

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 888

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MARCH 10, 2006

Change Request 4360

SUBJECT: April 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.1

I. SUMMARY OF CHANGES: This instruction is to inform the Fiscal Intermediaries that the April 2006 Outpatient Prospective Payment System Outpatient Code Editor (OPPS OCE) specifications have been updated with new additions, deletions, and changes.

NEW/REVISED MATERIAL

EFFECTIVE DATE: April 1, 2006

IMPLEMENTATION DATE: April 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
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III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
4360.2	Intermediaries and RHHI’s shall inform providers of the OPPS OCE changes for Version 7.1 detailed in this recurring change notification. A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X			

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: OPPS OCE/ PRICER

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: April 1, 2006</p> <p>Implementation Date: April 3, 2006</p> <p>Pre-Implementation Contact(s): For OCE related questions contact Diana Motsiopoulos at dmotsiopoulos@cms.hhs.gov, or Antoinette Johnson at ajohnson2@cms.hhs.gov For Policy related questions contact Marjorie Baldo at marjorie.baldo@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Regional Office</p>	<p>No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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Attachment A

ATTACHMENT A

April 2006 Outpatient Code Editor (OCE) Specifications Version (V7.1)

This attachment contains specifications issued for the January 2006 OCE (Version 7.0). All shaded material reflects changes incorporated into the April 2006 version of the OPSS OCE (Version 7.1).

Introduction

This attachment provides OCE instructions and specifications that will be utilized under the OPSS for hospital outpatient departments, community mental health centers (CMHCs), and for limited services as defined below when provided in a comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA) not under Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. Henceforth, this OCE will be referred to as the OPSS OCE. You are required, effective with unprocessed claims with dates of service on or after August 1, 2000, to send the following bills through the OPSS OCE:

- All outpatient hospital Part B bills (bill types 12X, 13X, or 14X) with the exception of critical access hospitals (CAHs), Indian Health Service Hospitals (IHS)/ Tribal hospitals including HIS/ Tribal CAHs, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan. In addition, claims from Virgin Island hospitals with dates of service January 1, 2002, and later, and claims from hospitals that furnish only inpatient Part B services with dates of service January 1, 2002, and later should not be sent through the OPSS OCE since they are also excluded from OPSS. (See below for more detail regarding these hospitals.);
- CMHC bills (bill type 76X);
- HHA bills containing certain Healthcare Common Procedure Coding System (HCPCS) codes as identified in the chart entitled "HCPCS Codes for Reporting Antigens, Vaccine Administration, Splints and Casts" below (bill types 34X); and
- Any bill containing a condition code 07, "treatment of non-terminal illness – hospice", with certain HCPCS codes as identified in the chart entitled "HCPCS Codes for Reporting Antigens, Vaccine Administration, Splints and Casts" below.

Send all other outpatient bill types (22X, 23X, 24X, 32X, 33X, 43X, 71X, 72X, 73X, 74X, 81X or 82X) through the OPSS OCE. Send Indian Health Service hospitals, CAHs, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan through the non-OPSS OCE (original OCE). Also send claims from Virgin Island hospitals with dates of service on or after January 1, 2002, and claims from hospitals that furnish only inpatient Part B services with dates of service on or after January 1, 2002, through the non-OPSS OCE. Refer to the IOM Chapter 100-04, Chapter 4, Section 150, for information regarding hospitals that provide Part B only services to their inpatients.

NOTE: For bill type 34X vaccine administration, splints, casts, and antigens will be paid under OPSS. For bills containing condition code 07, only splints, casts and antigens will be paid under OPSS.

You are also required to notify your providers of the OPSS OCE claim outputs.

The following information provides you with the OPSS OCE edit specifications that will be utilized to make appropriate payments under the OPSS system, which was effective August 1, 2000.

General Functions of the OCEs

The OPSS OCE performs the following two major functions:

- Edit claims data to identify errors and return a series of edit flags; and
- Assign an ambulatory payment classification (APC) number for each service covered under OPSS and return information to be used as input to the PRICER program.

A major change in processing was required to handle claims with service dates that span more than 1 calendar day. Each claim is represented by a collection of data, which consists of all necessary demographic (header) data, plus all services provided (line items). You are responsible for organizing all applicable services into a single claim record, and passing them as a unit to the OPSS OCE. OPSS OCE functions only on a single claim and does not have any cross-claim capabilities. OPSS OCE will accept up to 450 line items per claim. The OPSS OCE software is responsible for ordering line items by date of service.

The non-OPSS OCE focused solely on the presence or absence of specific edits and did not specify action that should be taken when an edit occurred (e.g., deny claim, suspend claim). Further, it did not compute any information that would be used for payment purposes. Therefore, it was structured to return a set of flags for each diagnosis and procedure that indicated the presence or absence of individual edits. The OPSS OCE not only identifies individual errors but also indicates actions to take and the reasons why these actions are necessary. In order to accommodate this expanded functionality, the OPSS OCE is structured to return lists of edit numbers instead of zero/one flags. This new structure facilitates the linkage between the action being taken, the reasons for the action, and the information on the claim (e.g., a specific diagnosis) that caused the action.

In general, the OPSS OCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes. Since these coding systems are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program will reduce effort for you and reduce the chance of inconsistent processing.

The span of time that a claim represents will be controlled by the from and through dates that will be part of the input header information. If the claim spans more than 1 calendar day, the OPSS OCE will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day.

Some edits will be date driven. For example, bilateral procedures will be considered an error if a pair of procedures is coded with the same service date, but not if the service dates are different.

Information Sent to OPPS OCE

Header and line item information is passed to the OPPS OCE by means of a control block of pointers. Table 1 contains the structure of the “OPPS OCE Control Block”. The shaded area separates input from return information. Multiple items are assumed to be in contiguous locations.

The header information must relate to the entire claim and must include the following:

- From date;
- Through date;
- Condition code;
- List of ICD-9-CM diagnosis codes;
- Age;
- Sex;
- Type of bill; and
- Medicare provider number.

The from and through dates will be used to determine if the claim spans more than 1 day and therefore represents multiple visits. The condition code (e.g., 41) specifies special claim conditions such as a claim for partial hospitalization, which is paid on a per diem basis. The diagnosis codes apply to the entire claim and are not specific to a line item.

Each line item contains the following information:

- HCPCS code with up to 2 modifiers;
- Revenue code;
- Service date;
- Service units; and
- Charge.

The HCPCS codes and modifiers are used as the basis of assigning the APCs. Not all line items will contain a HCPCS code. The line item service dates are used to subdivide a claim that spans more than 1 day into individual visits. The service units indicate the number of times a HCPCS code was provided (e.g., a lab test with a service unit of 2 means the lab test was performed twice).

Information Returned From OPPS OCE

The following is an overview of the information that will be returned from OPPS OCE and used as input into the PRICER program.

Field	UB-92 Form Locator	Number	Size (bytes)	Comments
HCPCS procedure	44	1	5	May be blank

code				
HCPCS modifier	44	5 x 2	10	
Service date	45	1	8	Required for all lines
Revenue code	42	1	4	
Service units	46	1	7	A blank or zero value is defaulted to 1
Charge	47	1	10	Used by Pricer to determine outlier payments

Line item input information

There are currently (72) different edits in the OCE, two of which are currently inactive. Each edit is assigned a number. A description of the edits is contained in the “Claim Return Buffer” Table 4. The edit return buffers consist of a list of the edit numbers that occurred for each diagnosis, procedure, modifier, date or revenue code. For example, if a 75-year-old male had a diagnosis related to pregnancy it would create a conflict between the diagnosis and age and sex. Therefore, the diagnosis edit return buffer for the pregnancy diagnosis would contain the edit numbers 2 and 3. There is more space allocated in the edit return buffers than is necessary for the current edits in order to allow future expansion of the number of edits. Table 3 describes the Edit Return Buffers.

The “Claim Return Buffer” described in the Table 4 summarizes the edits that occurred on the claim. The occurrence of an edit can result in one of six different dispositions.

Claim Rejection	There are one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.
Claim Denial	There are one or more edits present that cause the whole claim to be denied. A claim denial means that the provider cannot resubmit the claim but can appeal the claim denial.
Claim Return to Provider (RTP)	There are one or more edits present that cause the whole claim to be returned to the provider. A claim returned to the provider means that the provider can resubmit the claim once the problems are corrected.
Claim Suspension	There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not returned to the provider, but is not processed for payment until the FI makes a determination or obtains further information.
Line Item Rejection	There are one or more edits present that cause one or more individual line items to be rejected. A line item rejection means that the claim can be processed for payment with some line items rejected for payment. The line item can be corrected and resubmitted but cannot be appealed.
Line Item Denials	There are one or more edits present that cause one or more individual line items to be denied. A line item denial means that the claim can be processed for payment with some line items denied for payment. The line item can not be resubmitted but can be appealed.

