DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9892 **Related Change Request (CR) #: CR 9892**

Related CR Release Date: December 9, 2016 **Effective Date: January 1, 2017**

Related CR Transmittal #: R3674CP **Implementation Date: January 3, 2017**

January 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.0

Provider Types Affected

This MLN Matters® Article is intended for providers who submit institutional claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH+H) MACs, for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9892 provides instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) used for Outpatient Prospective Payment System (OPPS) and non-OPPS claims. This is 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 (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/. These specifications contain the appendices mentioned in the table below.

Key I/OCE Changes for January 2017

The following table summarizes the modifications of the IOCE for the January 2017 v18.0 release. Note that 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.

Effective Date	Edits Affected	Modification
1/1/2017		Implement new program logic for the Community Mental Health Center (CMHC) outlier limitation (see OPPS processing logic and Appendix E). Apply new Payment Method Flag 6 to all OPPS payable lines if condition code 66 is present for claims with bill type 76x.
1/1/2017		Implement new program logic to include Negative Pressure Wound Therapy (NPWT) procedure codes 97607 and 97608 to the list of codes reportable for Home Health claims with bill type 34x that are payable under OPPS (see OPPS special processing logic and Appendix F-(a)).
8/1/2016	67	Implement mid-quarter Food and Drug Administration (FDA) approval edit for 90674.
1/1/2017	100	Implement new edit: Claim for Hematopoietic Stem Cell Transplantation (HSCT) allogeneic transplantation lacks required revenue code line for donor acquisition services (claim is Returned to Provider (RTP)). Edit criteria: A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services (see Table 4).
1/1/2017	41	Add new revenue code 815 (Allogeneic stem cell acquisition services) to the valid revenue code list.
1/1/2017		Implement updated program logic to process conditional Ambulatory Payment Classification (APC)/packaging, critical care ancillary packaging and advance care planning across the claim rather than by day (see OPPS processing logic).
1/1/2017		Implement updated program logic for processing terminated device-intensive procedure offset determinations by HCPCS code, not by APC. Note: This also includes table changes for the quarterly data file reports.
1/1/2017		Implement new program logic for payment adjustment of film x-ray HCPCS codes. Film x-ray HCPCS codes with modifier FX reported are assigned new payment adjustment flag 21 (see OPPS processing logic, Table 7 and Appendix G).
1/1/2017	22	Add new modifiers FX (X-ray taken using film), PN (Non-excepted off-campus svc), 95 (Synchronous Telemedicine Service) and V1, V2, V3 (Demonstration modifiers 1, 2, 3) to the valid modifier list.

Effective Date	Edits Affected	Modification
1/1/2017		Implement new Status Indicator (SI) value E1, to replace former SI E for non-covered services (see Table 7). Note: Edits 9, 28 and 50 applied formerly for HCPCS with SI = E are now applied to HCPCS with SI = E1.
1/1/2017		Implement new SI value E2 (Items and services for which pricing information and claims data are not available) (see Table 7).
1/1/2017	13	Reactivate edit 13: Separate payment for services is not provided by Medicare (LIR). Edit criteria: there is a line item HCPCS present with SI = E2 (see OPPS processing logic, Table 4, Table 7).
1/1/2014		Correction of program logic for Extended Assessment and Management (EAM) composite APC 8009 to not consider conditional APC processing of sometimes therapy codes with SI = Q1 resulting in final SI = A as criteria for preventing assignment of the EAM composite APC. Also, units of service are not reduced to one under conditional APC processing for sometimes therapy codes resulting in final SI = A (see OPPS processing logic and Appendix K).
9/28/2016	68	Implement mid-quarter NCD coverage for G0499.
1/1/2016	99	Update the edit logic to include exceptions for certain blood clotting factor HCPCS codes that may be self-administered and do not require that an OPPS payable procedure is present. Also, program logic only is updated to apply edit 99 only to those OPPS bill types where APC information is returned (see Appendix F(a) for reference).
1/1/2016		Update the inpatient procedure processing when the patient expires to also include claims with discharge status codes indicating transfer to another hospital facility (see OPPS processing logic and Appendix L).
1/1/2016	70	Update the edit logic and description to include transfer discharge status: Edit description: CA modifier requires patient discharge status indicating expired or transferred
1/1/2017		Implement new program logic for identifying non-excepted items or services under Section 603 requirements that are provided in off-campus provider-based hospital outpatient departments that are reported with modifier PN may be subject to alternative payment method or reduction (see OPPS processing logic and new Appendix Q).

