conditionally packaged lines (SI = Q1, Q2) and FQHC payment codes; payment adjustment flag 11 is provided (v16.2). Input service units also may be reduced for some Drug administration APCs, based on Appendix I (v6.0 – v7.3 only).
Charge	10	nnnnnnnnnn	Transferred from input for Pricer; COBOL pic 9(8)v99
Line Item Action Flag**	1	0-5	Transferred from input to Pricer, and can impact selection of discounting formula (Appendix D). 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 5 – Non-covered service excluded from payment under FQHC PPS
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. For FQHC PPS claims (bill type 77x) only, the following values are defined for composite adjustment flag: 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC medical clinic visit (modifier 59 reported)

Table 7 Notes:

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).
5. Payment adjustment flag values 7 and 8 discontinued effective January, 2014 (v15.0).
6. Composite adjustment flag values 01, 02, 03 are defined as unique values when used for FQHC PPS processing for claims with bill type 77x without condition code 65; no composite APCs are assigned (v15.3).
7. Status indicator X is deactivated as of January 1, 2015 (v16.0).
8. *ASC group number returned **only** for TOB 83x, on the PC version output report, for v8.2 and v8.3.
9. ** 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. Exception: If modifier 76 or 77 is submitted on the second and subsequent line(s) or unit(s).	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
<p>The bilateral code occurs with modifier 50 and more than one unit of service on the same line.</p> <p>Modifications for TOB 85x with RC 96x, 97x, 98x (v9.0):</p> <p>a) Sum up units for multiple lines with the same HCPCS and same revenue code on the same day, if some or all the lines have modifier 50.</p> <p>b) Exclude any lines that have any other modifier, other than 50, present.</p>	Return claim to provider	74

Appendix A Notes:

1. For ER and observation claims, all services on the claim are treated like any normal claim, including multiple day processing.
2. The “exclusively bilateral” list was eliminated, effective 10/1/05 (v6.3); edits 16 and 17 are not triggered by the presence/absence of modifier 50 on certain bilateral codes for dates of service on or after 10/1/05.
3. Exception: For codes with SI of V that are also on the Inherent Bilateral list, condition code ‘G0’ takes precedence over the bilateral edit; these claims do not receive edit 17 nor are returned to provider.
4. Exception: Edit 17 is not applied to Non-OPPS TOB 85x.

Appendix B (OPPS Only): Medical Visit Processing

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

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.

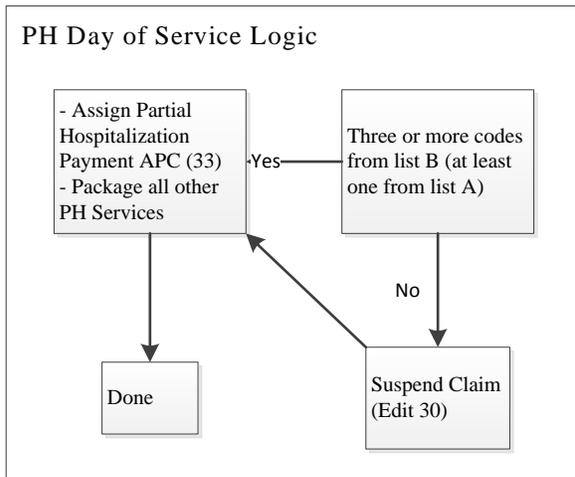
E&M Code	Revenue Center	Condition Code	Action	Edit
2 or more	Revenue center is different for each E&M code, and all E&M codes have units equal to 1.	Not G0	Assign medical APC to each line item with E&M code	-
2 or more	Two or more E&M codes have the same revenue center OR One or more E&M codes with units 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).

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

Appendix C-a (OPPS Only)

Partial Hospitalization Logic (v1.0 – v9.3)



PH = Partial Hospitalization

PH Services
 List A – Psychotherapy (extended, family, group)
 List B – All PH Services (all psych; neuro I&I, 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.

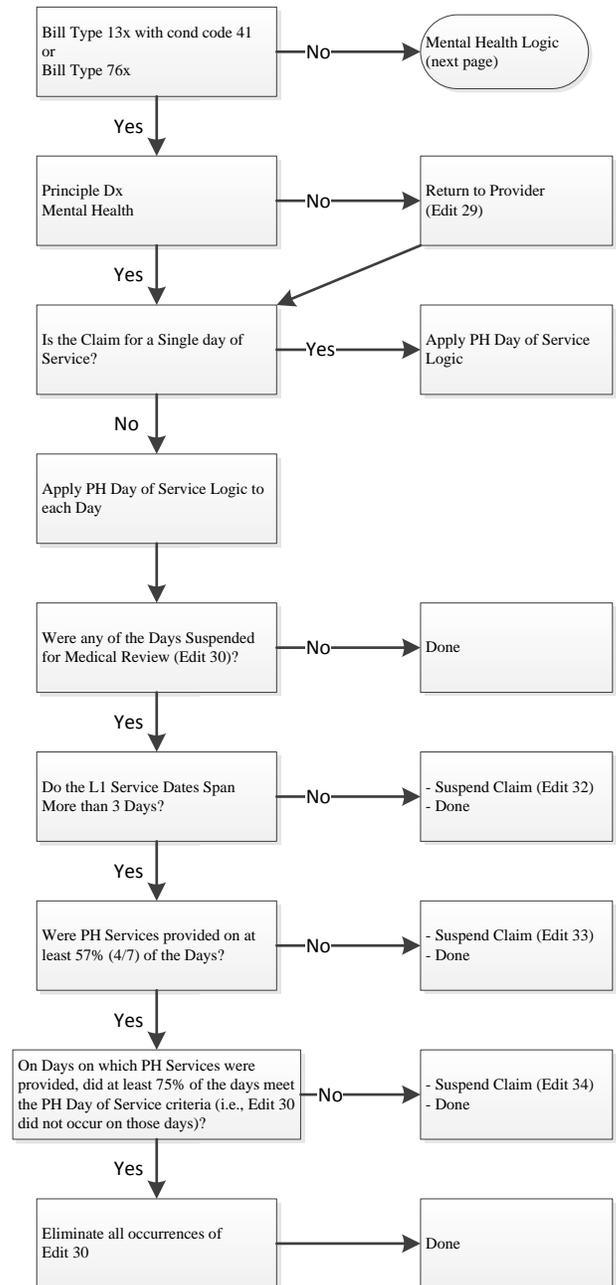
Assign Partial Hospitalization Payment APC

For any day that has PH service, the first listed line item from the following hierarchical list (List A, other codes in List B) is assigned the PHP payment APC, 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

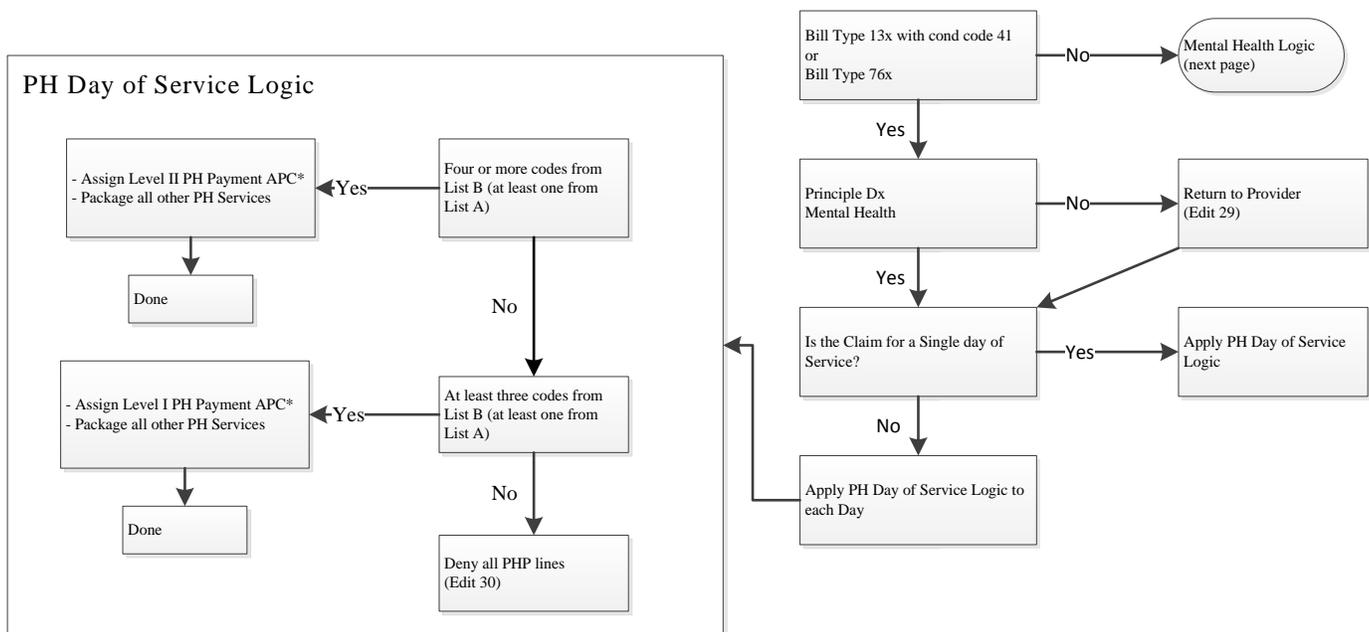
For ALL lines with a partial hospital service (List B), the HCPCS APC is set to 0 (effective 1/1/08)

Note: If mental health services, that are not approved for the partial hospitalization program, are submitted on a 13x TOB with CC41, or on a 76x TOB, the claim is returned to the provider (Edit 80).



Appendix C-a

Daily Partial Hospitalization Logic (effective v10.0)



PH Services (PH = Partial Hospitalization)

List A – Psychotherapy (extended, family, group)
 List B – All PH Services (all psych; neuro I&I, AT, ET, OT)
 List C – Add-on codes not counted toward APC

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

Notes:

+ 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 according to Bill Type

For bill type 13xw/cc41: Level I (3 services) or Level II (4 or more services) Partial Hospitalization for Hospital-Based PHPs

For bill type 76x: Level I (3 services) or Level II (4 or more services) Partial Hospitalization for CMHCs

For any day that meets the criteria for Level I PHP APC, the first listed line item from the following hierarchical list (List A, other codes in List B, excluding List C codes) is assigned the PHP payment APC, 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.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the PHP APC, assign units of service = 1 and payment adjustment flag = 11.

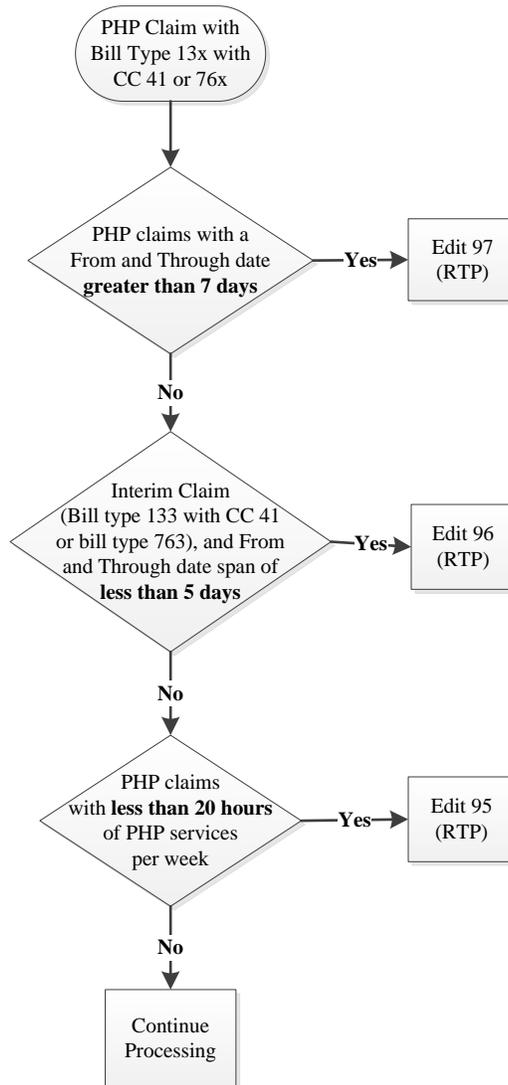
For all other line items with a partial hospital service (List B) on the day, the SI is changed to N, the packaging flag is set to 1, and the same composite adjustment flag value as for the PHP APC is assigned.

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, that are not approved for the partial hospitalization program, are submitted on a 13x TOB with CC41, or on a 76x TOB, the claim is returned to the provider (Edit 80).