In the OPSS OCE, many of the edits had a disposition of RTP in order to give providers time to adapt to OPSS. In subsequent releases of OPSS OCE, the disposition of some edits was changed to other more automatic dispositions such as a line item denial. A single claim can have one or more edits in all six dispositions. Six 0/1 dispositions are contained in the claim return buffer that indicate the presence or absence of edits in each of the six dispositions. In addition, there are six lists of reasons in the claim return buffer that contain the edit numbers that are associated with each disposition. For example, if there were three edits that caused the claim to have a disposition of RTP, the edit numbers of the

three edits would be contained in the claim RTP reason list. There is more space allocated in the edit return buffers than is necessary for the current edits in order to allow for future expansion of the number of edits.

In addition to the six individual dispositions, there is also an overall claim disposition, which summarizes the status of the claim.

Table 5 describes the “APC Return Buffer” that contains the APC for each line item along with the relevant information for computing OPSS payment. Two APC numbers are returned: HCPCS APC and payment APC.

Except for partial hospitalization and some inpatient-only procedure claims, the HCPCS APC and the payment APC are always the same. The APC return buffer contains the information that will be passed to the Pricer. The APC is only returned for HOPDs and the special conditions specified in Appendix F.

Partial hospitalizations are paid on a per diem basis. There is no HCPCS code that specifies a partial hospitalization related service. Partial hospitalizations are identified by means of condition codes; bill types and HCPCS codes specifying the individual services that constitute a partial hospitalization (See Appendix C). Thus, there are no input line items that directly correspond to the partial hospitalization service. In order to assign the partial hospitalization APC to one of the line items, the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC.

Reimbursement for a day of outpatient mental health services in a non-PH program is capped at the amount of the partial hospital per diem. On a non-PHP claim, the OCE totals the payments for all MH services with the same date of service; if the sum of the payments for the individual MH services exceeds the partial hospital per-diem, the OCE assigns a special “Daily Mental Health Service” payment APC to one of the line items that represent MH services. The packaging flag is turned on for all other MH services for that day (See appendix C). The payment rate for the Daily Mental Health Services APC is the same as that for the partial hospitalization APC.

For outpatients who undergo inpatient-only procedures on an emergency basis and who expire before they can be admitted to the hospital, a specified APC payment is made to the provider as reimbursement for all services on that day. The presence of modifier –CA on the inpatient-only procedure line assigns the specified payment APC and associated status and payment indicator to the line. The packaging flag is turned on for all other lines on that day. Payment is only allowed for one procedure with modifier –CA. If multiple inpatient-only procedures are submitted with the modifier –CA, the claim is returned to the provider. If modifier CA is submitted with an inpatient-only procedure for a patient who did not expire (patient status code is not 20), the claim is returned to the provider.

Inpatient-only procedures that are on the separate-procedure list (do not generate edit 18) are bypassed when performed incidental to a surgical procedure with Status Indicator T. The line(s) with the inpatient-separate procedure is rejected and the claim is processed according to usual OPSS rules.

When multiple occurrences of any APC that represents drug administration are assigned in a single day, modifier-59 is required on the code(s) in order to permit payment for additional units of that APC, up to a specified maximum; additional units above the maximum are packaged. If modifier -59 is not used, only one occurrence of any drug administration APC is allowed and any additional units are packaged (see Appendix I).

The use of a device is necessary to the performance of certain outpatient procedures. If any of these procedures is submitted without a code for the required device, the claim is returned to the provider. Discontinued procedures are not returned for a device code.

Observations may be paid separately if they meet specific criteria (See Appendix H).

Not all edits are performed for all sites of service. See “OPPS OCE Edits Applied by Bill Type” below for OPPS OCE edits that apply for each bill type.

OPPS PRICER computes the standard OPPS payment for a line item as the product of the payment amount corresponding to the assigned payment APC, the discounting factor, and the number of units for all line items for which the following is true:

Criteria for Applying Standard OPPS Payment Calculations

- APC value is not 00000
- Payment indicator has a value of 1
- Packaging flag has a value of zero or 3
- Line item denial or rejection flag is zero or the line item action flag is 1
- Line item action flag is not 2, 3 or 4
- Payment adjustment flag is zero
- Payment method flag is zero

If payment adjustments are applicable to a line item (payment adjustment flag is not 0), then nonstandard calculations are necessary to compute payment for a line item (see Appendix E). The line item action flag is passed as input to the OPPS OCE as a means of allowing you to override a line item denial or rejection (used by you to override OPPS OCE and have OPPS PRICER compute payment ignoring the line item rejection or denial) or allowing you to indicate that the line item should be denied or rejected even if there are no OPPS OCE edits present. The action flag is also used for handling external line item adjustments. For some sites of service (e.g., HHAs) only some services are paid under OPPS. The line item action flag also impacts the computation of the discounting factor as described in Appendix D “Computation of Discounting Fraction”. OPPS payment for the claim is computed as the sum of the payments for each line item with the appropriate conversion factor, wage rate adjustment, outlier adjustment, etc., applied. The OPPS OCE overview below summarizes the process of filling in the APC return buffer.

If a claim spans more than 1 day, OPPS OCE subdivides the claim into separate days for the purpose of determining discounting and multiple visits on the same day. Multiple day claims are determined based on calendar day. The OPPS OCE deals with all multiple day claims issues by means of the return information. OPPS PRICER does not need to be aware of the issues associated with multiple day claims. It simply applies the payment computation as described above and the result is the total OPPS payment for the claim regardless of whether the claim was for a single day or multiple days. If a multiple day

claim has a subset of the days with a claim denial, RTP, or suspend, the whole claim is denied, RTP, or suspended.

For the purpose of determining the version of the OPSS OCE to be applied, the from date on the header information is used.

Tables

Table 1: OPSS OCE Control Block

Pointer Name		UB-92 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-9-CM diagnosis codes	76 (adx) 67-75 (pdx/sdx)	Up to 16	6	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First listed diagnosis is considered 'admit dx', second diagnosis is considered 'principal dx'
Ndxptr	Count of the number of diagnoses pointed to by <i>Dxptr</i>		1	4	Binary fullword count
Sgptr	Line item entries	44-46	Up to 450	Table 2	
Nsgptr	Count of the number of Line item entries pointed to by <i>Sgptr</i>		1	4	Binary fullword count
Flagptr	Line item action flag Flag set by FI and passed by OCE to Pricer		Up to 450	1	(See Table 7)
Ageptr	Numeric age in years		1	3	0-124
Sexptr	Numeric sex code	15	1	1	0, 1, 2 (unknown, male, female)
Dateptr	From and Through dates (yyyymmdd)	6	2	8	Used to determine multi-day claim
CCptr	Condition codes	24-30	Up to 7	2	Used to identify partial hospitalization and hospice claims
NCCptr	Count of the number of condition codes entered		1	4	Binary fullword count
Billptr	Type of bill	4	1	3	Used to identify CMHC and claims pending under OPSS. It is presumed that bill type has been edited for validity by the Standard System before the claim is sent to OCE
NPIProvptr	National provider identifier (NPI)	51	1	13	Pass on to Pricer
OSCARProvptr	OSCAR Medicare provider number	51	1	6	Pass on to Pricer
PstatPtr	Patient status	22	1	2	UB-92 values
OppsPtr	Opps/Non-OPSS flag		1	1	1=OPSS, 2=Non-OPSS (For future use)
OccPtr	Occurrence codes	36	Up to 10	2	For FI use
NOccptr	Count of number of occurrence codes		1	4	Binary fullword count
Dxeditptr	Diagnosis edit return buffer		Up to 16	Table 3	Count specified in Ndxptr
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Meditptr	Modifier edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Dteditptr	Date edit return buffer		Up to 450	Table 3	Count specified in Nsgptr

Rcreditptr	Revenue code edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
APCptr	APC return buffer		Up to 450	Table 7	Count specified in Nsgptr
Claimptr	Claim return buffer		1	Table 5	
Wkptr	Work area pointer		1	256K	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by Wkptr		1	4	Binary fullword

For those using X12N 837 formats, the following is provided to assist in your implementation efforts:

The Medicare A 837 Health Care Claim version 4010 implementations 3A.01 and 1A.C1 (Appendix C of both documents have UB-92 mapping), along with the UB-92 version 6.0 are at www.hcfa.gov/medicare/edi/edi3.htm. These formats are effective through October 16, 2003. The X12N 837 version 4010 to UB-92 version 6.0 mapping is at <http://cms.hhs.gov/providers/edi/hipaadoc.asp>. The HIPAA X12N 837 can be downloaded at www.wpc-edi.com.

Table 2: Edit Return Buffers

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	0,1-5	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 16 diagnoses.
Procedure edit return buffer	3	30	0,6,8-9,11-21, 28,37-40, 42-45, 47, 49-50, 52-64, 66-69, 70-73	Three-digit code specifying the edits that applied to the procedure.	There is one 30x3 buffer for each of up to 450 line items.
Modifier edit return buffer	3	4	0,22	Three-digit code specifying the edits that applied to the modifier.	There is one 4x3 buffer for each of the five modifiers for each of up to 450 line items.
Date edit return buffer	3	4	0,23	Three-digit code specifying the edits that applied to <u>line item</u> dates.	There is one 4x3 buffer for each of up to 450 line items.
Revenue center edit return buffer	3	5	0, 41,48, 65	Three-digit code specifying the edits that applied to revenue centers.	There is one 5x3 buffer for each of up to 450 line items.

