

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of Medicare’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network’s [Special Edition Article #SE1126](#), titled “Further Details on the Revalidation of Provider Enrollment Information.”

MLN Matters® Number: MM7668 **Revised**

Related Change Request (CR) #: 7668

Related CR Release Date: December 16, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2370CP

Implementation Date: January 3, 2012

## January 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.0

**Note: This article was updated on August 2, 2012, to reflect current Web addresses. All other information remains the same.**

### Provider Types Affected

This article is for providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the Home Health Prospective Payment System or claims for services to a hospice patient for the treatment of a non-terminal illness.

#### Disclaimer

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## Provider Action Needed

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This article is based on Change Request (CR) 7668, which describes changes to the I/OCE and OPSS to be implemented in the January 2012 OPSS and I/OCE updates. Be sure your billing staff is aware of these changes.

## Background

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The full list of I/OCE specifications can now be found at <http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.

A summary of the changes for January 2012 is within Appendix M of Attachment A of CR7668 and that summary is captured in the following key points.

- Effective January 1, 2011, correct the logic for assignment of PAF #4 on the PT modifier – to apply only when the PT modifier is present on a CPT code in the range of 10000 – 69999.
- Effective May 9, 2011, Medicare will change the mid-quarter FDA approval date from 5/10/11 to 5/9/11 for code 90654. Edit 67 is affected.
- Effective October 1, 2011, Medicare will add new G-codes (G0442 – G0447) to the list of preventive services for Payment Adjustment Flag (PAF) 9.
- Effective October 14, 2011, Medicare will add new codes G0442, G0443, G0444 with a mid-quarter National Coverage Determination (NCD) approval date of 10/14/11. Edit 68 is affected.
- Effective November 8, 2011, Medicare will add new codes G0445 and G0446 with a mid-quarter NCD approval date of 11/8/11. Edit 68 is affected.
- Effective November 29, 2011, Medicare will add new codes G0447 with a mid-quarter approval date of 11/29/11. Edit 68 is affected.
- Effective January 1, 2012, Medicare will:
  - Make HCPCS/APC/SI changes (data change files);
  - Implement version 18.0 of the NCCI (as modified for applicable institutional providers). Edits 19, 20, 39 and 40 are affected. [To bring NCCI version current with IOCE version; effective date of NCCI = IOCE version date];
  - Update procedure/device and device/procedure edit requirements. Edits 71 and 77 are affected;
  - Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS website;
  - Update modifier FB/FC device reduction amounts & crosswalk;
  - Update Nuclear medicine/Radio labeled product edit requirements. Edit 78 is affected;

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- Update composite Ambulatory Payment Classification (APC) 34 requirements – Add code G0451 (replacement for 96110);
- Modify the logic such that if procedure codes 33249 and 33225 are submitted on the same date of service:
  - Assign 33249 to standard APC for payment, package 33225 (change SI to N); and
  - Ignore FB or FC modifier on 33225 if the SI has been changed to N;
- Change SI for 33249 to T; change SI for 33225 to T when it is not submitted with 33249 on the same day.
- Add new edit 84 – Claim lacks required primary code (Return to Provider RTP)).  
Criteria: Add-on code 33225 is submitted without one of the following primary codes on the same day: 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33222, 33234, 33235, 33240, 33249;
- Add new edit 85 – Claim lacks required device code or required procedure code (RTP).  
Criteria: Code C9732 and C1840 not submitted together on the same day. (Code for insertion of ocular telescopic lens submitted without the code for the lens, or vice versa).

## Additional Information

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The official instruction, CR7668 issued to your Medicare MAC, RHHI, or FI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2370CP.pdf> on the CMS website. If you have any questions, please contact your Medicare MAC, RHHI, or FI at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

**News Flash - It's a Busy Time of Year.** Make each office visit an opportunity to remind your patients about the importance of getting the seasonal flu vaccination and a one-time pneumococcal vaccination. Medicare pays for these vaccinations for all beneficiaries with no co-pay or deductible. The Centers for Disease Control and Prevention also recommends that healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu.** **Remember:** The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related educational provider resources, visit the following CMS web pages [Medicare Learning Network® Preventive Services](#) and [Immunizations](#). **Get the Flu Vaccine -- Not the Flu.** For the 2011-2012 seasonal flu vaccine payment limits, visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>.

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