Appendix C-a

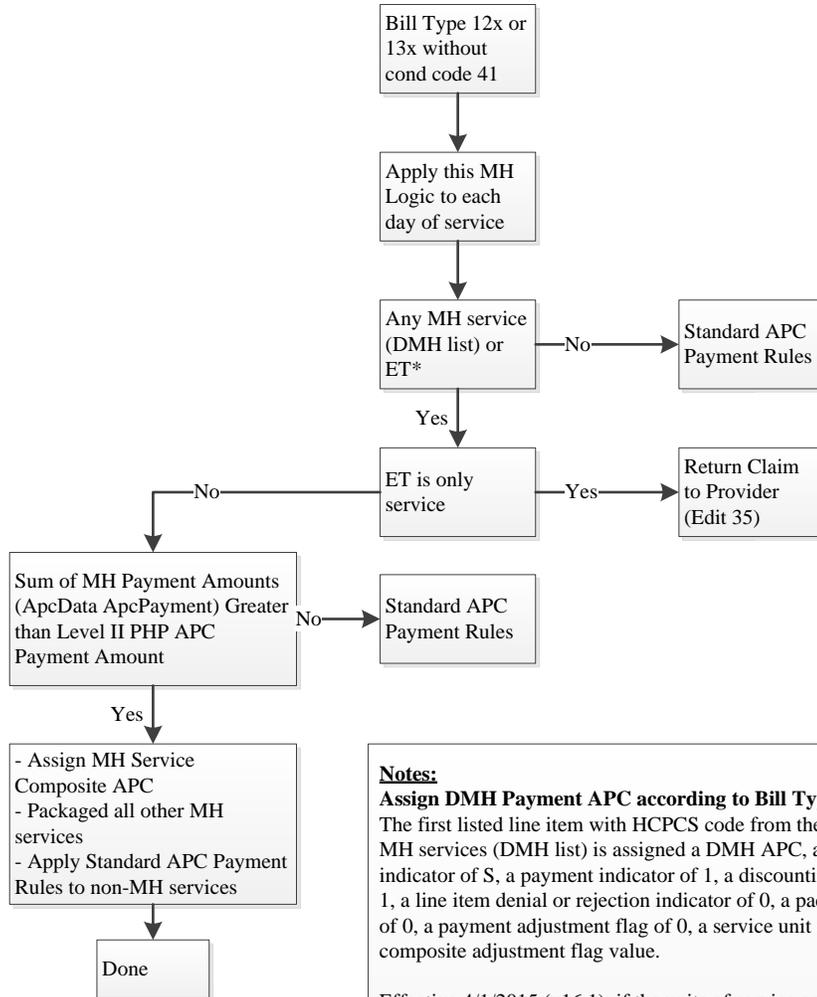
Weekly Partial Hospitalization Logic (effective v17.2)



Note: The weekly processing for PHP occurs after the daily logic is completed (see previous page).

- 1) PHP claims require weekly claim submission of at least 20 hours of PHP services.
- 2) Hours of service for PHP services that result in packaging (SI = N) due to PHP APC processing are included in the total count of hours per week.
- 3) If the PHP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week.

Appendix C-b Mental Health Logic



PH = Partial Hospitalization
MH = Mental Health

Notes:

Assign DMH Payment APC according to Bill Type

The first listed line item with HCPCS code from the list of Daily MH services (DMH list) is assigned a DMH APC, 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.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the DMH APC, assign units of service = 1 and payment adjustment flag = 11.

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 DMH APC 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 or 13x 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 is not multiple procedure discounted, and all other “T” line items are multiple procedure discounted. All line items that do not have a status indicator of “T” are ignored in determining the multiple procedure discount. A modifier of 52 or 73 indicates that a procedure was terminated prior to anesthesia. A terminated type “T” procedure is also discounted although not necessarily at the same level as the discount for multiple type “T” procedures.

Terminated bilateral procedures or terminated procedures with units greater than one should not occur, and have the discounting factor set so as to result in the equivalent of a single procedure. Claims submitted with terminated bilateral procedures or terminated procedure with units greater than one are returned to the provider (edit 37).

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

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

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

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

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 [Discontinued 1/1/2008, v9.0]
7. $D(1 + D)/U$ [Discontinued 1/1/2008, v9.0]
8. 2.0
9. $2D/U$

Where

D = discounting fraction (currently 0.5)

U = number of units

T = terminated procedure discount (currently 0.5)

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

Discount formulas applied to type “T” procedures:

Payment Amount	Modifier 52 or 73	Modifier 50	Conditional or Independent Bilateral	Inherent or Non Bilateral
Highest	No	No	2	2
Highest	Yes	No	3	3
Highest	No	Yes	4	2
Highest	Yes	Yes	3	3
Not Highest	No	No	5	5
Not Highest	Yes	No	3	3
Not Highest	No	Yes	9	5
Not Highest	Yes	Yes	3	3

Discount formulas applied to non-type “T” procedures:

Payment Amount	Modifier 52 or 73	Modifier 50	Conditional or Independent Bilateral	Inherent or Non Bilateral
Highest	No	No	1	1
Highest	Yes	No	3	3
Highest	No	Yes	8*	1
Highest	Yes	Yes	3	3
Not Highest	No	No	1	1
Not Highest	Yes	No	3	3
Not Highest	No	Yes	8*	1
Not Highest	Yes	Yes	3	3

Appendix D Notes:

1. For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (T) and any applicable offset, is applied prior to selecting the type T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset is applied first, before the terminated procedure discount.
2. *For Discount Formulas applied to non-type T procedures: If not terminated, non-type T Conditional bilateral procedures with modifier 50 are assigned discount formula #8 effective 10/1/08; non-type T Independent bilateral procedures with modifier 50 are assigned to formula #8.
3. If modifier 50 is present on an independent or conditional bilateral line that has a composite APC, or a separately paid STVX/T-packaged procedure, or a comprehensive APC, the modifier is ignored in assigning the discount formula.
4. Effective 1/1/08 (v9.0), formula #6 and formula #7 discontinued; replaced by formula #3 and new formula #9.

Appendix E-a

Logic for Assigning Payment Method Flag Values to Status Indicators by Bill Type [OPPS flag = 1]

Payment Method Flag (PMF) Values:

- 0 – OPPS Pricer determines payment for service
- 1 – Service is not paid based on coverage or billing rules
- 2 – Service is not subject to OPPS
- 3 – Service is not subject to OPPS, and has an IOCE line item denial or rejection
- 4 – Line item is denied or rejected by MAC; IOCE not applied to line item
- 5 – Payment for service determined under FQHC PPS

Type Of Bill	PMF = 0	PMF = 1	PMF = 2	Comments
HOPD 13x w or w/o Condition Code 41	G, H, J, J1, J2, K, N, P, R, S, T, U, V, X	C, E, B, M, Q, Q1, Q2, Q3, Q4, W, Y, Z	A, F, L	
HOPD 12x, 14x with CC41	Not set	Not set	Not set	PMF is not set, edit 46 is generated, claim processed flag is set to 1 and no further processing occurs.
HOPD 12x, 14x Without CC 41	G, H, J, J1, J2, K, N, P, R, S, T, U, V, X	C, E, B, M, Q, Q1, Q2, Q3, Q4, W, Y, Z	A, F, L	
CMHC 76x	PH services (any SI/code on PH list) & Non-PH w/SI = N	Non-PH & non- Telehealth service: A, B, C, E, F, G, H, J, J1, J2, K, L, M, R, S, T, U, V, X, Q, Q1, Q2, Q3, Q4, W, Y, Z	Telehealth (Q3014)	
CORF 75x	Vaccine [v1-6.3] (any SI/code on the vaccine list)	C, E, M, W, Y, Z	A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	
Home Health 34x	Vaccine, Antigen, Splint, Cast (any SI/code on specified lists)	Not vaccine, Antigen, splint, cast: C, E, M, W, Y, Z	Not vaccine, Antigen, splint, cast: A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	
RNHC (43x) RHC (71x) FQHC (73x/77x)		C, E, M, W, Y, Z	A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	
Any 'OPPS' bill type not listed above, with Condition Code 07	Antigen, splint, cast: (any SI/code on specified lists)	Not antigen, splint, cast: C, E, M, W, Y, Z	Not antigen, splint, cast: A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	
Any 'OPPS' bill type not listed above, without Condition Code 07		C, E, M, W, Y, Z	A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	

Appendix E(a) Notes:

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 above, 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).
7. Effective 10/1/2014, if the bill type is 77X and CC 65 is not present, all lines are assigned PMF = 5, regardless of SI assignment.
8. Status Indicator of X is deactivated effective 1/1/2015 (v16.0).
9. Status Indicator of J1 has been added effective 1/1/2015 (v16.0).
10. Claims with bill type 12X without CC 41 process status indicator J1 and set the PMF = 0 only when condition code W2 is present.
11. PMF 5 is for FQHC PPS only; status indicators are not applicable.
12. Status Indicators J2 and Q4 are added effective 1/1/2016 (v17.0).
13. Effective 1/1/2016, laboratory codes with SI = Q4 that result in a final SI = A are assigned PMF = 2.

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]

Bill Type	Status Indicator	PMF
HOPD (12x, 13x, 14x) CAH (85x) ASC (83x w OPPS flag = 2	C, E,M, W, Y, Z	1
HOPD (12x, 13x, 14x) CAH (85x) ASC (83x w OPPS flag = 2	A, B, F, G, H, K, L, N, P, Q, Q1, Q2, Q3, R, S, T, U, V, X	2

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

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12x or 14x with condition 41	46	Buffer not completed
2	12x or 14x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52-54, 56-58, 60-79, 81-85, 87, 92, 93, 94, 98	Buffer completed
3	13x with condition code 41	1-9, 11-18, 20-23, 25-28, 29-34, 37, 38, 40-45, 47-50, 52, 54, 56-58, 60-62, 65-80, 82-85, 87, 92, 93, 94, 95, 96, 97, 98	Buffer completed
4	13x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52, 54, 56-58, 60-79, 81, 82-85, 87, 92, 93, 94, 98	Buffer completed
5	76x (CMHC)	1-9, 11-13, 15, 18, 23, 25, 26, 29-34, 38, 41, 43-45, 47-50, 53-55, 61, 65, 69, 71-73, 75, 77-80, 82, 84, 85, 87, 92, 93, 94, 95, 96, 97, 98	Buffer completed
6	34x (HHA) with Vaccine, Antigen, Splints or Casts	1-9, 11-13, 15, 18, 20, 25-26, 28, 38, 40, 41, 43-45, 47, 49-50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87, 92, 93, 94, 98	Buffer completed
7	34x (HHA) without Vaccine, Antigen, Splints or Casts	1-9, 11-13, 20, 25, 26, 40-41, 44, 50, 53-55, 65, 69, 94	Buffer not completed
8	75x (CORF) with Vaccine (PPS) [v1.0-6.3]	1-9, 11-13, 15, 18, 20, 25, 26, 38, 40-41, 43-45, 47-50, 53-55, 61, 62, 65, 69, 71-73, 77	Buffer completed
9	43x (RNHCI)	25, 26, 41, 44, 46, 55, 65	Buffer not completed
10	71x (RHC), 73x/77x (FQHC)	1-5, 6, 25, 26, 41, 61, 65, 72, 91, 94	Buffer not completed
11	Any bill type except 12x, 13x, 14x, 34x, 43x, 71x, 73x/77x, 76x, with CC 07, with Antigen, Splint or Cast	1-9, 11-13, 18, 23, 25, 26, 28, 38, 41, 43-45, 47, 49, 50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87, 92, 93, 94, 98	Buffer completed
12	75x (CORF)	1-9, 11-13, 15, 20, 23, 25, 26, 40, 41, 44, 48, 50, 53-55, 61, 65, 69, 72, 94	Buffer not completed
13	22X, 23X (SNF), 24X [24X: v1.0 – 6.2 only]	1-9, 11-13, 20, 23, 25, 26, 28, 40-41, 44, 50, 53, 54, 55, 61, 62, 65, 69, 72, 94	Buffer not completed
14	32X, 33X (HHA) [33X: v1.0 – 14.2 only]	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53-55, 65, 69, 86, 94	Buffer not completed
15	72X (ESRD)	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53, 54, 55, 61, 65, 69, 72, 94	Buffer not completed
16	74X (OPT)	1-9, 11-13, 20, 25, 26, 40-41, 44, 48, 50, 53, 54, 55, 61, 65, 69, 72, 94	Buffer not completed
17	81X (Hospice), 82X	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53-55, 65, 69, 86, 94	Buffer not completed
18	77X (FQHC PPS) [v15.3 -]	1-6, 25, 26, 41, 65, 72, 84, 88, 89, 90, 91, 94	Buffer not completed