Each of the return buffers is positionally representative of the source that it contains information for, in the order in which that source was passed to OPSS OCE. For example, the seventh diagnosis return buffer contains information about the seventh diagnosis; the fourth modifier edit buffer contains information about the modifiers in the fourth line item.

Table 3: Description of Edits/Claim Reasons

Edit	Description	Disposition
1	Invalid diagnosis code	RTP
2	Diagnosis and age conflict	RTP
3	Diagnosis and sex conflict	RTP
4 ⁴	Medicare secondary payor alert	(V1.0 and V1.1 only) Suspend
5 ⁴	E-diagnosis code can not be used as principal diagnosis	RTP
6	Invalid procedure code	RTP
7	Procedure and age conflict	(Not activated) RTP

8	Procedure and sex conflict	RTP
9	Non-covered for reasons other than statute	Line item denial
10	Service submitted for verification of denial (condition code 21)	Claim denial
11	Service submitted for FI review (condition code 20)	Suspend
12	Questionable covered service	Suspend
13	Separate payment for services is not provided by Medicare (Active V1.0 – V6.3 only)	Line item rejection
14	Code indicates a site of service not included in OPPS (Active V1.0 – V6.3 only)	Claim RTP
15	Service unit out of range for procedure ¹	RTP
16	Multiple bilateral procedures without modifier 50 (see Appendix A) (Active V1.0 – V6.2 only)	RTP
17	Inappropriate specification of bilateral procedure (see Appendix A)	RTP
18	Inpatient procedure ²	Line item denial
19	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
21	Medical visit on same day as a type “T” or “S” procedure without modifier 25 (see Appendix B)	Line item rejection
22	Invalid modifier	RTP
23	Invalid date	RTP
24	Date out of OCE range	Suspend
25	Invalid age	RTP
26	Invalid sex	RTP
27	Only incidental services reported ³	Claim Rejection
28	Code not recognized by Medicare; alternate code for same service may be available (see Appendix C for logic of edits 29-36, and 63-64)	Line item rejection
29	Partial hospitalization service for non-mental health diagnosis	RTP
30	Insufficient services on day of partial hospitalization	Suspend
31	Partial hospitalization on same day as ECT or type T procedure (Active V1.0 – V6.3 only)	Suspend
32	Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days	Suspend
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	Suspend
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	Suspend
35	Only Mental Health education and training services provided	RTP
36	Extensive mental health services provided on day of ECT or type T procedure (Active V1.0 – V6.3 only)	Suspend
37	Terminated bilateral procedure or terminated procedure with units greater than one	RTP
38	Inconsistency between implanted device and implantation procedure	RTP
39	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present	Line item rejection
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection
41	Invalid revenue code	RTP
42	Multiple medical visits on same day with same revenue code without condition code G0 (see Appendix B)	RTP
43	Transfusion or blood product exchange without specification of blood product	RTP
44	Observation revenue code on line item with non-observation HCPCS code	RTP
45	Inpatient separate procedures not paid	Line item rejection
46	Partial hospitalization condition code 41 not approved for type of bill	RTP
47	Service is not separately payable	Line item rejection
48	Revenue center requires HCPCS	RTP
49	Service on same day as inpatient procedure	Line item denial
50	Non-covered based on statutory exclusion	Line item rejection
51	Multiple observations overlap in time (Not activated)	RTP
52	Observation does not meet minimum hours, qualifying diagnoses, and/or ‘T’ procedure conditions (V3.0-V6.3)	RTP
53	Codes G0378 and G0379 only allowed with bill type 13x	Line item rejection
54	Multiple codes for the same service	RTP
55	Non-reportable for site of service	RTP

56	E/M-condition not met and line item date for obs code G0244 is not 12/31 or 1/1 (Active V4.0 – V6.3)	RTP
57	E/M condition not met for separately payable observation and line item date for code G0378 is 1/1	Suspend
58	G0379 only allowed with G0378	RTP
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis	RTP
60	Use of modifier CA with more than one procedure not allowed	RTP
61	Service can only be billed to the DMERC	RTP
62	Code not recognized by OPPS ; alternate code for same service may be available	RTP
63	This OT code only billed on partial hospitalization claims (See appendix C)	RTP
64	AT service not payable outside the partial hospitalization program (See appendix C)	Line item rejection
65	Revenue code not recognized by Medicare	Line item rejection
66	Code requires manual pricing	Suspend
67	Service provided prior to FDA approval	Line item rejection
68	Service provided prior to date of National Coverage Determination (NCD) approval	Line item rejection
69	Service provided outside approval period	Line item rejection
70	CA modifier requires patient status code 20	RTP
71	Claim lacks required device code	RTP
72	Service not billable to the Fiscal Intermediary	RTP
73	Incorrect billing of blood and blood products	RTP

¹ For edit 15, units for all line items with the same HCPCS on the same day are added together for the purpose of applying the edit. If the total units exceeds the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS is on a list of codes that are exempt, the unit edits are not applied.

² Edit 18 causes all other line items on the same day to be line item denied with Edit 49 (see APC return buffer "Line item denial or reject flag"). No other edits are performed on any lines with Edit 18 or 49.

³ If Edit 27 is triggered, no other edits are performed on the claim.

⁴ Not applicable for admitting diagnosis

Table 4: Claim Return Buffer

	Bytes	Number	Values	Description
Claim processed Flag	1	1	0-3, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, or 46 ^a). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 9 - Fatal error; OCE can not run - the environment can not be set up as needed; exit immediately.
Num of line items	3	1	nnn	Input value from Nsgptr, or 450, whichever is less.
National provider identifier (NPI)	13	1	aaaaaaaa aaaa	Transferred from input, for Pricer.
OSCAR Medicare provider number	6	1	aaaaaa	Transferred from input, for Pricer.
Overall claim disposition	1	1	0-5	0 - No edits present on claim. 1 - Only edits present are for line item denial or rejection. 2 - Multiple-day claim with one or more days denied or rejected. 3 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only post payment edits. 4 - Claim denied, rejected, suspended or returned to provider, or

				single day claim w all line items denied or rejected, w only pre-payment edits. 5 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w both post-payment and pre-payment edits.
Claim rejection disposition	1	1	0-2	0 - Claim not rejected. 1 - There are one or more edits present that cause the claim to be rejected. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be rejected.
Claim denial disposition	1	1	0-2	0 - Claim not denied. 1 - There are one or more edits present that cause the claim to be denied. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be denied, or single day claim with all lines denied (edit 18 only).
Claim returned to provider disposition	1	1	0-1	0 - Claim not returned to provider. 1 - There are one or more edits present that cause the claim to be returned to provider.
Claim suspension disposition	1	1	0-1	0 - Claim not suspended. 1 - There are one or more edits present that cause the claim to be suspended.
Line item rejection disposition	1	1	0-1	0 - There are no line item rejections. 1 - There are one or more edits present that cause one or more line items to be rejected.
Line item denial disposition	1	1	0-1	0 - There are no line item denials. 1 - There are one or more edits present that cause one or more line items to be denied.
Claim rejection Reasons	3	4	27	Three-digit code specifying edits (See Table 6) that caused the claim to be rejected. There is currently one edit that causes a claim to be rejected.
Claim denial Reasons	3	8	10,	Three-digit code specifying edits (see Table 6) that caused the claim to be denied. There is currently one active edit that causes a claim to be denied.
Claim returned to provider Reasons	3	30	1-3, 5-6, 8, 14-17, 22-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 52, 54, 55,56, 58-63, 70-73	Three-digit code specifying edits (see Table 6) that caused the claim to be returned to provider. There are 38 edits that could cause a claim to be returned to provider.
Claim suspension reasons	3	16	4, 11, 12, 24, 30-34, 36, 57, 66	Three-digit code specifying the edits that caused the claim to be suspended (see Table 6). There are 12 edits that could cause a claim to be suspended.
Line item rejection reasons	3	12	13, 19, 20, 21, 28, 39, 40, 45, 47, 50, 53, 64, 65, 67-69	Three-digit code specifying the edits that caused the line item to be rejected (See Table 6). There are 16 edits that could cause a line item to be rejected.
Line item denied reasons	3	6	9, 18, 49	Three-digit code specifying the edits that caused the line item to be denied (see Table 6). There are currently 3 active edits that cause a line item denial.
APC return buffer flag	1	1	0-1	0 - No services paid under OPSS. APC return buffer filled in with default values (See Appx. F).

				1 - One or more services paid under OPPS. APC return buffer filled in.
Version Used	8	1	yy.vv.rr	Version ID of the version used for processing the claim (e.g., 2.1.0).
Patient Status	2	1		Patient status code - transferred from input.
Opps Flag	1	1	1-2	OPPS/Non-OPPS flag - transferred from input.

