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January 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.0

MLN Matters Number: MM10385
Related Change Request (CR) Number: 10385
Related CR Release Date: December 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3940CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10385 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses under the Outpatient Perspective Payment (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10385 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer of the updates to the I/OCE for January 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html.The following table summarizes the modifications of the I/OCE for the January 2018 V19.0. Readers should also read through the entire document attached to CR10385 and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

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Effective Date	Edits Affected	Modification
1/1/2018		Updates to the following tables (additional details included in the tables listed in the attachment to CR10385): Table 1: IOCE Control Block - Add Value Codes and Value Code Amounts, up to 36 - Increase the number of Condition Codes to 30 - Increase the number of Occurrence Codes to 30 - Remove the following fields: Ndxptr, Nsgptr, NCCptr, NOccptr, CodeTypePtr - Modify the Comments for the following fields: Dxeditptr, Proceditptr, Mdeditptr, Dteditptr, Rceditptr, APCptr, Claimptr Table 5: Claim Return Buffer - Add Payer Condition Code field Table 7: APC Return Buffer - Add HCPCS Modifier field
1/1/2016		Update program logic for drug HCPCS lines with Status Indicator (SI) of G or K to return the Payment Ambulatory Payment Classification (APC) (see processing logic and Appendix E of the attachment to CR10385).
1/1/2018		Update Appendix K to note the deletion of composite APC 8001.
1/1/2018		Implement program logic for payment reduction of x-rays taken using computed radiography technology. HCPCS codes reporting modifier FY are assigned new payment adjustment flag value 22 (CAA Section 502b reduction on computed radiography) (see special processing section and Appendix G). Note: Currently the list of HCPCS codes affected by this logic is the same as that used with modifier FX.
1/1/2018		Implement program logic for OPPS claims to assign a HCPCS level modifier to the line level output when drug HCPCS with SI = K are reported with new modifier JG. The IOCE adds modifier V3 to the line in the new 'HCPCS modifier' field of the program output (see processing logic and Table 7).
1/1/2017	102	Implement new edit 102: Modifiers PO/PN not allowed on the same line (Return to Provider (RTP)). Edit criteria: A claim line has both modifiers PO and PN present (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type).
7/24/2017	103	Implement new edit 103: Modifier reported prior to FDA approval date (Line Item Denial (LID)). Edit criteria: A modifier is reported prior to the mid-quarter activation date (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type).
1/1/2017		Modify program logic for conditional packaging of laboratory services. Laboratory services with SI = Q4 have the SI changed to A if present with an OPPS procedure that has final SI = Q1 with a line item action flag of 2 or 3 applied (see processing logic).
6/5/2017	68	Implement mid-quarter NCD approval edit for procedure code 0421T.

Effective Date	Edits Affected	Modification
1/1/2018		Update program logic for Federally Qualified Health Center (FQHC) claims for new Chronic Care Management codes G0511, G0512. If either code is reported, assign Payment Indicator = 2 and bypass edits 88 and 89 if no FQHC payment code is reported (see Appendix M).
4/1/2011		Update program logic for services that may be subject to deductible or deductible/coinsurance waiver. If the services are packaged with SI = N and the line item charges = 0.00, do not assign payment adjustment flags 4, 9 or 10 (see processing logic where payment adjustment flags 4, 9 or 10 are applicable and Appendix G).
1/1/2018	22	Add the following new modifiers to the valid modifier list: - FY: Computed radiography x-ray - JG: 340B Acquired Drug - TB: Tracking 340b acquired drug - X1: Continuous/broad services - X2: Continuous/focused services - X3: Episodic/broad services - X4: Episodic/focused services - X5: Svc req by another clinician - 96: Habilitative services - 97: Rehabilitative services
1/1/2018		Update Appendix D to reference HCPCS codes that have SI values different from its APC SI value and impact to discounting (see Appendix D).
10/1/2017		Update program logic for Partial Hospitalization Program (PHP) claims to return Payer-defined Condition Codes in the following instances: - Return condition code MP if the PHP claim represents the initial admit week claim - Return condition code MQ if the PHP claim represents the final discharge week claim Note: edit 95 is not returned on an initial admit week or a final discharge week of a PHP claim (see processing logic).
1/1/2018		Update program logic for critical care ancillary services to discontinue the modifier 59 logic exception for code 36600; code no longer identified as critical care ancillary service (see processing logic).
1/1/2018		Add new payment adjustment flag value 22 (see Appendix G).

Effective Date	Edits Affected	Modification
1/1/2018		Update the following lists for the release (see quarterly data files): - Comprehensive APC ranking - Complexity-adjusted comprehensive APC code pairs - Critical care ancillary services (conditional packaging) - Procedure and sex conflict (edit 8) - Bilateral procedure editing - Blood clotting factor and biologic response HCPCS (edit 99 excusions) - Blood products (edit 73, code updates) - Skin substitute lists (edit 87 – code updates, see Appendix O) - Coinsurance/Deductible N/A list (code updates, Appendix O, Preventive Services) - Device Offset Code Pairs (code pair updates for pass-through device offset logic) - Device-Procedure; terminated device-procedures for offset (edit 92, code updates) - Pass-through drugs and biological APC offset amounts - Pass-through skin substitute products (code updates) - Radiation HCPCS for Section 603 (code updates) - CT Scan HCPCS subject to NEMA (code updates) - X-ray list for modifiers FX/FY (code updates) - Non-covered services lists (SI = E1, for edits 9, 28, 50, code updates) - Separate payment not provided list (SI = E2, edit 13) - Non-reportable for OPPS list (SI = B, edit 62) - Services not billable to MAC list (SI = M, edit 72) - FQHC non-covered list (code updates for FQHC and RHC claims) - FQHC flu vaccine list (code updates for FQHC claims) - FQHC Chronic Care Management (new codes for new list)
1/1/2018		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
1/1/2018	20, 40	Implement version **24.0** of the NCCI (as modified for applicable outpatient institutional providers).

ADDITIONAL INFORMATION

The official instruction, CR10385, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3940CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

DOCUMENT HISTORY

Date of Change	Description
December 22, 2017	Initial article released.