TABLE ROWS ARE IN HIERARCHICAL ORDER

Appendix F(a) Notes:

1. Edit 10, and edits 23 and 24 for From/Through dates, are not dependent on Appendix F.
2. If edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates and processing continues.
3. Edit 22 is bypassed if revenue code is 540.
4. Edit 77 is not applicable to bill type 12x (rows #1 and #2).
5. Bypass edit 48 if revenue code is 100x, 210x, 310x, 0500, 0509, 0521, 0522, 0524, 0525, 0527, 0528, 0583, 0637, 0660-0663, 0669, 0905-0907, 0931, 0932, 0948, 099x.
6. In V1.0 to V3.2, "vaccines" included all vaccines paid by APC; from V4.0 forward, "vaccines" includes Hepatitis B vaccines only, plus Flu, H1N1 and PPV administration.
7. Bypass diagnosis edits (1-5) for bill types 32x and 33x (HHA) & 12x (inpatient/PartB) if From date is before October 1 and Through date is on or after October 1. And for bill types 322 & 332 if From date is between 9/26 and 9/30, inclusive. Note: Bill type 33X is deleted as of 10/1/2013.
8. Bill type 24x deleted, effective 10/1/2005.
9. NCCI edits (20, and 40) applied to bill types 22x, 23x, 34x, 74x and 75x effective 1/1/06.
10. Edit 28 applied to bill type 22x and 23x effective 10/1/2005.
11. Effective 4/1/2006, MH edits (35, 36, 63, 64 and 81) not applicable to TOB 14x.
12. If TOB is 81x or 82x and RC = 657, bypass edit 72 for any HCPCS code with SI =M (& change the SI from M to A).
13. Change TOB for FQHC from 73x to 77x, effective 4/1/2010.
14. Psychiatric add-on codes trigger edit 84 only on PHP claims (TOB 13x w/CC41 & 76x).
15. Edit 86 applied to bill types 81x and 82x, effective 10/01/2013 and 32x effective 1/1/2015.
16. Bypass edit 27 for bill types 12x or 14x (row #2), or 13x with modifier L1 reported for laboratory services, when claims containing packaged laboratory codes have the SI changed to A (effective 1/1/2014).
17. Effective 10/1/2014, the list of edits for bill type 77x is added for applicability under the FQHC PPS (row 18). Editing is not performed for claims with bill type 770 (no payment claim). FQHC claims submitted as non-PPS claims continue to have edits applied as listed in row 10. Effective 1/1/2015 (v16.0), exclude edits 61 and 72 from hospice claims (bill type 81x, 82x) retroactive to 1/1/2014.
18. Effective 1/1/2015 (v16.0), apply edit 86 to home health claims (bill type 32x).
19. Effective 4/1/2015 (v16.1), edit 84 is applied for claims with bill type 77x (FQHC PPS, Row 18) only for versions 15.3 – 16.0.
20. Effective 4/1/2016 (v17.1), edit 6 and 91 are applied for claims with bill type 71x (RHC).
21. Edits 95, 96 and 97 are applied for PHP and CMHC claims; edit 96 is applicable only for interim claims submitted with bill type 133 w/ condition code 41 or 763.

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

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12X or 14X with condition code 41, and OPPS flag = 2	46	Buffer not completed
2	12X or 14X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 53, 54, 61, 65, 67-69, 72, 83, 94	Buffer not completed
3	13X with condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 83, 94	Buffer not completed
4	13X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 83, 94	Buffer not completed
5	85X, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 74, 83, 94	Buffer not completed
6	83X, and OPPS flag = 2 [v8.2-v8.3]	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 53, 54, 61, 65, 67-69, 72, 83	Buffer completed

TABLE ROWS ARE IN HIERARCHICAL ORDER.

Appendix F(b) Notes:

1. Edit 10, and edits 23 and 24 for From/Through dates, are not dependent on Appendix F.
2. If edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates and processing continues.
3. Edit 22 is bypassed if revenue code is 540
4. Bypass edit 72 if bill type is 85X and HCPCS with SI = M is submitted with revenue code 096x, 097x or 098x.
5. 83X bill type is invalid for IOCE effective for dates of service on or after 1/1/08 (IOCE v9.0).

Appendix G [OPPS Only] Payment Adjustment Flag Values

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	2
Status indicator J	3
Code is flagged as 'deductible not applicable' or condition code "MA" is present on the claim	4
Blood product with modifier BL on RC 38X line	5
Blood product with modifier BL on RC 39X line	6
Item provided without cost to provider	7
Item provided with partial credit to provider	8
Deductible/co-insurance not applicable	9
Co-insurance not applicable	10
Multiple service units reduced to one by OCE processing; payment based on single payment rate	11
Offset for first device pass-through	12
Offset for second device pass-through	13
PAMA Section 218 reduction on CT scan	14
<i>Placeholder reserved for future use</i>	15
Terminated procedure with pass-through device	16
Condition for device credit present	17
Offset for first pass-through drug or biological	18
Offset for second pass-through drug or biological	19
Offset for third pass-through drug or biological	20
First thru ninth composite APC present – prime and non-prime	91 – 99 [v9.0 - v9.3]
All others	0

Appendix G Notes:

1. Status indicator J was replaced by status indicator G starting in April 2002 (V3.0).
2. For PAF 5 and 6, see Appendix J for additional details on Blood Product assignment logic (v6.2).
3. PAF 91-99 were replaced by the Composite Adjustment Flag, 1/1/09 (v10.0).
4. PAF 9 and 10 apply to preventive services (see Appendix O) and lines with modifier Q3 (Live kidney donor and related services).
5. PAF 4: codes may be flagged in the database or by program logic (see special processing conditions under OPSS, item #19 for information regarding the reporting of modifier PT, or payer condition code MA).
6. PAF 7 and 8 deactivated 1/1/2014 (v15.0).
7. Description for PAF 11 modified 4/1/2015 (v16.1).
8. PAF 11 is not assigned if another PAF value has been set previously during processing.
9. PAF 12 and 13 are associated with conditions present for APC pass-through device offset; multiple conditions for the same claim requiring payment offset due to the presence of multiple device/procedure combinations may require the assignment of both PAF 12 and 13.
10. PAF 14 is assigned to a specific list of CT scan procedure codes; if there is a CT scan code reported with modifier CT that is packaged with SI = N as a result of composite APC or comprehensive APC processing, PAF 14 is not assigned to the packaged code.
11. PAF 16 is assigned to a terminated device intensive procedure reported with modifier 73.
12. PAF 17 is assigned to a device intensive procedure if condition code 49, 50 or 53 is reported.
13. PAF 18-20 are assigned for conditions that may be present for pass-through drugs or biologicals requiring payment offset.

Appendix H [OPPS Only] OCE Observation Criteria [v3.0 – v8.3]

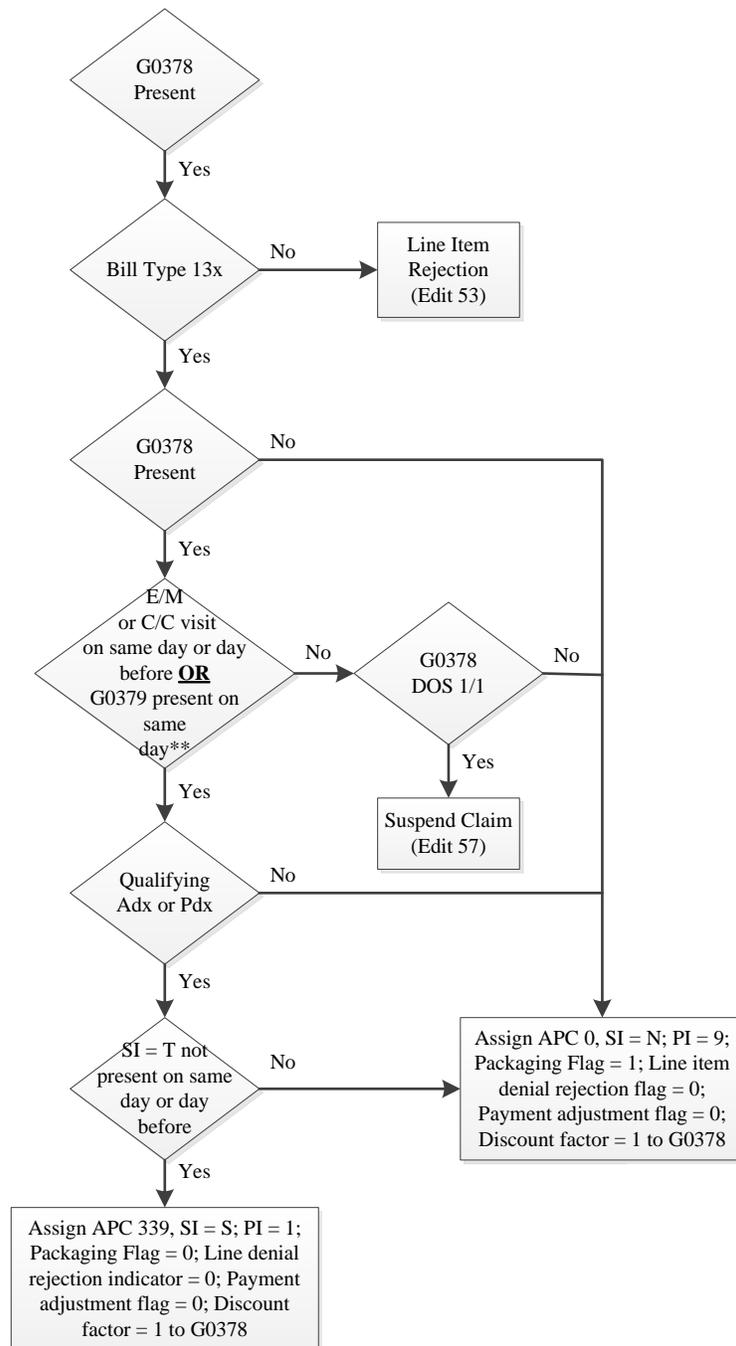
Note: Appendix H is not applicable to claims for dates of service on or after 1/1/2008 (v9.0). See Appendix K for rules governing payment for observation on or after 1/1/2008.

OCE Observation Rules (v3.0 – v8.3) [4/1/02 – 12/31/07]:

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 referral 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:
 - a. If the criteria are met for payable observation, the SI is changed to “S” and standard APC is assigned.
 - b. 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:
 - a. If associated with a payable observation (payable G0378 present on the same day), the SI for G0379 is changed to “N”.
 - b. If the observation on the same day is not payable, the SI is changed to “V” and standard APC is assigned.
 - c. 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 referral from physician’s office). E/M or C/C visit is required the day before or day of observation; direct referral is required on the day of observation.
9. If an observation cannot be paired with an E/M or C/C visit or Direct referral, the observation is packaged.
10. E/M or C/C visit or Direct referral 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 referral that have been denied or rejected, either externally or by OCE edits, are ignored.
12. Both the associated E/M or C/C visit, and the 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 are 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:

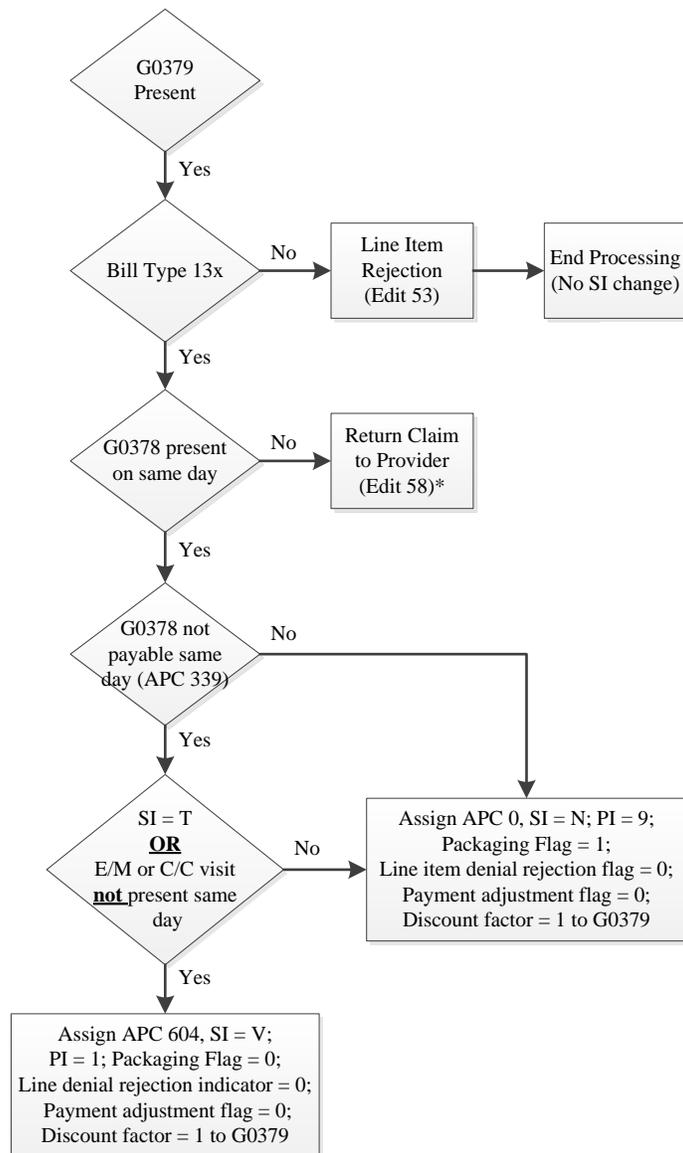
Chest Pain	Asthma	CHF
4110, 1, 81, 89	49301, 02, 11, 12, 21, 22, 91, 92	3918, 39891
4130, 1, 9		40201, 11, 91
78605, 50, 51, 52, 59		40401, 03, 11, 13, 91, 93
		4280, 1, 9, 20-23, 30-33, 40-43

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



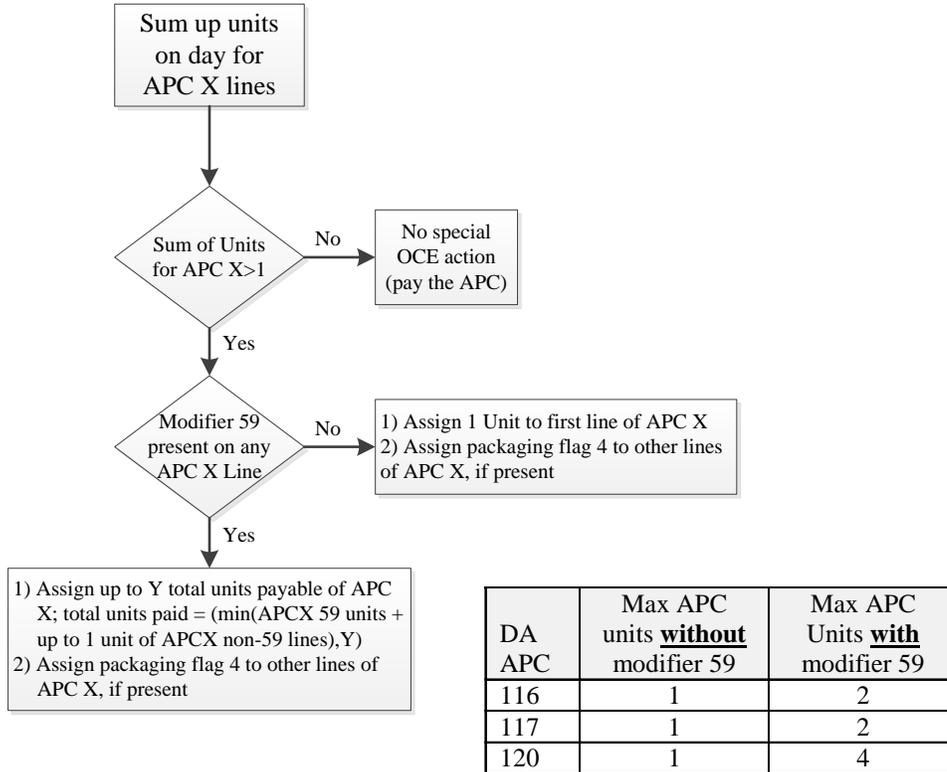
**not already paired
with another G0378

Appendix H-b Direct Referral Logic (v3.0 – v8.3)

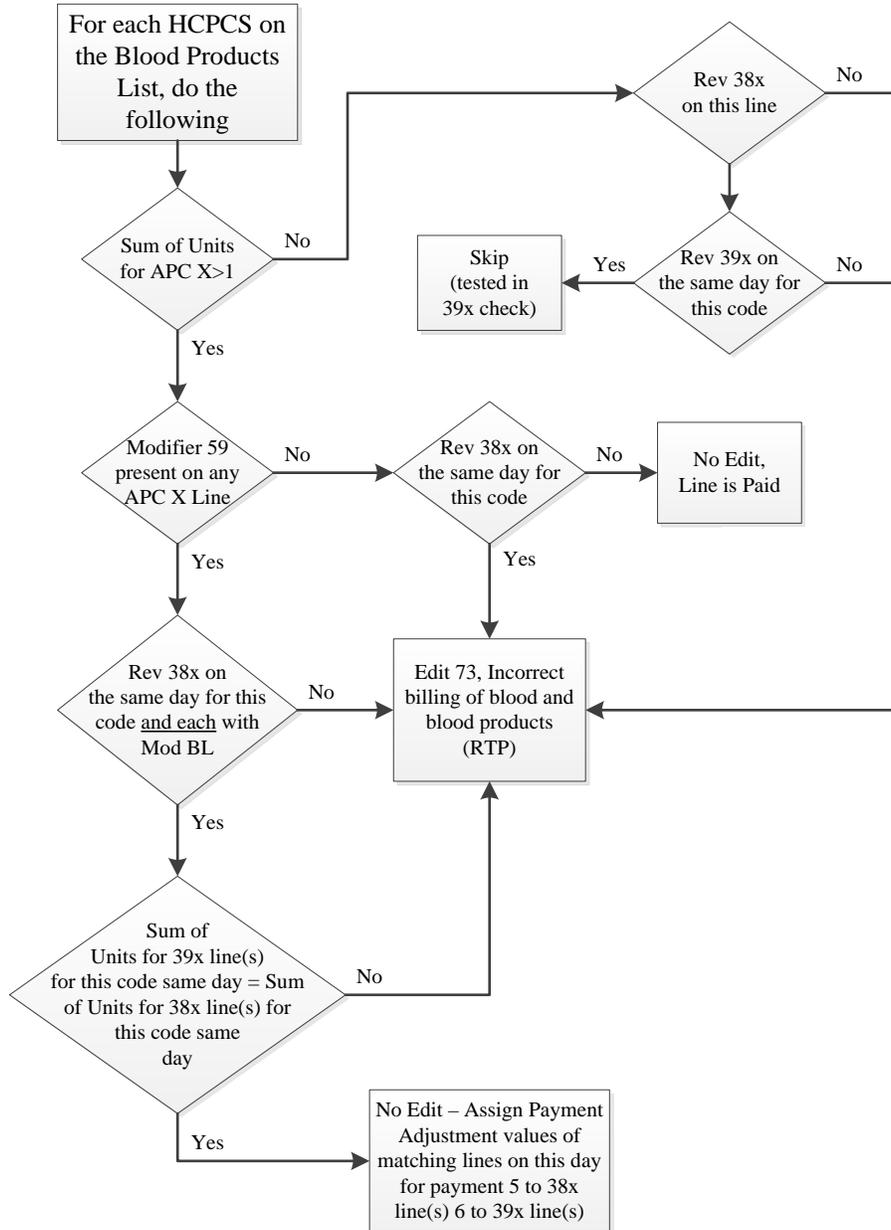


*Note: If G0378 is present with a 1/1 service date and G0379 is not present, edit 57 is also returned

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



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 is returned to the provider (edit 79).

Appendix K Composite APC Assignment Logic (v9.0)

LDR prostate brachytherapy composite APC assignment criteria:

1. 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.
 - a. Assign units of service = 1 to the line with the composite APC.
 - b. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
 - c. 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.
 - d. Assign the indicated composite adjustment flag to the composite and all component codes present.
2. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.
3. Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.
4. Procedures that are packaged (SI changed to ‘N’ in an earlier processing step) are not included in the composite assignment logic.

LDR Prostate brachytherapy composite

Prime/Group A code	Non-prime/Group B codes	Composite APC
55875	7778	8001

Electrophysiology/ablation composite APC assignment criteria: [v9.0 – v15.3]

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

1. If there is a single code present from group C, **or** one ‘prime’ code (group A) and at least one non-prime code (group B) on the same date of service, assign the composite APC and related status indicator to the group C code, or to the prime code & assign status indicator N to the non-primary code(s) present.
 - a. Assign units of service = 1 to the line with the composite APC.
 - b. If multiple codes from group C are present, assign the composite APC to the code with the lowest numerical value and assign status indicator N to additional group C codes on the same day.
 - c. 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.
 - d. If the criteria for APC assignment are met with a code from group C as well as from groups A&B, assign the composite APC to the group C code and assign SI of N to the codes from groups A&B.
 - e. If there is one or more codes from group C present with one or more codes from **either** group A **or** group B; assign the composite APC to the group C code and assign the standard APC and related SI to any separate group A **or** group B codes present.
 - f. Assign the indicated composite adjustment flag to the composite and all component codes present.
2. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component group A and group B codes present.
3. Terminated codes (modifier 52 or 73 present) in group C are assigned to the composite APC; terminated codes in groups A and B are ignored in composite APC assignment
4. Procedures that are packaged (SI changed to ‘N’ in an earlier processing step) are not included in the composite assignment logic.

Electrophysiology/ablation composite (v9.0 – 15.3)

Prime/Group A codes	Non-prime/Group B codes	Group C	Composite APC
93619 93620	93650	93653 93654 93656	8000

Extended Assessment & Management Composite APC Assignment Criteria: [v9.0 – v16.3]

(Note: Effective 1/1/2016 [v17.0], all EAM Composite APC logic is deactivated; observation claims meeting specified criteria are assigned under a comprehensive observation APC [see Appendix L]).

1. Code G0378 is used to identify all outpatient observation services, regardless of the reason for observation (diagnosis), the duration of the service or whether the criteria for the EAM composites are met.
2. Code G0379 is used to identify direct referral from a physician in the community to hospital for observation care, regardless of the reason for observation (diagnosis).
3. EAM logic is performed only for claims with bill type 13x, with or without condition code 41.
4. Lines with G0378 and G0379 are rejected if the bill type is not 13x (or 85x).

Extended Assessment and Management Composite APC rules: [v9.0 – v16.3]

1. 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).
2. Only one extended assessment and management APC is assigned per claim.
3. 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. (Level I and Level II EAM APCs deleted effective 1/1/2014).
4. If multiple qualifying prime codes (visit or C/C) 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.
5. 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.
6. The SI for G0378 is always N.
7. Extended assessment and management composite APCs have SI = V if paid.
8. The logic for extended assessment and management is performed only for bill type 13x, with or without condition code 41.
9. Hours/units of service for observation (G0378) must be at least 8 or the composite APC is not assigned.
10. If a “T” procedure occurs on the day of or day before observation, the composite APC is not assigned.
11. Assign units of service = 1 to the line with the composite APC.
12. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
13. Assign the composite adjustment flag to the visit line with the composite APC and to the G0378.
14. 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: (Level II EAM APC deleted effective 1/1/2014 [v9.0-v14.3])

1. 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.
2. 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

Level I Extended Assessment and Management criteria: (Level I EAM APC deleted effective 1/1/2014 [v9.0 – v14.3])

1. 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 referral code.
2. Additional clinic visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.
3. 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

Extended Assessment and Management criteria: (EAM APC effective 1/1/2014, [v15.0 – v16.3])

(Note: Effective 1/1/2016 [v17.0], all EAM Composite APC logic is deactivated; observation claims meeting specified criteria are assigned under a comprehensive observation APC [see Appendix L]).

1. If there is at least one of a specified list of critical care or emergency room or clinic visit codes on the day of or day before observation (G0378), or code G0379 is present on the same day as G0378, assign the composite APC and related status indicator to the critical care, emergency department, clinic visit or direct referral code.
2. Additional critical care, emergency or clinic visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.
3. Additional reporting of G0379 on the same claim, are assigned SI = N.