Table 5: APC Return Buffer

Name	Size (bytes)	Values	Description
HCPCS procedure code	5	Alpha	For potential future use by Pricer. Transfer from input
Payment APC	5	00001-nnnnn	APC used to determine payment. If no APC assigned to line item, the value 00000 is assigned. For partial hospitalization and some inpatient-only procedure claims the payment APC may be different than the APC assigned to the HCPCS code.
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status indicator	2	Alpha	A - Services not paid under OPPS B - Non-allowed item or service for OPPS C - Inpatient procedure E - Non-allowed item or service F - Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines G - Drug/Biological Pass-through H - Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents J - New drug or new biological pass-through ¹ K - Non pass-through drugs and biologicals L - Flu/PPV vaccines M - Service not billable to the FI N - Packaged incidental service P - Partial hospitalization service Q - Packaged services subject to separate payment based on criteria S - Significant procedure not subject to multiple procedure discounting T - Significant procedure subject to multiple procedure discounting V - Medical visit to clinic or emergency department W - Invalid HCPCS or Invalid revenue code with blank HCPCS X - Ancillary service Y - Non-implantable DME, Therapeutic Shoes Z - Valid revenue with blank HCPCS and no other SI assigned
Payment indicator	2	Numeric	1 - Paid standard hospital OPPS amount (status indicators K, S, T, V, X) 2 - Services not paid under OPPS (status indicator A) 3 - Not paid (Q, M, W, Y, E), or not paid under OPPS (B, C, Z) 4 - Paid at reasonable cost (status indicator F, L) 5 - Additional payment for drug or biological (status indicator G) 6 - Additional payment for device (status indicator H) 7 - Additional payment for new drug or new biological (status indicator J) 8 - Paid partial hospitalization per diem (status indicator P) 9 - No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy), or G0177 (patient education and training service))
Discounting formula number	1	1-8	See Appendix D for values
Line item denial or rejection flag	1	0-2	0 - Line item not denied or rejected 1 - Line item denied or rejected (edit return buffer for line item contains a 9, 13, 18, 19, 20, 21, 28, 39, 40, 45, 47, 49, 50, 53, 64, 65, 67, 68, 69)

			2- The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/1/02 - v3.0).
Packaging flag	1	0-4	0 - Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of partial hospital per diem or daily mental health service per diem 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < \$1.01) 4 – Packaged as part of drug administration APC payment
Payment adjustment flag	2	0-6	0 - No payment adjustment 1 – Additional payment for drug or biological applies to APC (status indicator G) 2 – Additional payment for device applies to APC (status indicator H) 3 – Additional payment for new drug or new biological applies to APC (status indicator J) ¹ 4 – Deductible not applicable (specific list of HCPCS codes) 5 – Blood/blood product used in blood deductible calculation 6 – Blood processing/storage not subject to blood deductible
Payment Method Flag	1	0-4	0 - OPSS pricer determines payment for service 1 - Based on OPSS coverage or billing rules, the service is not paid 2 - Service is not subject to OPSS 3 - Service is not subject to OPSS, and has an OCE line item denial or rejection 4 - Line item is denied or rejected by FI; OCE not applied to line item
Service units	7	1-x	Transferred from input, for Pricer. For the line items assigned APCs 33 or 34, the service units are always assigned a value of one by the OCE even if the input service units were greater than one [Input service units also may be reduced for some Drug administration APCs, based on Appendix I]
Charge	10	nnnnnnn nnn	Transferred from input, for Pricer; CO
Line item action flag	1	0-4	Transferred from input to Pricer, and can impact selection of discounting formula (Appx. D). 0 - OCE line item denial or rejection is not ignored 1 - OCE line item denial or rejection is ignored 2 - External line item denial. Line item is denied even if no OCE edits 3 - External line item rejection. Line item is rejected even if no OCE edits 4 - External line item adjustment. Technical charge rules apply.

¹ Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)

Table 6: HCPCS Codes for Reporting Antigen, Vaccine Administration, Splints, and Casts

List of HCPCS codes in the following chart specify vaccine administration, antigens, splints, and casts, which were paid under OPSS for hospitals. In addition in certain situations these services when provided by HHAs, and to hospice patients for the treatment of a non-terminal illness are paid under OPSS.

Category	Code
Antigens	95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, 95180, 95199
Vaccine Administration	90471, 90472, G0008, G0009
Splints	29105, 29125, 29126, 29130, 29131, 29505, 29515
Casts	29000, 29010, 29015, 29020, 29025, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29086, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29445, 29450, 29700, 29705, 29710, 29715, 29720, 29730, 29740, 29750, 29799

Correct Coding Initiative (CCI) Edits

The OPPS OCE will generate CCI edits. All CCI edits will be incorporated in the OPPS OCE with the exception of anesthesiology, E&M, and mental health. In addition, CCI edits for computer-aided detection (CAD) devices were removed from the July 2003 version of the OPPS OCE. They will be re-incorporated in a subsequent release. Bypass modifiers and coding pairs in the OCE may differ from those in the NCCI because of differences between facility and professional services.

Effective January 1, 2006 the Medicare CCI edits will apply to ALL services billed, using bill types 22X, 23X, 34X, 74X, and 75X, by the following providers: Skilled Nursing Facilities (SNF's), Comprehensive Outpatient Rehabilitation Facilities (CORF's), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPT's), and Home Health Agencies (HHA's).

The CCI edits are applicable to claims submitted on behalf of the same beneficiary, provided by the same provider, and on the same date of service. The edits address two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. One such code combination consists of one code that represents a service 'with' something and the other is 'without' the something. The edit is set to pay the lesser-priced service.

Version 12.0 of CCI edits is included in the April OPPS OCE.

NOTE: The CCI edits in the OPPS OCE are always one quarter behind the Carrier CCI edits.

See Appendix F "OPPS OCE Edits Applied by Bill Type" for bill types that the OPPS OCE will subject to these and other OPPS OCE edits.

Units of Service Edit

The OPSS OCE edit 15 “Service Unit Out of Range for Procedure” was revised for the April 2003 version of the OPSS OCE. As part of the recurring quarterly update of the OPSS OCE, CMS lifted the moratorium on application of the OPSS OCE Edit 15. Therefore, you were instructed to reactivate OPSS OCE Edit 15 for claims with dates of service on or after April 1, 2003. This unit of service edit is not applied to all services at this time. Instead, there are limited edits applied to certain services beginning with the April 2003 release. However subsequent modifications to this edit will be made in upcoming OPSS OCE releases.

Appendix A Bilateral Procedure Logic

There is a list of codes that are exclusively bilateral if a modifier of 50 is present*. The following edits apply to these bilateral procedures*.

Condition	Action	Edit
The same code which can be performed bilaterally occurs two or more times on the same date of service, all codes <i>without</i> a 50 modifier	Return claim to provider	1 6
The same code which can be performed bilaterally occurs two or more times (based on units and/or lines) on the same date of service, all or some codes <i>with</i> a 50 modifier	Return claim to provider	1 7

In addition, there is a list of codes that are considered inherently bilateral even if a modifier of 50 is not present. The following edits apply to these bilateral procedures.

Condition	Action	Edit
The same bilateral code occurs two or more times (based on units and/or lines) on the same date of service	Return claim to provider	17

Note: For ER and observation claims, all services on the claim are treated like any normal claim, including multiple day processing.

*Note: The “exclusively bilateral” list was eliminated, effective 10/1/05 (v6.3); edits 16 and 17 will not be triggered by the presence/absence of modifier 50 on certain bilateral codes for dates of service on or after 10/1/05.

Appendix B

Rules for Medical and Procedure Visits on the Same Day and for Multiple Medical Visits on Same Day