Effective Date	Edits Affected	Modification
1/1/2017	101	Implement new edit 101: Item or service with modifier PN not allowed under PFS (RTP). Edit criteria: Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603.
1/1/2016		Update the advance care planning logic to include add-on code 99498; change the SI to A if reported with 99497 and the annual wellness visit, otherwise package with SI = N.
1/1/2017		Update the program logic and flowcharts for partial hospitalization and daily mental health to refer to a single level per diem APC (level I/II APCs no longer applicable) (see OPPS processing logic and Appendix C ('a' and 'b'). Appendices are attached to CR9892.
1/1/2017	87	Update the skin substitute product lists (Appendix O, List E: Lists A and B)
1/1/2017	22	Modifier L1, associated with the reporting of conditionally packaged laboratory procedures is deactivated (see OPPS processing logic).
1/1/2017		Update program logic for LDR brachytherapy composite APC primary code 55875 is assigned under comprehensive APCs if conditions are not met for composite APC 8001 assignment (see Appendix K).
1/1/2017		Add the following new payment method flags (see Table 7 and Appendix E): - 6 (CMHC Outlier limitation reached) - 7 (Section 603 service with no reduction in OPPS Pricer) - 8 (Section 603 service with PFS reduction applied in OPPS Pricer)
1/1/2017		Update the description for Payment Indicator value of 2: "Services not paid by OPPS Pricer; paid under fee schedule or other payment system (SIs A, G, K)" (see Table 7).
1/1/2017		Add new payment adjustment flag 21 (CAA Section 502b reduction on film x-ray) (see Table 7 and Appendix G).
1/1/2017		Add new SI values E1 and E2 (Items and services for which pricing information and claims data are not available) (see Table 7).
1/1/2017		Update Appendix F (a) to include new edits 100 and 101.
1/1/2017		Add new Appendix Q: processing steps and criteria for non-excepted items and services under Section 603.

Effective Date	Edits Affected	Modification
1/1/2017		Update Appendix L to include new SI values E1 and E2 in the list of SI's that are edited as usual under comprehensive APC processing.
1/1/2017		Update table 4 to add new columns noting versions and dates effective for edits.
1/1/2017		Update the following lists for the release (see quarterly data files): - Bilateral flag lists - Procedure and gender conflict lists (edit 8) - Comprehensive APC list - Complexity-adjusted Comprehensive APC code pairs - Device and Device-Procedure lists (edit 92) - Terminated Device offset (offset by HCPCS) - Pass-through device offset amounts - Film x-ray HCPCS (new logic) - Negative pressure wound therapy (new logic) - Section 603 override HCPCS (new logic) - Blood clotting factor HCPCS (edit 99 exclusion) - Skin substitutes (edit 87) - Pass-through Radiopharmaceuticals - Pass-through Radiopharmaceutical APC offset amounts - Pass-through Contrast APC offset amounts - Pass-through Skin substitutes - Pass-through Skin substitute APC offset amounts - Deductible-Coinsurance N/A list (Appendix O, List C) - Service not paid Medicare list (new SI = E2) - Not recognized Medicare list (edit 28) - Non-covered service list (edit 9) - Statutory exclusion list (edit 50) - Not recognized OPPS list (edit 62) - FQHC vaccines - FQHC code pairs
1/1/2017		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
1/1/2017	20, 40	Implement version **23.0** of the NCCI (as modified for applicable outpatient institutional providers).

Additional Information

The official instruction, CR9892, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3674CP.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/**.