Prime /List A codes	Non-prime/List B code	Composite APC
99284, 99285, 99291, G0384, G0463, G0379	G0378	8009

Separate Direct Referral (G0379) Processing Logic:

1. Code G0378 must be present on the same day.
2. No SI = T or J1, E/M, or Critical Care visit on the same day.
3. Code G0379 may be paid under the comprehensive observation APC (effective v17.0), the EAM composite APC (v9.0 – v16.3), a standard APC, or packaged with SI = N.

Critical Care Packaging

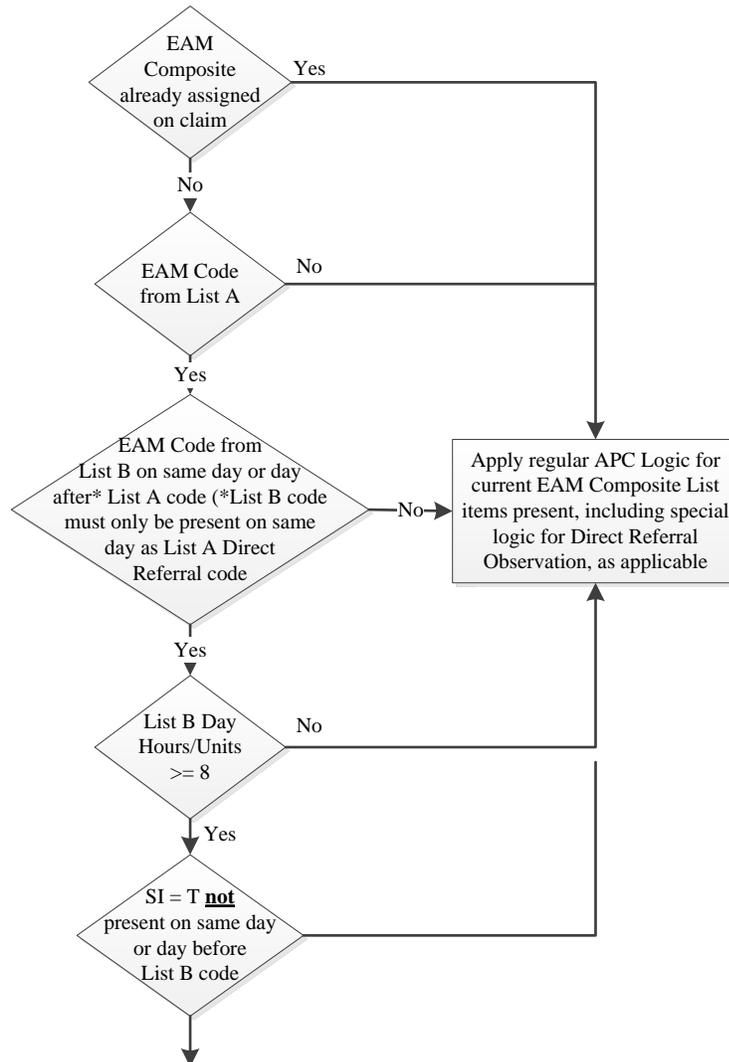
A specified list of ancillary procedure codes that are packaged when submitted on the same date of service as the critical care E/M code (99291) have the default SI of Q3; however, they are not required components of any composite APCs and are not used to assign any composite APCs. The Q3 status indicator is changed to N when 99291 is present; otherwise, it is changed to the standard SI and APC for the specified code. The composite adjustment flag is not assigned nor any special composite logic applied.

Implantable Cardioverter Defibrillator and Pacing Electrode

Codes 33249 and 33225 have default SI of Q3, however, they are not components of a composite APC. When submitted together on the same date of service, the SI for 33249 is changed to the standard SI/APC for payment and the SI for 33225 is changed to N. The composite adjustment flag is not assigned, but 33249 and 33225 are paid as a single, composite service. For all other processing, the SI for both codes is changed to the standard SI/APC. [v13.0 - v15.3]

Extended Assessment & Management Flowchart (v9.0 – v16.3)

For each Extended Assessment and Management (EAM) Composite APC (Level II first, then Level I – Level I & Level II EAM APCs effective v9.0 – v14.3 only), do the following:



Assign EAM Composite:

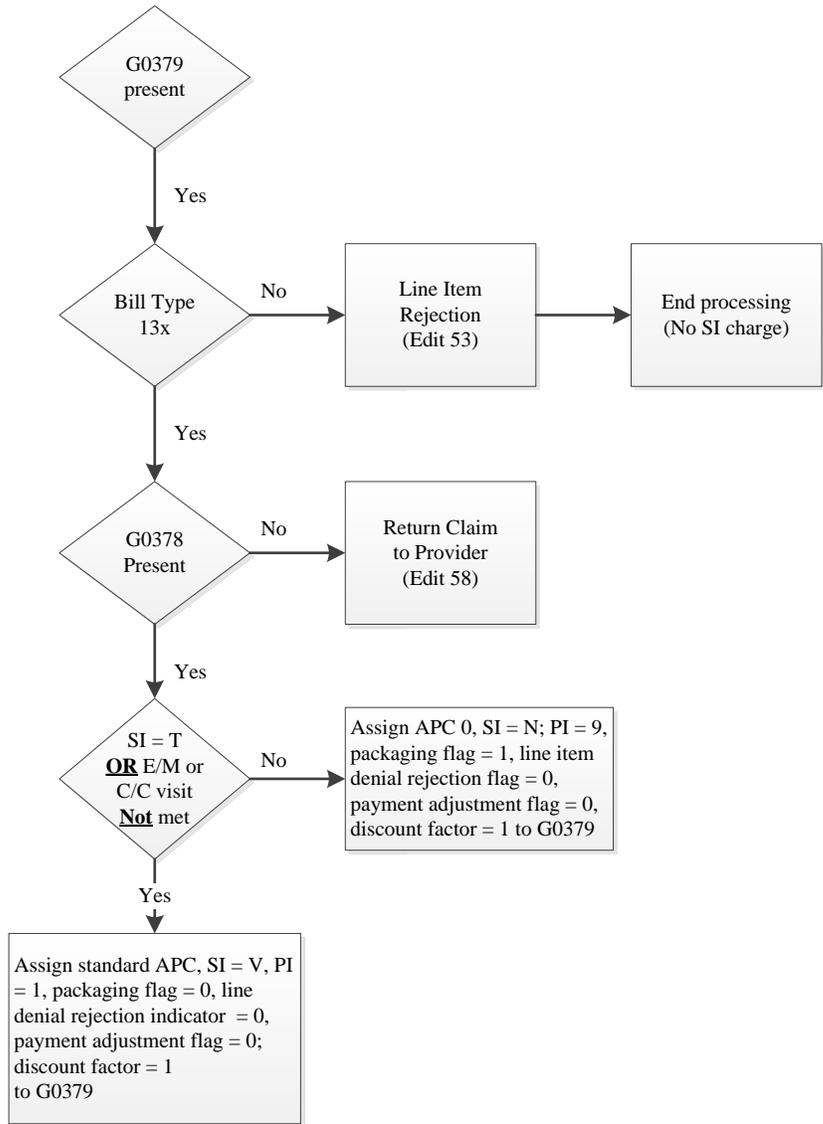
Assign the composite APC, SI, PI, packaging flag = 0, payment adjustment flag = 9 [1-9]**, composite adjustment flag = (01-xx)***, discount factor = 1, units output = 1 to the highest weighted List A code present.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.

Assign standard APC, SI, PI to other List A* codes and List B code
 *Package special Direct Referral List A code on same claim as EAM composite assignment. Edit 57 is returned if G0378 (List B) is reported with service date of 1/1 and the E/M condition is not met.
 Claims prior to 1/1/09. *effective 1/1/09

Direct Referral Logic (v9.0)

If there is no Extended Assessment & Management APC (v9.0-v16.3) or no Comprehensive Observation APC (v17.0) assigned on the claim:



Notes:

1. Edit 57 is returned if G0378 is reported with service date of 1/1 and G0379 is not reported.
2. Edit 58 is returned if G0378 and G0379 are not reported on the same service date.
3. Effective v17.0, direct referral logic only applied if conditions not met for Comprehensive Observation APC.

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 (i.e., CT/CTA and MRI/MRA), imaging composite APCs are further assigned based on procedures performed with contrast and procedures performed without contrast. There is currently a total of five multiple imaging composite APCs.
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 count to assign the composite APC; independent or conditional bilateral imaging procedures with modifier 50 count as 2 units.
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).
7. Imaging procedures that are packaged (SI changed from Q# to N in an earlier processing step) are not included in the multiple imaging composite assignment logic.
8. If the imaging composite APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.
9. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
10. Effective 1/1/2016 (v17.0), certain CT scan codes performed on equipment not meeting NEMA standards are reported with modifier CT. If multiple CT scan codes reported with modifier CT are present, and contribute to the assignment of a composite APC, the first eligible line assigned to the composite APC receives payment adjustment flag 14, whether or not modifier CT is reported on the line. All other CT scan codes reported with modifier CT that are included for composite APC assignment are packaged (SI = N), and do not have payment adjustment flag 14 assigned.

Family 1 – Ultrasound:

1. Ultrasound Composite (APC 8004)

APC Number	Codes
8004	76604, 76700, 76705, 76770, 76775, 76776, 76831, 76856, 76857, 76870

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

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

APC Number	Codes
8005	70450, 70480, 70486, 70490, 71250, 72125, 72128, 72131, 72192, 73200, 73700, 74150, 74176, 74261

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

APC Number	Codes
8006	70460, 70470, 70481, 70482, 70487, 70488, 70491, 70492, 70496, 70498, 71260, 71270, 71275, 72126, 72127, 72129, 72130, 72132, 72133, 72191, 72193, 72194, 73201, 73202, 73206, 73701, 73702, 73706, 74160, 74170, 74175, 74177, 74178, 74262, 75635

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

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

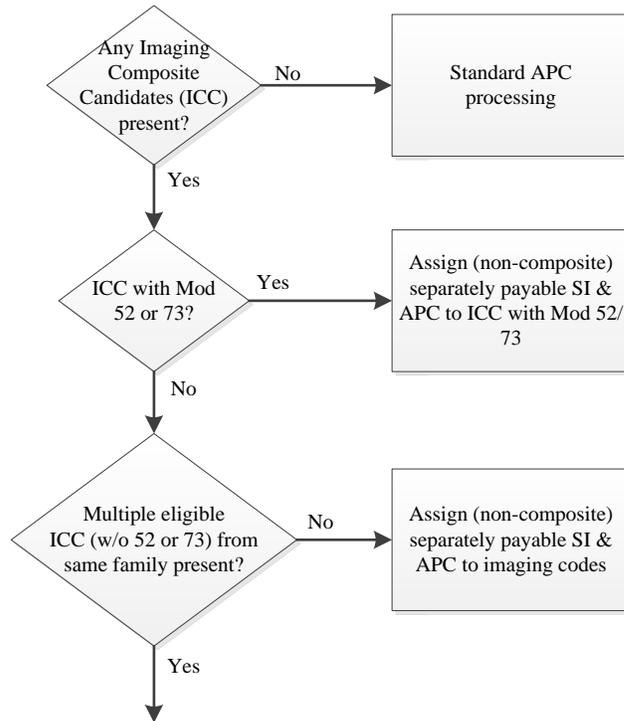
APC Number	Codes
8007	70336, 70540, 70544, 70547, 70551, 70554, 71550, 72141, 72146, 72148, 72195, 73218, 73221, 73718, 73721, 74181, 75557, 75559, C8901, C8904, C8907, C8910, C8913, C8919, C8932, C8935

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

APC Number	Codes
8008	70542, 70543, 70545, 70546, 70548, 70549, 70552, 70553, 71551, 71552, 72142, 72147, 72149, 72156, 72157, 72158, 72196, 72197, 73219, 73220, 73222, 73223, 73719, 73720, 73722, 73723, 74182, 74183, 75561, 75563, C8900, C8902, C8903, C8905, C8906, C8908, C8909, C8911, C8912, C8914, C8918, C8920, C8931, C8933, C8934, C8936

*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.

Multiple Imaging Composite Flowchart (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

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.

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: Comprehensive APC Assignment Logic (OPPS Only, v16.0)

General Comprehensive APC Assignment Rules and Criteria:

1. Comprehensive APC processing is performed only for OPPS claims with bill type 13x, or claims with bill type 12x with condition code W2.
2. Comprehensive APCs are assigned using the following hierarchy:
 - a. Inpatient-Only Patient Expired (SI = J1)
 - b. High-Cost Procedures (SI = J1)
 - c. Comprehensive Observation (SI = J2)

If there are multiple comprehensive APC procedures existing on the same claim from the different categories listed above, the comprehensive APC procedures are packaged (SI = N) according to the hierarchy of services present; the procedure or service highest in the hierarchy is assigned the comprehensive APC for the claim. Additional processing conditions for each of the different categories is listed separately below.