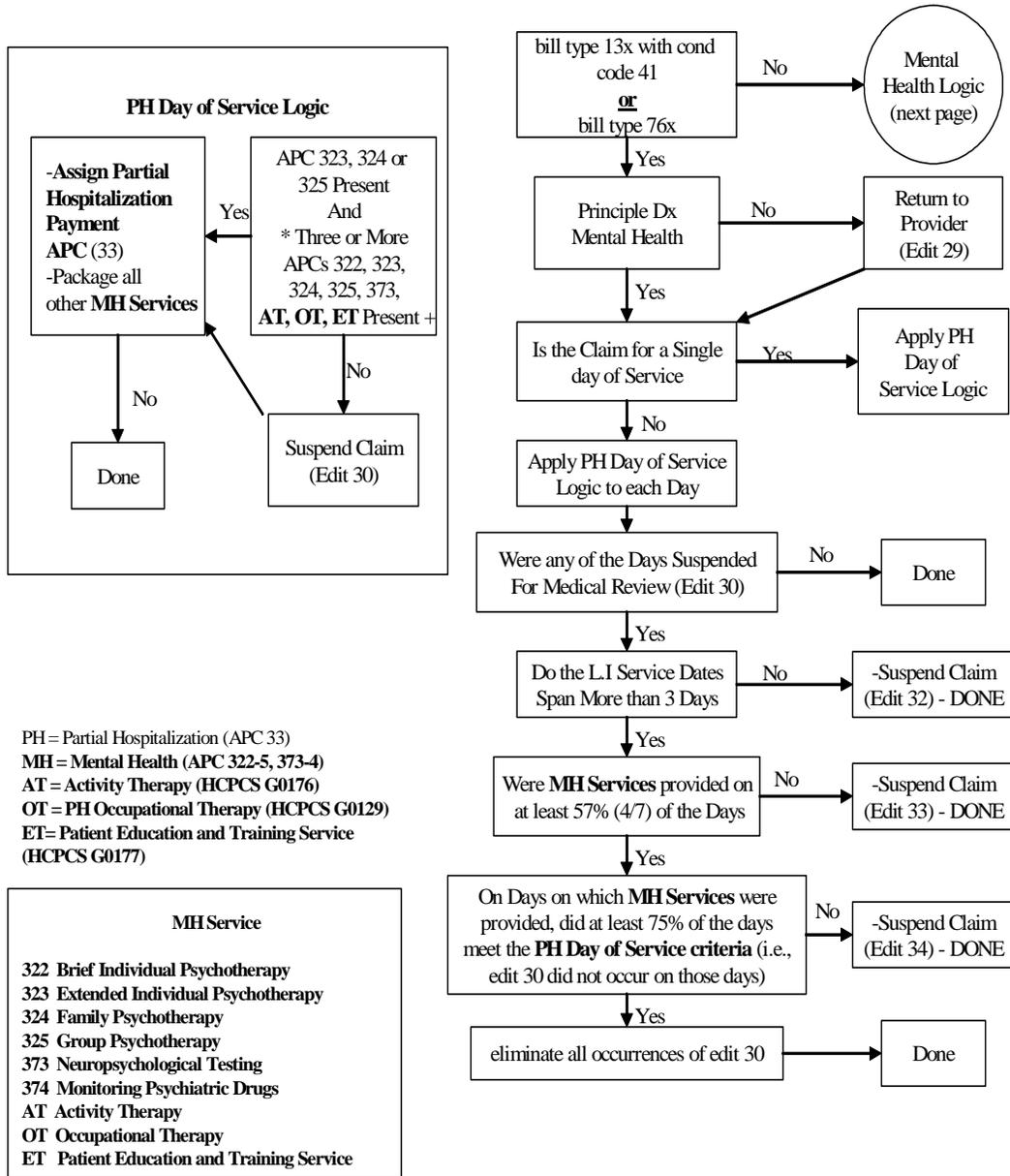
Under some circumstances, medical visits on the same date as a procedure will result in additional payments. A modifier of **25** with an Evaluation and Management (E&M) code, status indicator V, is used to report a medical visit that takes place on the same date that a procedure with status indicator S or T is performed, but that is significant and separately identifiable from the procedure. However, if any E&M code that occurs on a day with a type “T” or “S” procedure does not have a modifier of 25, then edit 21 will apply and there will be a line item rejection.

If there are multiple E&M codes on the same day, on the same claim the rules associated with multiple medical visits are shown in the following table.

E&M Code	Revenue Center	Condition Code	Action	Edit
2 or more	Revenue center is different for each E&M code, and all E&M codes have units equal to 1.	Not G0	Assign medical APC to each line item with E&M code	-
2 or more	Two or more E&M codes have the same revenue center OR One or more E&M codes with units greater than one had same revenue center	Not G0	Assign medical APC to each line item with E&M code and Return Claim to Provider	42
2 or more	Two or more E&M codes have the same revenue center OR one or more E&M codes with units greater than one had same revenue center	G0	Assign medical APC to each line item with E&M code	-

The condition code G0 specifies that multiple medical visits occurred on the same day with the same revenue center, and that these visits were distinct and constituted independent visits (e.g., two visits to the ER for chest pain).

Appendix C Partial Hospitalization Logic



+ Multiple occurrences of APC 322, 323, 324, 325, and 373; AT and ET are treated as separate units in determining whether 3 or more MH services are present. However, multiple occurrences of OT are treated as a single service.

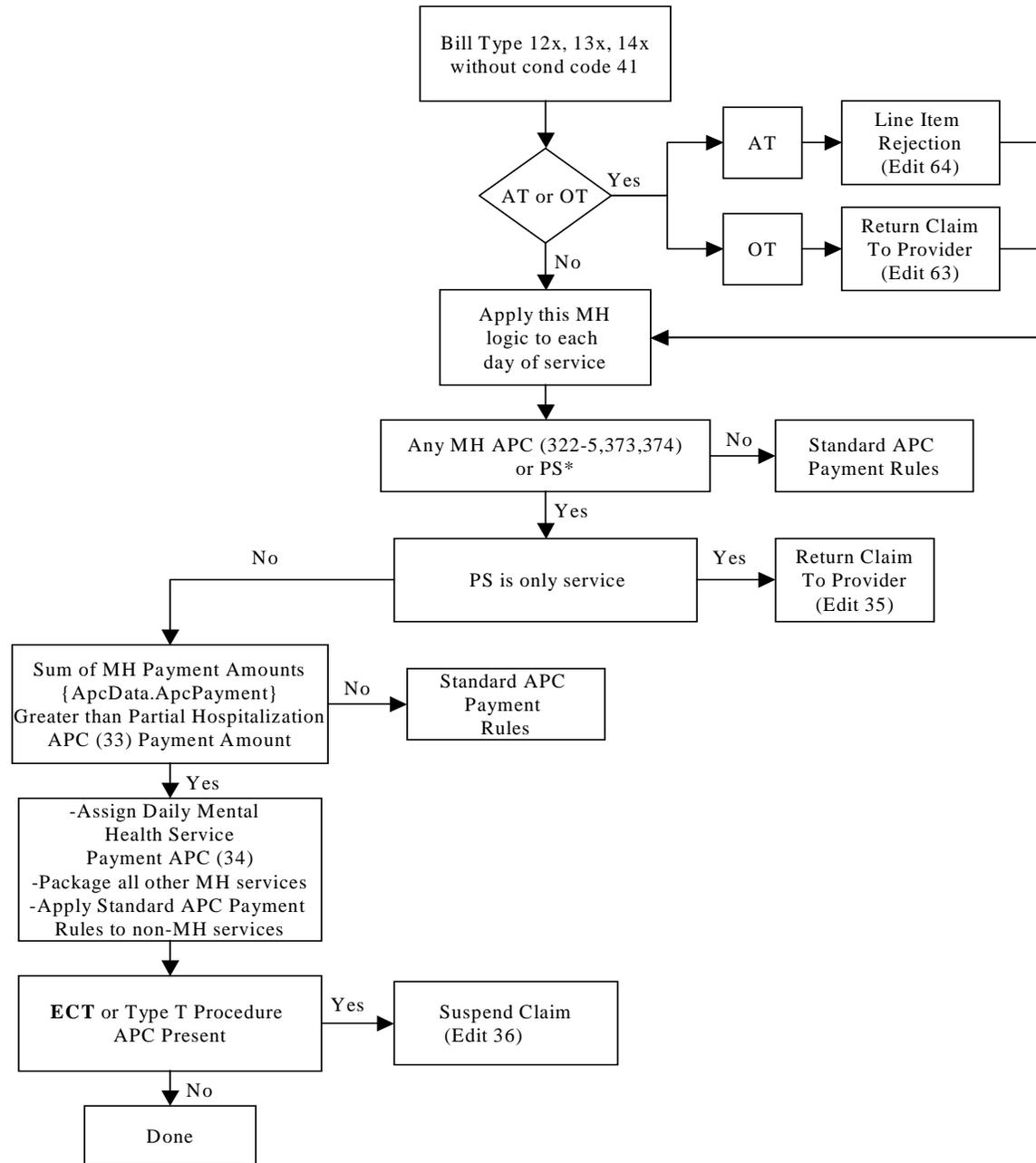
*To avoid confusion over this programming language, the OCE will continue to verify that the claim has, at a minimum, a total of 3 partial hospitalization HCPCS codes for each day of service, one of which must be a psychotherapy HCPCS that groups to APC 323, 324 or 325.

Assign Partial Hospitalization Payment APC

For any day that has an MH Service, the first listed line item with HCPCS APC from the hierarchical list of APCs (323, 324, 325, 322, 373, 374, AT, OT, ET) is assigned a payment APC of 33, a status indicator of P a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, and a service unit of 1

For all other line items with a **mental health service** (APC 322, 323, 324, 325, 373, 374, AT, OT, ET) the packaging flag is set to 2.

Appendix C (cont'd) Mental Health Logic



Assign Daily Mental Health Service Payment APC

The first listed line item with HCPCS APC from the list of MH APCs (322-5, 373, 374) is assigned a payment APC of 34, a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0 and a service unit of 1.

For all other line items with a **mental health service** (APC 322-5, 373, 374, PS) the packaging flag is set to 2.

*NOTE: The use of code G0177 (PS) is allowed on MH claims that are not billed as Partial Hospitalization

Appendix D

Computation of Discounting Fraction

Type “T” Multiple and Terminated Procedure Discounting:

Line items with a status indicator of “T” are subject to multiple procedure discounting *unless modifiers 76, 77, 78 and/or 79 are present*. The “T” line item with the highest payment amount will *not* be multiple procedure discounted, and all other “T” line items will be multiple procedure discounted. All line items that do not have a status indicator of “T” will be ignored in determining the multiple procedure discount. A modifier of 52 or 73 indicates that a procedure was terminated prior to anesthesia. A terminated type “T” procedure will also be discounted although not necessarily at the same level as the discount for multiple type “T” procedures.

