

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



MLN Matters® Number: MM9459

Related Change Request (CR) #: CR 9459

Related CR Release Date: January 6, 2016

Effective Date: January 1, 2016

Related CR Transmittal #: R3437CP

Implementation Date: January 4, 2016

## January 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.0

### Provider Types Affected

---

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

### Provider Action Needed

---

CR 9459 provides the instructions and specifications for the I/OCE to be used 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 (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to [Chapter 4](#), Section 40.1 of the “Medicare Claims Processing Manual”. Make sure that your billing staffs are aware of these changes.

### Background

---

CR 9459 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for January 1, 2016. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at <http://www.cms.gov/OutpatientCodeEdit/> on the Centers for Medicare & Medicaid Services (CMS) website. The modifications of the I/OCE for the January 2016 Version 17.0 release are summarized in the table below. Some

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.

I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

You should also read through the entire CR9459 document and note the highlighted sections, which also indicate changes from the prior release of the software. A full summary of data changes in I/OCE V17, including diagnosis, Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes, Status Indicators (SIs), and Ambulatory Payment Classification (APC) codes, is attached to CR9459.

<b>Effective Date</b>	<b>Edits Affected</b>	<b>Modification</b>
1/1/2016		Move the former Appendix O (Summary of Modifications) to the beginning of the specification document and rename to “Summary of Quarterly Release Modifications”; rename Appendix P (Code Lists) to Appendix O.
1/1/2016		Implement new program logic for pass-through device offset amount passed to Pricer by way of Payer Value Code with Payer Value Code Amount field in the Claim Return Buffer (Table 5 of I/OCE specifications). Assign new payment adjustment flag values to identify pass-through devices (see OPSS special processing logic, Table 5, 7 and Appendix G).
1/1/2016		Update comprehensive APC program logic to add new Comprehensive Observation C-APC 8011, and SI = J2 (see OPSS special processing logic and Appendix L); add new flowchart for Comprehensive Observation APC logic.
1/1/2016		Update the program logic for processing inpatient procedures when the patient expires to be assigned under comprehensive APCs (see OPSS special processing logic and Appendix L).
1/1/2016		Add new program logic to exclude SRS (stereotactic radiosurgery) planning and preparation services from packaging under C-APCs if present on the same claim as the SRS C-APC (see OPSS special processing logic and Appendix L).
1/1/2016		Update the Critical care ancillary packaging to remove the exception when ancillary services are reported with modifier 59 as not applicable under C-APCs (see OPSS special processing logic).
1/1/2016		Add program logic for processing Advanced Care Planning services for payment by either the Medicare Physician Fee Schedule (SI = A) or by APC through conditional packaging (SI = Q1) (see OPSS special processing logic).
1/1/2016		Add program logic for conditionally packaged laboratory services with new SI = Q4 (see OPSS special processing logic).

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.

<b>Effective Date</b>	<b>Edits Affected</b>	<b>Modification</b>
1/1/2016		Add program logic for certain CT scan codes reported with modifier CT that do not meet National Electrical Manufacturers Association (NEMA) equipment standards; pass new payment adjustment flag 14 (see OPSS special processing logic, Appendix G and Appendix K).
1/1/2016		Update Appendix K to note the deactivation of composite APC 8009; add reference to Comprehensive Observation APC for direct referral logic.
1/1/2016		Implement new Status Indicators (see Table 7): J2: Hospital Part B services that may be paid through a comprehensive APC Q4: Conditionally packaged laboratory services
1/1/2016		Implement new Payment Adjustment Flag values (see Table 7 and Appendix G): 12: Offset for device pass-through 13: Offset for additional device pass-through 14: Protecting Access to Medicare Act of 2014 (PAMA) Section 218 reduction on CT scan
1/1/2016		Implement new Payment Indicator values (see Table 7): 14: Grandfathered tribal Federally Qualified Health Center (FQHC) encounter payment
1/1/2016	93	Implement new edit 93 (Corneal tissue processing reported without cornea transplant procedure) (see Table 4). Edit criteria: Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date (LIR).
1/1/2016	94	Implement new edit 94 (Biosimilar HCPCS reported without biosimilar modifier) (see Table 4). Edit criteria: A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier (RTP).
<b>10/1/2015</b>	2	Remove the age edit restriction for ICD-10 diagnosis codes F930, F938, F939, F941-F949, F9821, F9829, F983, F988, and F989.
1/1/2016	8	Updates to the male and female sex restriction edit for new procedure codes.

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.

<b>Effective Date</b>	<b>Edits Affected</b>	<b>Modification</b>
1/1/2016	22	New modifiers: CP: C-APC adjunctive service CT: CT does not meet NEMA standards ZA: Novartis/Sandoz
1/1/2016		Update program logic and documentation for any references to APC values that now reflect new APC values due to restructure of APC groups (for example, Partial Hospitalization Program (PHP) logic, Mental Health composite).
1/1/2016		Update FQHC program logic for Grandfathered Tribal FQHC encounters (see special processing conditions for FQHC claims and Appendix M).
1/1/2016		Update FQHC program logic for separate payment of Chronic Care Management services (see special processing conditions for FQHC claims and Appendix M).
1/1/2016		Update FQHC program logic for Advanced Care Planning services; treat as qualifying visit code or packaged preventive service (see special processing conditions for FQHC claims and Appendix M).
1/1/2016	67	Update mid-quarter FDA effective dates for the following codes: - 90621: 10/29/2014 - 90620: 01/23/2015
<b>6/2/2014</b>	68	Update the SI assignment for HCPCS G0472 to SI = A, effective with the mid-quarter NCD edit already in place.
1/1/2016	68	Implement mid-quarter NCD effective dates for the following codes: - G0296: 02/05/2015 - G0297: 02/05/2015 - G0476: 07/09/2015 - 90630: 08/01/2015

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.

Effective Date	Edits Affected	Modification
1/1/2016		Update the following lists for the release (see quarterly data files): <ul style="list-style-type: none"> <li>- Comprehensive APCs (C-APC list, ranking, exclusions, complexity-adjusted code pairs)</li> <li>- Skin substitute products (edit 87, Appendix O)</li> <li>- Conditionally STV-packaged and T-packaged</li> <li>- Deductible/Coinsurance N/A</li> <li>- Inpatient Only procedures (edit 18)</li> <li>- Device and Device-Procedures (edit 92)</li> <li>- Lab Services (conditional packaging)</li> <li>- FQHC (preventive services, flu/PPV vaccine, non-covered and qualifying visit pairs)</li> <li>- Cornea transplant procedures (new edit 93)</li> <li>- CT Scan not meeting NEMA standard (new, payment adjustment flag 14)</li> <li>- Device Offset (new, payment adjustment flag 12, 13)</li> <li>- SRS planning and preparation codes (new C-APC logic)</li> <li>- ICD-10 diagnosis age edit restrictions (edit 2)</li> <li>- Procedure and sex conflict edit restrictions (edit 8)</li> </ul>
1/1/2016	57	Update the edit description to remove the reference to ‘Composite’.
1/1/2016		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
1/1/2016	20, 40	Implement version <b>22.0</b> of the NCCI (as modified for applicable institutional providers).

## Additional Information

The official instruction, [CR 9459](#), issued to your MAC regarding this change, is available 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> on the CMS website, under - How Does It Work.

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.