3. Claims containing a payable inpatient procedure (modifier CA and patient status 20) suppress comprehensive APC processing (**v16.0 – v16.3**).
4. Multiple service units reported on a comprehensive APC line are reduced to one for processing payment based on a single comprehensive APC payment rate; payment adjustment flag 11 is assigned.
5. Except for services that are exempt by statute, all allowed adjunctive services submitted on the claim with a comprehensive APC procedure are packaged into the comprehensive APC payment (the SI is changed to N). Services that are excluded from packaging include ambulance, brachytherapy (SI=U), mammography, pass-through drugs, biologicals and devices (SI= G or H), preventive care including influenza and pneumococcal vaccines (SI=L), corneal tissue acquisition, certain CRNA services and Hepatitis B vaccines (SI = F). **Certain blood products (i.e. packed red cells or whole blood) reported with the appropriate revenue code are also excluded from packaging under comprehensive APCs.** Services that are exempt by statute from the all-inclusive payment retain the standard APC (if applicable) and SI for standard processing.
6. Procedures that are not allowed on OPPS claims (SI = B, C, E or M) are edited as usual and retain the standard SI, with the exception of procedure codes representing DME services with SI = Y (Billable only to DMERC); DME codes with SI = Y are packaged into the comprehensive APC payment; edit 61 is not returned.

Comprehensive APC Assignment for Inpatient-Only Procedure where Patient Expired (v17.0)

1. Effective January 1, 2016, claims reporting a payable inpatient-only procedure where the patient expired (modifier CA and patient status 20) are assigned under a comprehensive APC (SI = J1).
2. If the claim meets the criteria for the Inpatient-Only comprehensive APC assignment, all other services reported on the claim are packaged with SI = N, except for those items excluded under comprehensive APC processing. **Excluded items with non-covered SI = B, E, C or M return the standard SI; any edits associated with the non-covered SI are not returned.**
3. Additional comprehensive APC procedures (SI = J1 or J2) reported on the same claim as the inpatient-only procedure where the patient expired comprehensive APC are packaged (SI = N).
4. Conditions that may be present for pass-through device payment offset are performed.

Comprehensive APC Assignment for High-Cost Procedures (v16.0)

1. If a single comprehensive procedure (SI = J1) is present on a claim, assign the standard comprehensive APC for all-inclusive claim payment.
2. If multiple comprehensive APC procedures are present, select the highest ranked comprehensive procedure for standard comprehensive APC assignment.
3. Once the highest ranked comprehensive procedure is determined, if there are multiple comprehensive procedures present with SI = J1 or there are qualifying add-on procedure codes present (SI = N), determine if there are any pairings that may qualify for a complexity adjustment. Multiple occurrences or service units of the same comprehensive procedure, or the reporting of modifier 50, may qualify for complexity adjustment. If there

is a qualifying pair present associated with the highest ranked comprehensive procedure, assign the complexity-adjusted comprehensive APC.

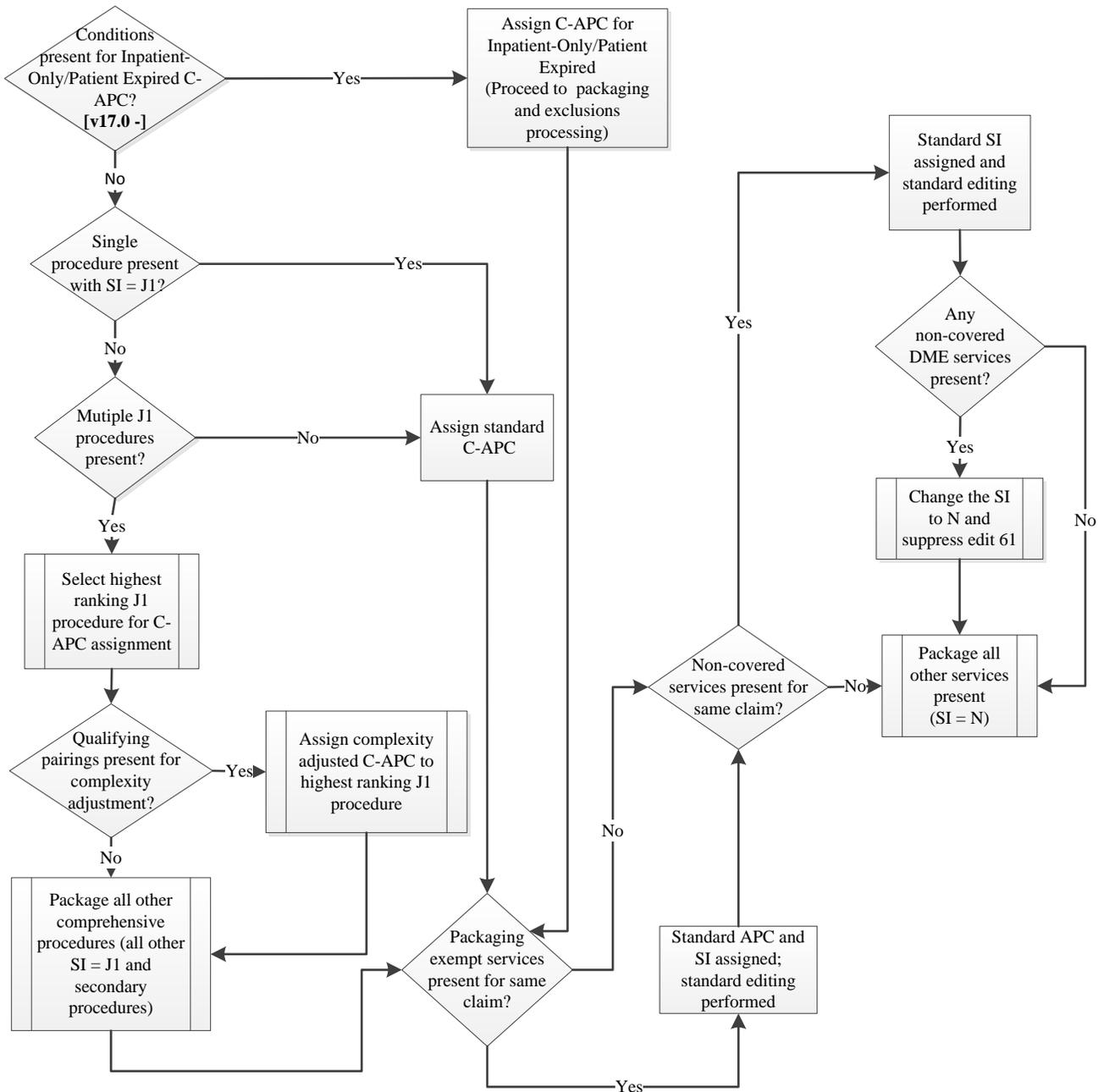
4. If the highest ranked comprehensive procedure has service units greater than one, reduce the service units to one and assign payment adjustment flag 11.
5. If a comprehensive APC procedure is terminated by the reporting of modifier 52, 73 or 74, no complexity adjustment is performed for the claim; the standard comprehensive APC is assigned to the comprehensive procedure with the highest rank. Usual terminated procedure discounting is applied if modifiers 52 or 73 are reported (modifier 74 does not apply the terminated procedure discount).
6. If the comprehensive APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.
7. Effective 1/1/2016 (v17.0), when SRS (stereotactic radiosurgery) planning and preparation codes are reported on the same claim as the comprehensive APC for SRS (APC 5627), the planning and preparation codes are excluded from packaging; the standard SI and APC, or the composite APC and SI (if criteria is met for multiple CT scan imaging procedures) are assigned. If the SRS planning and preparation codes are reported on a claim with any other comprehensive APC procedure, the codes are packaged under the comprehensive APC packaging criteria.
8. Effective 1/1/2016 (v17.0), if conditions are present for pass-through device offset, a single device offset is provided for comprehensive APC claims only if the comprehensive APC procedure is paired with the pass-through device. Otherwise, no device offset is provided for device offset conditions that may be present for procedures that are packaged (SI = N) as a result of comprehensive APC processing.

Comprehensive APC for Observation Services (v17.0)

1. Claims for observation services (SI = J2) meeting the following conditions are assigned under a single Comprehensive Observation APC payment rate, to include all services submitted on the claim:
 - a. There is no procedure with SI = T present for the claim
 - b. HCPCS G0378 is reported with 8 or more service units
 - c. There is a visit code present from the following list on the same day or one day before HCPCS G0378: Type A/Type B emergency department visits, critical care, outpatient clinic visit, or HCPCS G0379 for direct referral is present on the same day as G0378
 - d. The claim does not contain a comprehensive APC procedure with SI = J1
2. If multiple visit codes with SI = J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged (SI = N).
3. If the claim does not meet the conditions for comprehensive observation APC assignment, the visit code(s) is/are assigned their standard APC and SI.

If HCPCS G0379 is present and criteria is not met for comprehensive observation APC, and there are other visit codes present (SI = J2 resulting in standard APC and SI = V), G0379 is packaged. Additional reporting (subsequent occurrences) of HCPCS G0379 are packaged (SI = N).

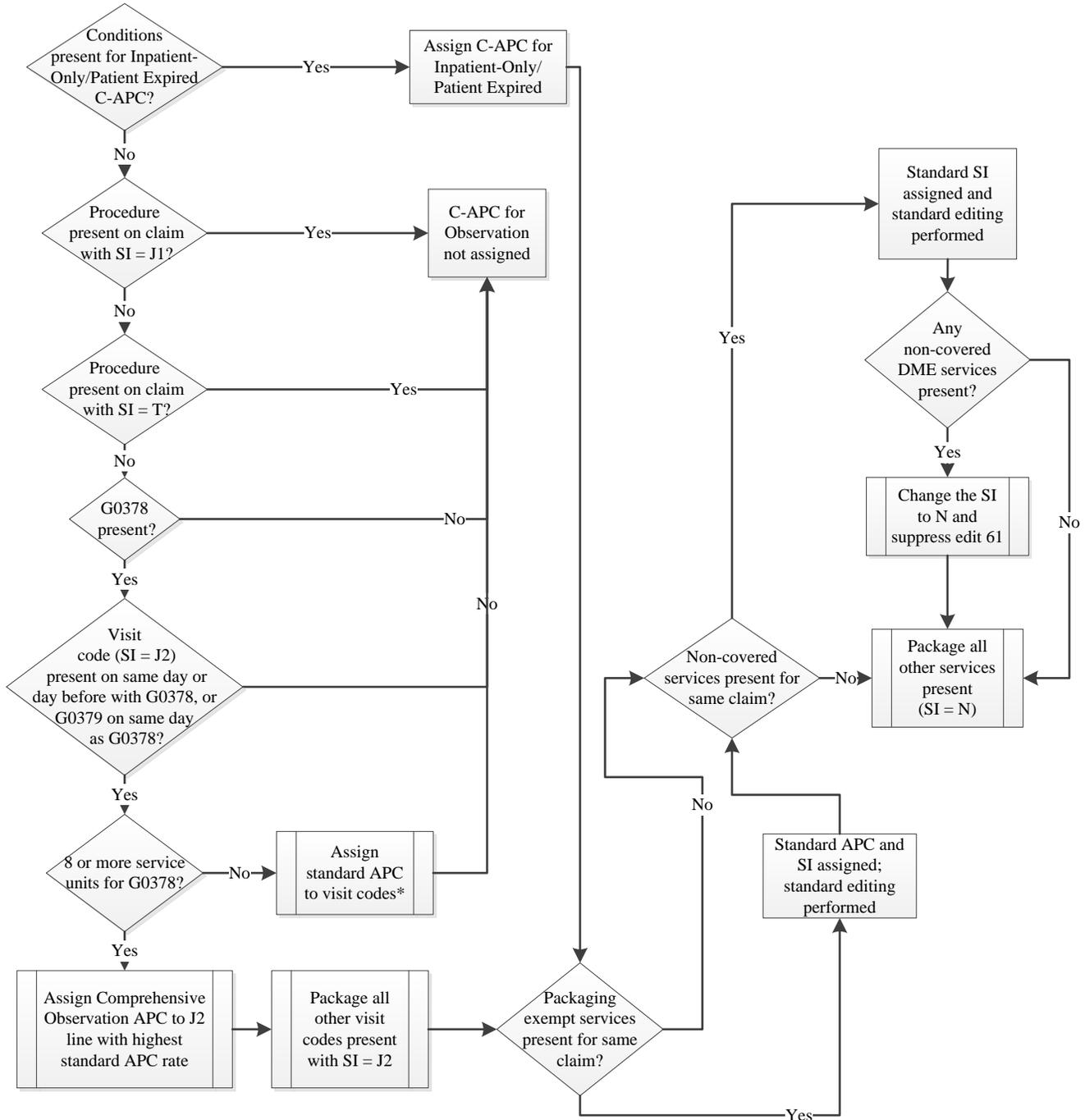
Comprehensive APC Processing Flowchart (SI = J1) (v16.0)



Notes:

1. C-APC = Comprehensive APC.
2. Units of service greater than one for a comprehensive APC procedure line are reduced to one. Payment adjustment flag = 11 is assigned indicating to Pricer that only a single comprehensive APC payment rate is calculated for lines reporting multiple units of service.
3. The highest ranked J1 procedure is where the C-APC is assigned; all other services are packaged with SI = N, except for non-covered services and services excluded from C-APC packaging logic.
4. Complexity adjusted comprehensive APC assignment occurs when there is a qualifying pair of comprehensive procedures with SI = J1, or a comprehensive procedure with a qualifying add-on procedure code with SI = N, or may be multiple occurrences or service units of the same comprehensive procedure.
5. Effective v17.0, conditions for inpatient-only procedures when the patient expires are assigned a C-APC with J1. If this condition exists, no other C-APC is assigned for the claim.
6. Effective v17.0, if SRS planning and preparation codes are present on the same claim with the SRS C-APC, the planning and preparation codes are excluded from the C-APC packaging logic.