Terminated bilateral procedures or terminated procedures with units greater than one for type “T” any procedures should not occur, and have the discounting factor set so as to result in the equivalent of a single procedure. Claims submitted with procedures having modifier 50 or multiple units in addition to modifier 52 or 73, are returned to the provider (edit 37).

Bilateral procedures are identified from the “bilateral” field in the physician fee schedule. Bilateral procedures have the following values in the “bilateral” field:

1. Conditional bilateral (i.e. procedure is considered bilateral if the modifier 50 is present)
2. Inherent bilateral (i.e. procedure in and of itself is bilateral)
3. Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures))

Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code. For bilateral procedures the type “T” procedure discounting rules will take precedence over the discounting specified in the physician fee schedule. All line items for which the line item denial or reject indicator is 1 and the line item action flag is zero, or the line item action flag is 2, 3 or 4, will be ignored in determining the discount; packaged line items, (the packaging flag is not zero or 3), will also be ignored in determining the discount. The discounting process will utilize an APC payment amount file. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type “T” procedures.

Non-Type T Procedure Discounting:

For non-type “T” procedures there is ~~no terminated procedure discounting with modifier 73 and no multiple procedure discounting and no bilateral procedure discounting with modifier 50 performed~~. Line items with SI other than “T” are subject to terminated procedure discounting ~~only~~ when modifier 52 or 73 is present. Modifier 52 or 73 on a non-type “T” procedure line will result in a 50% discount being applied to that line.

Appendix D (cont.) Computation of Discounting Fraction

There are eight different discount formulas that can be applied to a line item.

1. 1.0
2. $(1.0 + D(U-1))/U$
3. T/U
4. $(1 + D)/U$
5. D
6. TD/U
7. $D(1 + D)/U$
8. 2.0

Where

D = discounting fraction (currently 0.5)

U = number of units

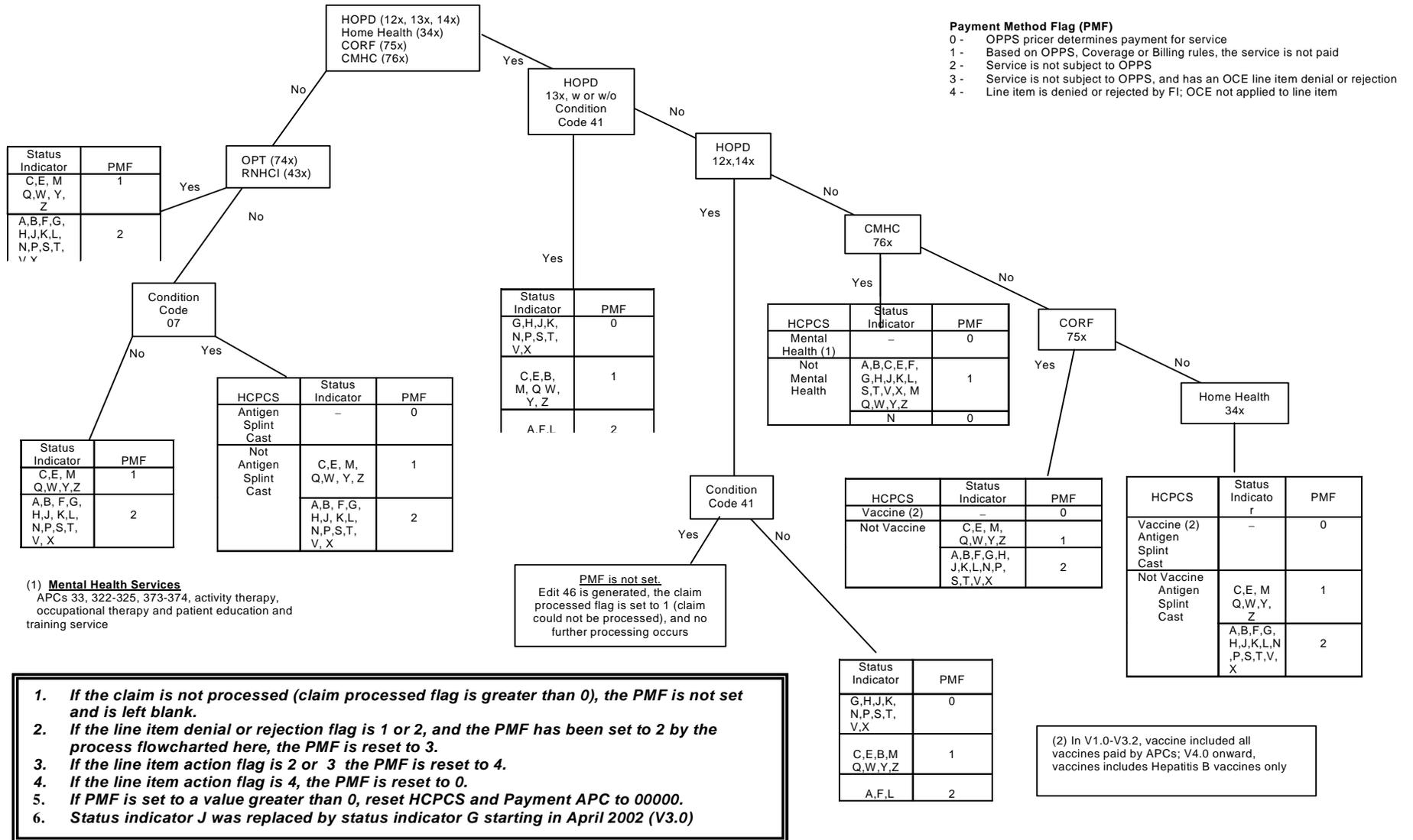
T = terminated procedure discount (currently 0.5)

The discount formula that applies is summarized in the following table.

			Discounting Formula Number					
			Type "T" Procedure		Non Type "T" Procedure			
Payment Amount	Modifier 52 or 73	Modifier 50	Conditional or Independent Bilateral	Inherent or Non Bilateral	Conditional or Independent Bilateral		Inherent or Non Bilateral	
					w/o Mod 52 / 73	w Mod 52 / 73	w/o Mod 52 / 73	W Mod 52/73
Highest	No	No	2	2	1	5	1	5
Highest	Yes	No	3	3	1	5	1	5
Highest	No	Yes	4	2	8	5	1	5
Highest	Yes	Yes	3	3	8	5	1	5
Not Highest	No	No	5	5	1	5	1	5
Not Highest	Yes	No	6	6	1	5	1	5
Not Highest	No	Yes	7	5	8	5	1	5
Not Highest	Yes	Yes	6	6	8	5	1	5

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (**T**) will be applied prior to selecting the type T procedure with the highest payment amount.

Appendix E Logic for Assigning Payment Method Flag Values



1. If the claim is not processed (claim processed flag is greater than 0), the PMF is not set and is left blank.
2. If the line item denial or rejection flag is 1 or 2, and the PMF has been set to 2 by the process flowcharted here, the PMF is reset to 3.
3. If the line item action flag is 2 or 3 the PMF is reset to 4.
4. If the line item action flag is 4, the PMF is reset to 0.
5. If PMF is set to a value greater than 0, reset HCPCS and Payment APC to 00000.
6. Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)

Appendix F - OCE Edits Applied by Bill Type

FLOW CHART CELL (*)	Provider/Bill Types	<div style="display: flex; justify-content: space-between; text-align: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Proc & Modifier [18,38,43,45,47,49,71,73]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Non Medicare [28] Non OPPS [62]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">OPPS site of svc [14]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">HCPC [6,13]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Dx & Proc [1-5,7-9]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">[11-12,50,53,54,59, 69]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Modifier [16,17, 22,37]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">CCI [19,20,39,40]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">" Line Item Date [23]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Units [15]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Rev Code [41,44, 65]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Age, Sex [25,26]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Partial Hosp [29-34]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">APC [21,27,42]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">MH [35,36, 63, 64]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">APC buffer completed</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Manual Price [66, 70], FDA/NCD [67, 68]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Obs Logic [32,56,57], DirAdm [38], Spec Inpt [60]</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">DME (61); Not FI (72)</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">Opps Proc (55)</div> </div>																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	12X or 14X w condition code 41	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
2	12X or 14X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	No	Yes
3	13X w condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
4	13X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes
5	76X (CMHC)	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	Yes
6	34X ^h (HHA) w Vaccine ^c , Antigen, Splint or Cast	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No	No	No	No	Yes	No	Yes	No
7	34X ^h (HHA) w.o Vaccine ^c , Antigen, Splint or Cast	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No
8	75X ^h (CORF) w Vaccine ^c (PPS)	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes
9	43X (RNHCI)	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	No	No	Yes	No
10	Any bill type except 12x, 13x, 14x, 76x, 34x, or [75x with Vaccine ^c], w condition code 07, w Antigen, Splint or Cast	Yes ^f	Yes	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	No
11	75X ^h (CORFs) w.o Vaccine ^c	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
12	22X ^h , 23X ^h (SNF), 24X ^g	Yes	Yes	No	Yes	No	No	No	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
13	32X, 33X (HHA)	Yes ^f	No	Yes	Yes	No	No	No	No	No	No	Yes	No								
14	71X (RHC), 73X (FQHC)	Yes	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes								
15	72X (ESRD)	Yes	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes								
16	74X ^h (OPTs)	Yes	Yes	No	No	No	Yes	No	Yes	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
17	81x (Hospice), 82x	Yes	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes								

(*) FLOW CHART CELLS ARE IN HIERARCHICAL ORDER

Yes = edits apply, No = edits do not apply

Edit 10, and Edits 23 and 24 for From/Through dates, are not dependent on AppxF

^a if edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates, and processing continues.

