DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8879 **Related Change Request (CR) #: CR 8879**

Related CR Release Date: August 8, 2014 **Effective Date: October 1, 2014**

Related CR Transmittal #: R3018CP **Implementation Date: October 6, 2014**

October 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.3

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8879 informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that will be utilized under the Outpatient Prospective Payment System (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 not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

Background

This instruction informs MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2014. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications is available at **http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html** on the Centers for Medicare & Medicaid Services (CMS) website. CR8879 includes an attachment with a summary of changes for October 2014 in Appendix N of the attachment with key changes for providers in the following table:

Effective Date	Modification
10/1/2014	Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this October 2014 release is 1/1/2008).
01/01/2008	Add code 52630 to the male-only procedure list, retroactive to the earliest version of the program.
10/1/2014	Add logic for processing claims with bill type 77x that do not contain Condition Code 65 under new FQHC PPS logic (see page 10 and new Appendix L).

Effective Date	Modification
10/1/2014	Add new values to the following output fields returned in the APC Return Buffer (see Table 7) in support of FQHC processing: a) Payment Indicator: 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 b) Packaging Flag: 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment, not subject to coinsurance payment c) Payment Method Flag 5 – Payment for service determined under FQHC PPS d) Line Item Action Flag 5 - Non-covered service excluded from payment under FQHC PPS e) Composite Adjustment Flag 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC clinic visit, medical or mental health (modifier 59 reported) Note: The values defined above for Composite Adjustment flag are used only for FQHC claims with bill type 77x when CC 65 is not present.
10/1/2014	New edit 88 - FQHC payment code not reported for FQHC claim (RTP) Criteria: FQHC payment code not reported for a claim with bill type 77x and without Condition Code 65 Note: If the bill type is 770 (No payment claim), edit 88 is not applicable.
10/1/2014	New edit 89 - FQHC claim lacks required qualifying visit code (RTP) Criteria: FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS.

Effective Date	Modification
10/1/2014	New edit 90 - Incorrect revenue code reported for FQHC payment code (RTP) Criteria: FQHC payment code not reported with revenue code 519, 52X or 900.
10/1/2014	New edit 91 - Item or service not covered under FQHC PPS (LIR) Criteria: A service considered to be non-covered under FQHC PPS is reported.
10/1/2014	Add edit 6 (Invalid procedure code) and edit 84 (Claim lacks required primary code) to the list of edits to be applied for FQHC PPS claims.
10/1/2014	Update Appendix F(a) OCE Edits Applied by Bill Type table, to include a new row for edits applicable for FQHC (bill type 77x) effective 10/1/2014. Modified row10 to document the previous bill type 77x applicable versions.
10/1/2014	Update Appendix E(a) Logic for Assigning Payment Method Flag Values to Status Indicators by Bill type to add new Payment Method Flag value of 5.
10/1/2014	Make HCPCS/APC/SI changes as specified by CMS (data change files).
10/1/2014	Implement version **20.3** of the NCCI (as modified for applicable institutional providers).
7/1/2014	Updated skin substitute product list (Appendix O, List E) to move Q4137 from low cost to high cost (List A to List B).
10/1/2014	Updated skin substitute product list (Appendix O, List E) to move Q4138 and Q4140 from low cost to high cost (List A to List B).
1/1/2012	Remove the Deductible/CoInsurance N/A flag from HCPCS code G0448, which was erroneously flagged in the program, retroactively to 1/1/2012.
10/1/2014	Add new Appendix L (FQHC Processing Logic and Flowchart) and rename OCE Overview to Appendix M, rename the Summary of Modifications to Appendix N, and rename the Code Lists to Appendix O.
10/1/2014	Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS web site.
10/1/2014	Deliver quarterly software update & all related documentation and files to users via electronic means.

Additional Information

The official instruction, CR8879 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3018CP.pdf**on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.