Comprehensive APC for Observation Processing Flowchart (SI = J2) (v17.0)



Notes:

1. C-APC = Comprehensive APC.
2. The visit code with SI = J2 and the highest standard APC rate is where the C-APC is assigned; all other services are packaged with SI = N, except for non-covered services and services excluded from C-APC packaging logic.
3. Conditions for inpatient-only procedures when the patient expires are assigned a C-APC with J1. If this condition exists, no other C-APC is assigned for the claim.
4. Observation claims not meeting the conditions for C-APC assignment are processed as visits under standard APC assignment (SI = V). *If G0379 is present and there is also a procedure present with SI = T or another SI = V procedure present, G0379 is packaged (SI = N).

Appendix M: FQHC (Federally Qualified Health Center) PPS Overview (v15.3)

FQHC Assignment Rules and Criteria:

1. FQHC processing occurs for claims with From Dates on or after 10/01/2014, bill type = 77x and Condition Code 65 is absent. Processing occurs for each date of service if the claim contains multiple dates.
2. A FQHC payment code reported with revenue code 519, 52x or 900 is required for FQHC PPS claims. If a FQHC payment code is not found, the claim is returned to the provider. If the correct revenue code is not found for the FQHC payment code, the claim is returned to the provider. Payable FQHC payment code lines are flagged with Payment Indicator (PI) = 10, unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported, PI = 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. If multiple visits are reported, only one new patient FQHC payment HCPCS is assigned PI = 13 per day. Any additional FQHC payment codes present for the same day are assigned PI = 10.

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

- a. Medical visit codes G0466, G0467 and G0468 require revenue code 52x or 519
 - b. Mental health visit codes G0469 and G0470 require revenue code 900 or 519
3. A qualifying visit HCPCS code is also required. If the qualifying visit code from the list below is not found with the required FQHC payment code, the claim is returned to the provider. Qualifying visit codes are flagged with PI = 12 and are packaged with Packaging Flag = 5. The table below illustrates the pairing of the FQHC payment code with the qualifying visit code.

FQHC Payment Code	Qualifying Visit Codes
G0466: FQHC visit, new patient	92002, 92004, 97802, 99201, 99202, 99203, 99204, 99205, 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345, 99497, G0101, G0102, G0108, G0117, G0118, G0296, G0436, G0437, G0442, G0443, G0444, G0445, G0446, G0447, Q0091
G0467: FQHC visit, established patient	92012, 92014, 97802, 97803, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99495, 99496, 99497, G0101, G0102, G0108, G0117, G0118, G0270, G0296, G0436, G0437, G0442, G0443, G0444, G0445, G0446, G0447, Q0091
G0468: FQHC visit, IPPE/AWV	G0402, G0438, G0439
G0469: FQHC visit, mental health, new patient	90791, 90792, 90832, 90834, 90837, 90839, 90845
G0470: FQHC visit, mental health, established patient	90791, 90792, 90832, 90834, 90837, 90839, 90845

4. Effective 1/1/2016 (v17.0), Advance Care Planning services reported with code 99497 are considered a preventive service only when reported with annual wellness visit (initial or subsequent) codes, and is assigned as a packaged preventive service (Packaging Flag = 6). If Advance Care Planning is reported without the annual wellness visit codes, it is treated as a qualifying visit code used to satisfy the FQHC encounter requirements, and is packaged (Packaging Flag = 5).
5. Multiple visits reported for the same day are processed for FQHC encounter payment up to a maximum of three visits, with the FQHC payment codes marked for FQHC encounter payment (PI = 10 or PI = 13 for new patient or IPPE/AWV), provided all criteria are met for each visit: one medical clinic visit, one mental health clinic visit and one additional subsequent established patient visit for an unrelated illness or injury reported with modifier 59. Any additional visits reported on the same day are packaged (Packaging Flag = 5).

FQHC payment codes are processed in the following hierarchical order when multiple visits are present for the same day: G0468, G0466, G0467, G0469, G0470.

6. Effective 1/1/2016 (v17.0), Grandfathered Tribal FQHC providers are identified by the presence of condition code MG. If condition code MG is present, only a single FQHC encounter is eligible for payment. If there are multiple visits present that include both medical and mental health visits, the medical visit is identified as the single payable visit for the day, and is assigned PI = 14 (Grandfathered tribal FQHC encounter payment). If the claim contains multiple days, PI = 14 is assigned to the identified payable visit for each day. Modifier 59 is ignored for processing of additional FQHC encounters. Special identification for new or IPPE/AWV encounters is not required.
7. Units of service reported greater than 1 for a line with a qualifying FQHC payment code are assigned units of service = 1 (Payment Adjustment Flag 11 is assigned for this condition, effective 7/1/2015 [v16.2]).
8. A composite adjustment flag is assigned to each FQHC payment code, indicating for the Pricer program the type of FQHC visit(s) that is/are present. A value of 01 is assigned to FQHC payment codes representing new or established medical visits or the IPPE/AWV, a value of 02 is assigned to FQHC payment codes representing new or established mental health visits, and a value of 03 is assigned for subsequent visits for established patients, reported with modifier 59.

For Grandfathered Tribal FQHC providers, only a single composite adjustment flag is assigned per day, value of 01 or 02 only, depending on whether the identified payable visit is a medical visit (01) or mental health (02). Composite adjustment flag value 03 is not applicable for Grandfathered Tribal FQHC claims; modifier 59 is ignored.

9. If a psychotherapy add-on code is reported for a mental health clinic visit, the look-up of the primary procedure code for the add-on code is performed after the assignment criteria for the qualifying FQHC visits. If multiple visits are reported for the day, the add-on criteria is satisfied only when a primary procedure code is available that has not been previously utilized by another payable FQHC visit [v15.3 – v16.0 only].
10. Preventive services are packaged under FQHC PPS, however, a special Packaging Flag value of 6 is assigned to identify that the preventive service is not to be included in any coinsurance calculation. The PI value for preventive services is 12.
11. Flu/PPV vaccine and administration services continue to be paid under reasonable cost and are not packaged under FQHC PPS; PI = 11.
12. Telehealth facility services reported with HCPCS code Q3014 and revenue code 78x are not packaged under FQHC PPS and continue to be paid by fee schedule; PI = 2. Effective 7/1/2015 (v16.2), if Q3014 is reported for Telehealth facility services and there is no FQHC payment code or qualifying visit code, edits 88 and 89 are bypassed.

Effective 1/1/2016 (v17.0), Chronic Care Management services reported with code 99490 are not packaged under FQHC PPS. If 99490 is reported, PI = 2 is assigned, indicating that it be paid under the Medicare Physician Fee Schedule. Chronic Care Management services reported without a FQHC payment code or qualifying visit code bypass edits 88 and 89.

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

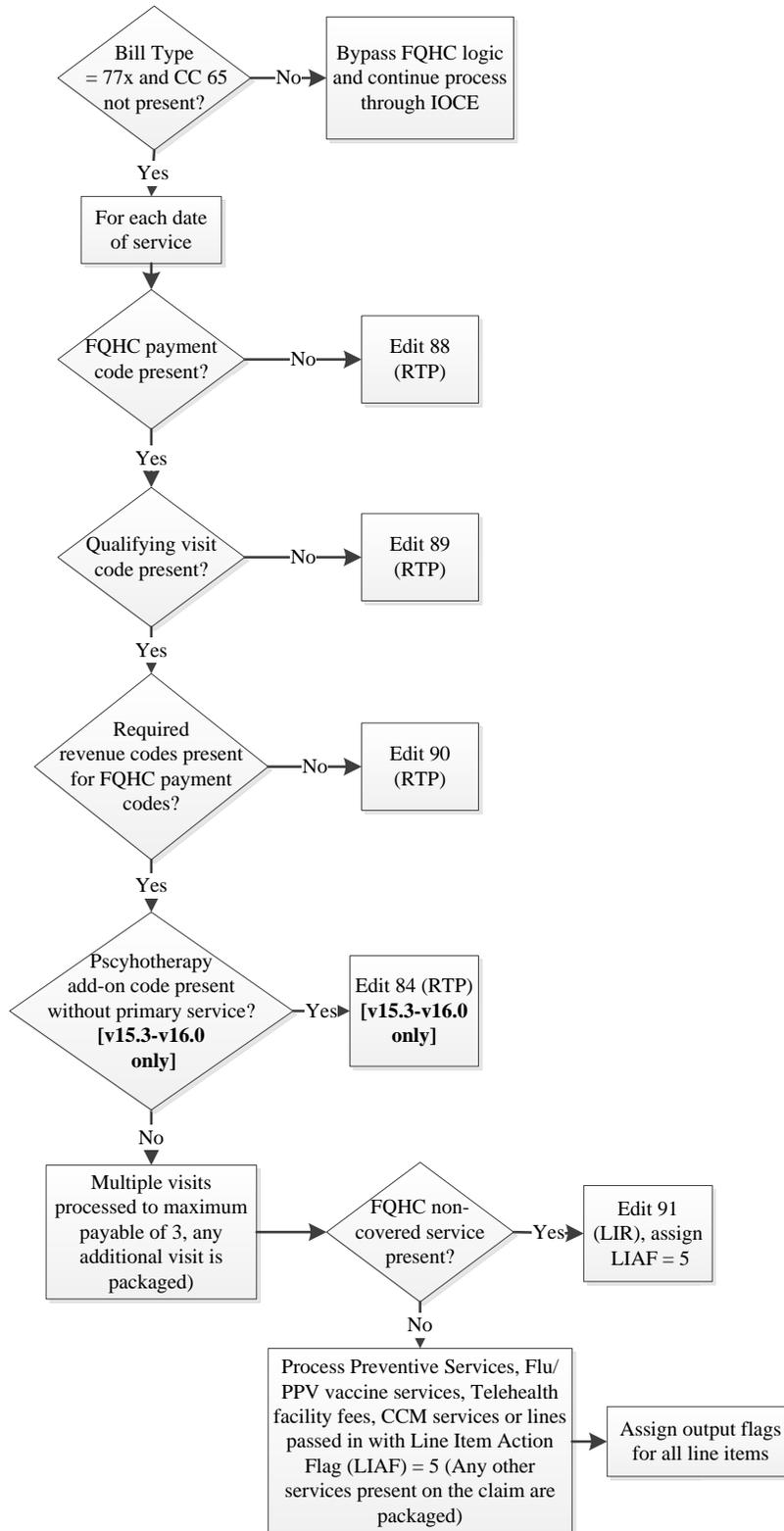
Effective 10/1/2015 (v16.3), if only FQHC non-covered services are reported, edits 88 and 89 are not returned.

Effective 4/1/2016 (v17.1), claims with bill type 71x (RHC) that contain non-covered services under FQHC PPS are subject to edit 91 and line item action flag 5 assignment.

14. Any additional services reported on the claim for the same day that are not part of the aforementioned criteria are packaged. This includes the qualifying visit codes. All packaged services that are not packaged preventive services are assigned Packaging Flag = 5 and PI = 12.

15. The APC Buffer is not completed for bill type 77x; although the APC = 0 and default values for the SI and PI are assigned for each HCPCS code, these values are ignored, and resulting values for the PI may change as a result of FQHC processing.
16. Refer to Appendix F (a) for a list of edits applied to FQHC PPS claims.
17. Values output from the IOCE for FQHC claims which are specifically used by the Pricer program for payment purposes are Payment Method flag, Payment Indicator, Packaging flag, Composite Adjustment Flag and Line Item Action flag. Refer to Table 7 (APC Return Buffer) for a list of applicable flag output values.

FQHC Logic Flowchart (v15.3)



Notes:

1. Effective v16.2, if only Telehealth facility fees are reported, edits 88 and 89 are not returned.
2. Effective v16.3, if only FQHC non-covered services are present, edits 88 and 89 are not returned.
3. Effective v17.0, if condition code MG is present for Grandfathered Tribal FQHC provider, only a single FQHC encounter is eligible for payment.
4. Effective v17.0, Advanced Care Planning services may be treated as a qualifying visit code or if reported with an annual wellness visit, is treated as a packaged preventive service.

FQHC Processing Logic

Appendix N: 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:

APC Return Buffer Item	Default Value
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, 25 and 26
Composite adjustment flag	00

3. If no HCPCS code is on a line 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.

APC Return Buffer Item	Default list value	Default list value	Default list value	Default list value
Line item	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

4. 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:

APC Return Buffer Item	Default Value
HCPCS APC	00000
Payment APC:	00000
Status Indicator:	Z
Payment Indicator	3
Packaging flag:	0

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

APC Return Buffer Item	Default Value
HCPCS APC	00000
Payment APC:	00000
Status Indicator:	W
Payment Indicator	3
Packaging flag:	0

6. 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.
7. Effective with v15.0, for each line with a laboratory procedure HCPCS with SI = N that is submitted with bill type 12x (without condition code W2), 13x for laboratory services reported with modifier L1 or 14x, change the SI to A and set the packaging flag to 0.

Effective with v17.0, for each line with a laboratory procedure HCPCS with SI = Q4 that is submitted with bill type 12x (without condition code W2) or 14x, change the SI to A and set the packaging flag to 0. If the bill type is 13x, change the SI to A if modifier L1 is present, or if only laboratory services are reported.

8. If procedure with status indicator “C” and modifier CA is present on a claim and patient status = 20, assign the special inpatient-only payment APC to the “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.
Effective with v17.0, if procedure with SI = C and modifier CA is present on a claim with patient status = 20, the procedure is assigned to a comprehensive APC (SI = J1). All other line items on the claim have the packaging flag set to 1 except for services excluded under comprehensive APCs or non-covered services which retain original SI and APC (if applicable).
9. 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 28.
10. Effective for 10/1/2014 with v15.3, if the bill type is 77x and Condition Code 65 is not present, the claim processes through the FQHC PPS logic, and applicable edits are performed. Go to step 32.
11. 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 29.
12. 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.
13. Perform edits that are not based on the status indicator.
14. If bill type is 13x and condition code = 41, or type of bill = 76x, apply partial hospitalization logic from Appendix C.
15. If bill type is 12x or 13x without condition code 41, apply mental health logic from Appendix C-b.
16. Apply special packaging logic (T-packaged (SI of Q2); followed by STVX-packaged (SI of Q1); followed by critical care-packaged (specified list of ancillary procedures)).
17. Apply general composite logic from Appendix K. (Note: If any composite candidate has its SI changed to N in any other previous step; do not use the packaged item to fulfill the composite criteria).
18. Apply Multiple Imaging composite logic from Appendix K. (Note: If any composite candidate has its SI changed to N in any other previous step; do not use the packaged item to fulfill the composite criteria).
19. If bill type is 13x, apply Extended Assessment and Management composite logic from Appendix K and Direct Referral for Observation logic from Appendix K-b. (Note: If any composite candidate has its SI changed to N in any other previous step; do not use the packaged item to fulfill the composite criteria). (v9.0 – v16.3)
20. 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.
21. If code is present for Advance Care Planning with annual or subsequent wellness visit, set the SI to A; otherwise advance care planning is subject to conditional packaging logic (SI = Q1).
22. Apply special skin substitute logic (Change the SI/APC for the skin substitute to N/ APC 0 if there is none of the specified application procedures on the same date of service). (v13.1 – v14.3).
23. Perform all remaining edits that are driven by the status indicator, except for edits associated with visit processing (SI = V).
24. If the payment APC for a line item has not been assigned a value in steps 11 – 23, set payment APC in the APC return buffer for the line item equal to the HCPCS APC for the line item.
25. If any procedure with status indicator J1, or effective with v17.0, status indicator J2, is present on a claim, apply the comprehensive APC assignment logic in Appendix L. Perform edits associated with visit processing.
26. If there are lines present with pass-through HCPCS, perform APC offset logic.
27. If edits 9, 13, 20, 28, 30, 40, 45, 47, 49, 53, 64, 65, 67, 68, 69, 76, 83, 93 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.

28. 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:
 - i. Line item action flag is 2, 3, or 4
 - ii. 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
 - iii. Packaging flag is not 0 or 3
29. 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.
30. 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.
31. For all bill types where APCs are assigned, apply drug administration APC consolidation logic from appendix I. (v6.0 – v7.3 only).
32. Set the payment adjustment flag for a line item based on the criteria in Appendix G and Appendix J, and apply logic to assign Payment Adjustment flag based on the presence of PT modifier.
33. 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'.
34. 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”:

1. Set Non-OPPS bill type flag as applicable, based on the presence or absence of ASC procedures (v8.2 – v8.3).

Appendix O: 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, 90473, 90474, G0008, G0009, G0010
Splints	29105, 29125, 29126, 29130, 29131, 29505, 29515
Casts	29000, 29010, 29015, 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, 29720, 29730, 29740, 29750, 29799

B. Partial Hospitalization Services

PHP List A	90832, 90834, 90837, 90845, 90846, 90847, 90865, 90880, G0410, G0411
PHP List B	90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90846, 90847, 90865, 90880, 96101, 96102, 96103, 96116, 96118, 96119, 96120, G0129, G0176, G0177, G0410, G0411
PHP List C*	90785, 90833, 90836, 90838

*Add-on codes that are not counted in meeting the numerical requirement for APC assignment.

C. Preventive Services

Deductible/co-insurance not applicable	76977, 77078, 77080, 77081, G0008, G0009, G0010, G0101, G0104, G0105, G0121, G0130, G0296, G0297, G0389, G0402, G0436, G0437, G0442, G0443, G0444, G0445, G0446, G0447, G0473, Q0091
Deductible not applicable	G0106, G0120

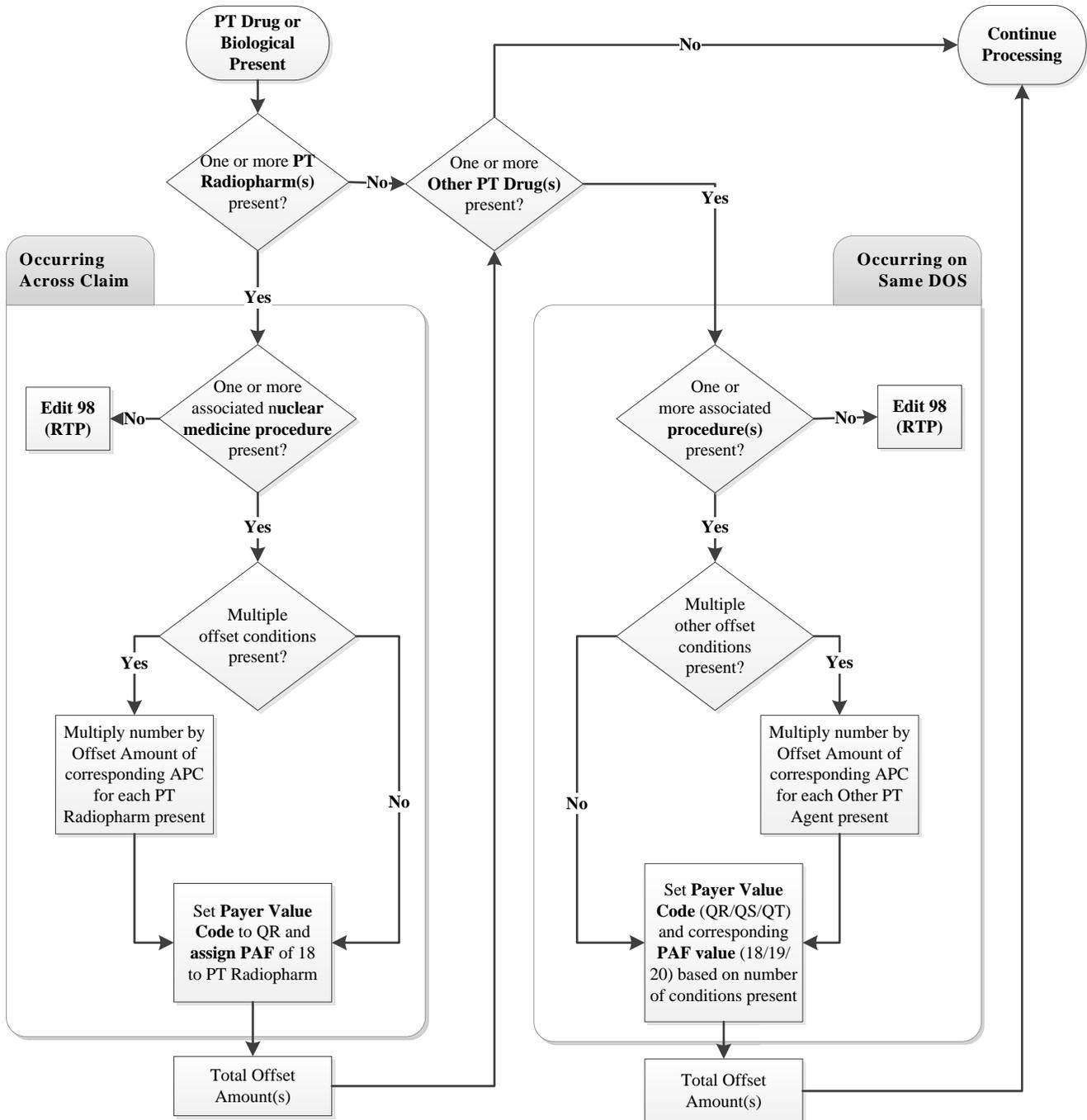
D. HCPCS Codes for Skin Substitute Procedures (v13.0 – v14.3)

Skin substitute	C9358, C9360, C9363, Q4101 – Q4108, Q4110 – Q4116, Q4118, Q4119, Q4121- Q4128, Q4131 - Q4136
Skin substitute application	15271 – 15278

E. HCPCS Codes for Skin Substitute Procedures (v15.0)

List	Skin substitute application	Skin substitute product
List A	C5271, C5272, C5273, C5274, C5275, C5276, C5277, C5278	Q4100, Q4102, Q4111, Q4115, Q4117, Q4119, Q4124, Q4129, Q4134 - Q4136, Q4143, Q4146, Q4157, Q4158, Q4161 – Q4163, Q4165
List B	15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278	C9349, C9363, Q4101, Q4103 - Q4108, Q4110, Q4116, Q4120 - Q4123, Q4126 – Q4128, Q4131 – Q4133, Q4137, Q4138, Q4140, Q4141, Q4147, Q4148, Q4150 - Q4154, Q4156, Q4159, Q4160, Q4164

Appendix P: Pass-through Drugs and Biologicals Processing (v17.2)



Notes:

- 1) PT = Pass-through; PAF = Payment Adjustment Flag
- 2) Pass-through drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents.
- 3) Radiopharmaceutical (radiopharm) pass-through processing occurs across the claim. "Other" PT drugs refers to contrast, skin substitute products and stress agents, which are processed across each day of service for a multiple day claim.
- 4) Each PT drug present must be paired with an associated procedure (APC) in order to complete processing (edit 98).
- 5) The setting of the Payer Value Code is dependent upon the type and number of PT conditions present. PT radiopharms are processed first if present, and occupy the first QR position with PAF 18 assigned to the radiopharm. "Other" PT drug conditions occupy the subsequent Payer Value Code positions and PAF 19 and 20 depending upon the number of conditions present.