^b Bypass edit 22 if Revenue code is 540 ^c Edits 53 not relevant for bill type 13x

^d Bypass edit 48 if Revenue code is 100x, 210x, 310x, 0905, 0906, 0907; 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932

^e In V1.0 to V3.2, "vaccines" included all vaccines paid by APCs; from V4.0 onward, "vaccines" includes Hepatitis B vaccines only; plus Flu and PPV administration

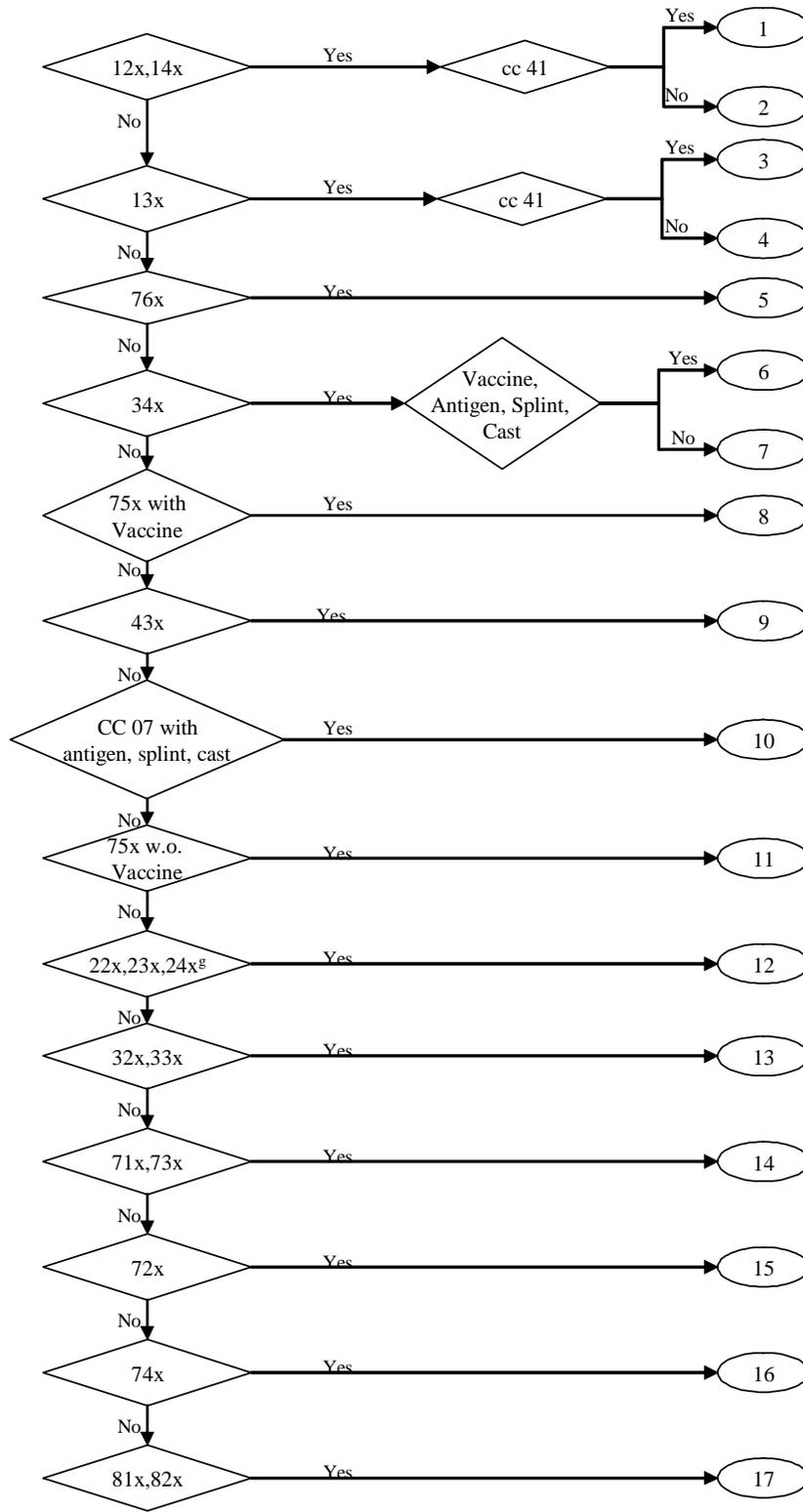
^f Bypass diagnosis edits (1-5) for bill types 32X and 33X (HHA) if from date is <10/1/xx and Through date is >= 10/1/xx

^g Delete TOB 24X effective 10/1/05

^h Apply CCI edits to TOB 22x, 23x, 34x 74x and 75x, effective 1/1/06

ⁱ Apply edits 28,62 effective 10/1/05

Appendix F Flow Chart



Appendix G

The payment adjustment flag for a line item is set based on the criteria in the following chart:

Criteria	Payment Adjustment Flag Value
Status indicator G	1
Status indicator H	2
Status indicator J ¹	3
Code is flagged as 'deductible not applicable'	4
Blood product with modifier BL on RC 38X line ²	5
Blood product with modifier BL on RC 39X line ²	6
All others	0

¹ Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)

² See Appendix J for assignment logic (v6.2)

Appendix H OCE Observation Criteria

Rules:

1. Code G0378 is used to identify all outpatient observations, regardless of the reason for observation (diagnosis) or the duration of the service.
2. Code G0379 is used to identify direct admission from a physician's office to observation care, regardless of the reason for observation.
3. Code G0378 has default Status Indicator "Q" and default APC 0
 - a. If the criteria are met for payable observation, the SI is changed to "S" and APC 339 is assigned.
 - b. If the criteria for payable observation are not met, the SI is changed to "N".
4. Code G0379 has default Status Indicator "Q" and default APC 0
 - a. If associated with a payable observation (payable G0378 present on the same day), the SI for G0379 is changed to "N".
 - b. If no payable observation on the same day, the SI is changed to "V" and APC 600 is assigned.
5. Observation logic is performed only for claims with bill type 13x, with or without condition code 41.
Lines with G0378 and G0379 are rejected if the bill type is not 13x.
6. If any of the criteria for separately payable observation is not met, the observation is packaged, or the claim or line is suspended or rejected according to the disposition of the observation edits.
7. In order to qualify for separate payment, each observation must be paired with a unique E/M or critical care (C/C) visit, or with code G0379 (Direct admission from physician's office).
E/M or C/C visit is required the day before or day of observation; Direct admission is required on the day of observation.
8. If an observation cannot be paired with an E/M or C/C visit or Direct admission, the observation is packaged.
9. E/M or C/C visit or Direct admission on the same day as observation takes precedence over E/M or C/C visit on the day before observation.
10. E/M, C/C visit or Direct admission that have been denied or rejected, either externally or by OCE edits, are ignored.
11. Both the associated E/M and C/C visit (APCs 600-602, 610-612, 620) and observation are paid separately if the criteria are met for separately payable observation.
12. If a "T" procedure occurs on the day of or the day before observation, the observation is packaged.
13. Multiple observations on a claim are paid separately if the required criteria are met for each one.
14. If there are multiple observations within the same time period and only one meets the criteria for separate APC payment, the observation with the most hours is considered to have met the criteria, and the other observations will be packaged.
15. Observation date is assumed to be the date admitted for observation.
16. The diagnoses (admitting or principal) required for the separately payable observation criteria are:

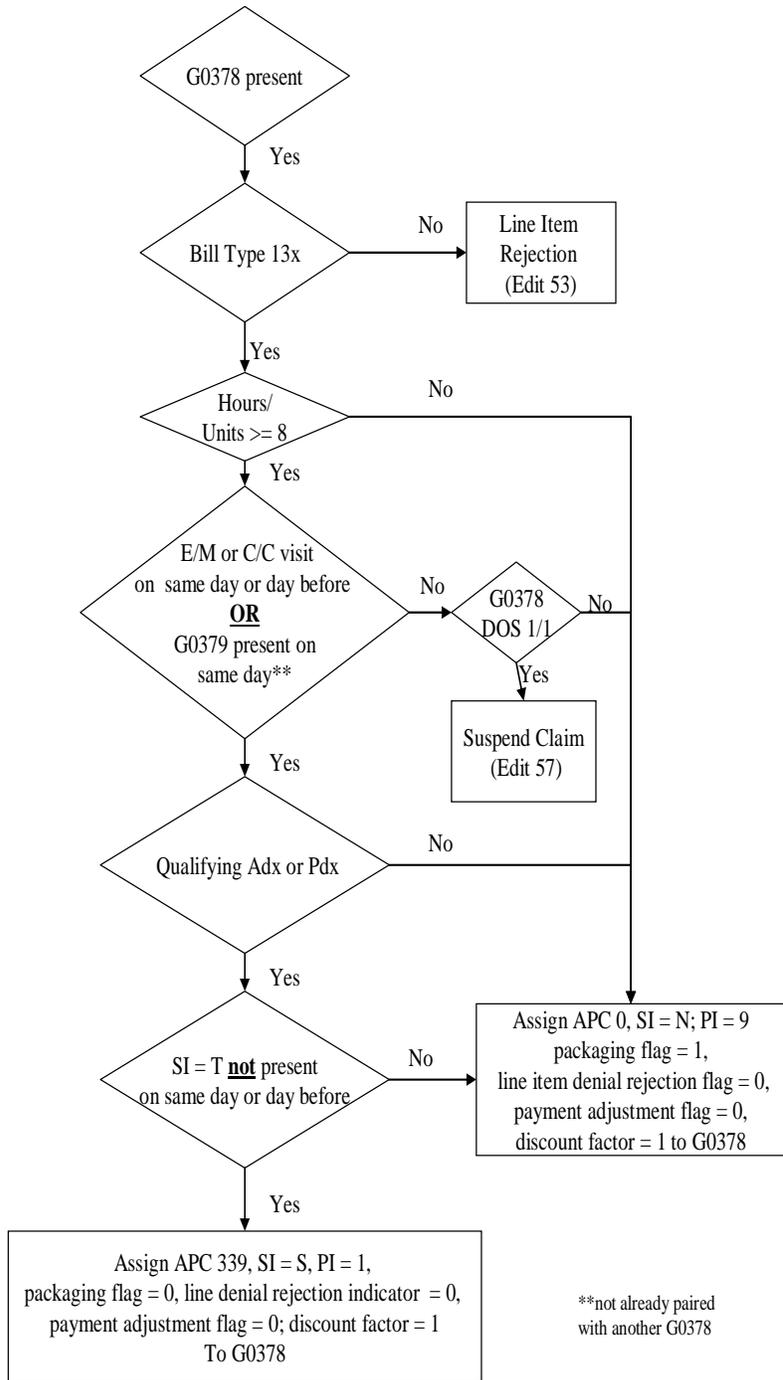
Chest Pain	Asthma	CHF
<u>4110</u> , 1, 81, 89	<u>49301</u> , 02, 11, 12, 21, 22, 91, 92	3918
<u>4130</u> , 1, 9		39891
<u>78605</u> , 50, 51, 52, 59		<u>40201</u> , 11, 91
		<u>40401</u> , 03, 11, 13, 91, 93
		<u>4280</u> , 1, 9, 20-23, 30-33, 40-

		43
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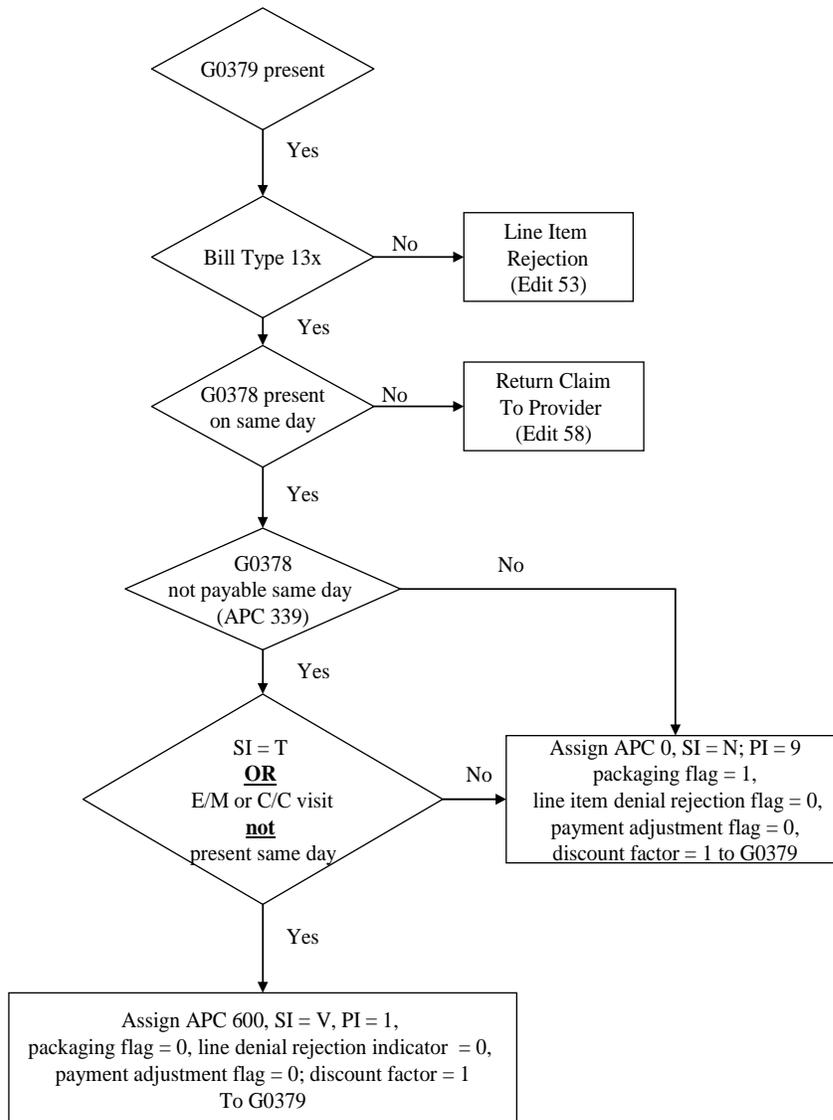
17. The APCs required for the observation criteria to identify E/M or C/C visits are 600*-602, 610-612, 620.

*Except when APC 600 is assigned based on code G0264.

Appendix H OCE Observation Criteria (cont'd)



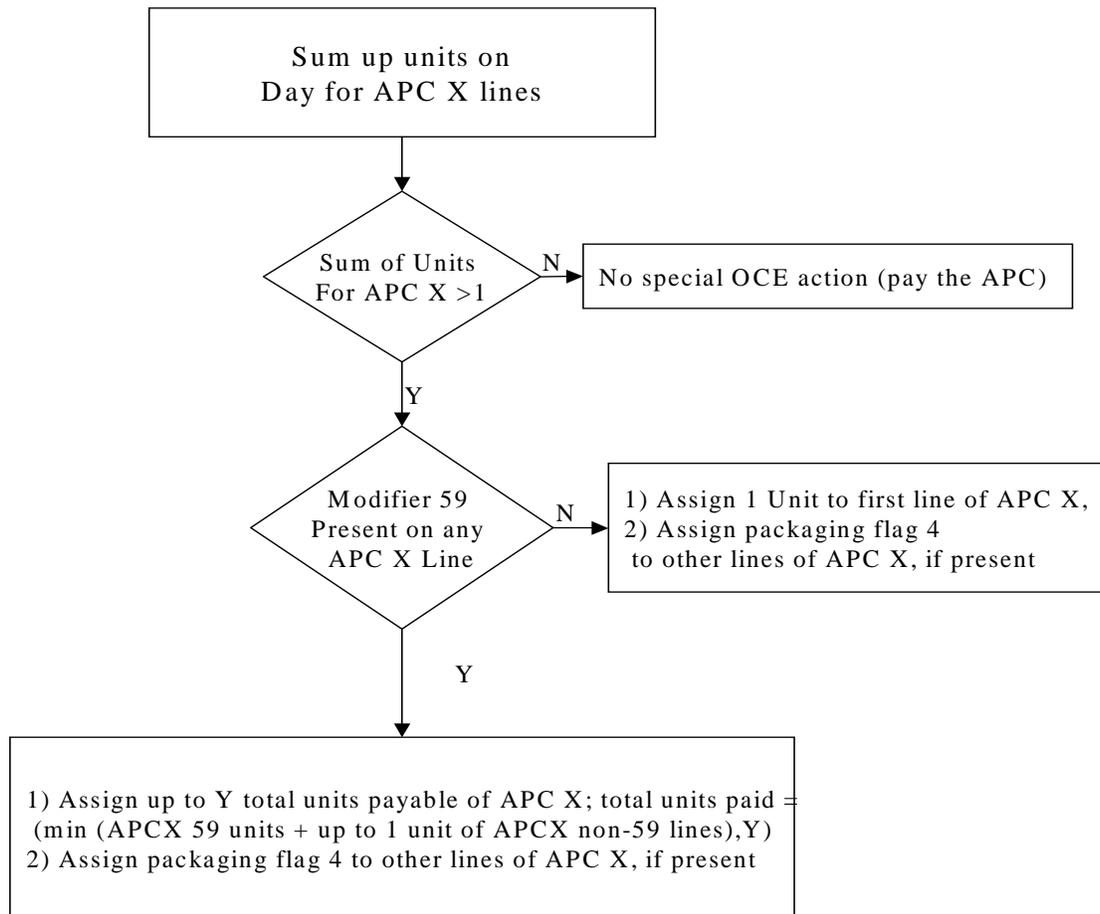
Appendix H (cont'd) Direct Admission Logic



Appendix I

Drug Administration

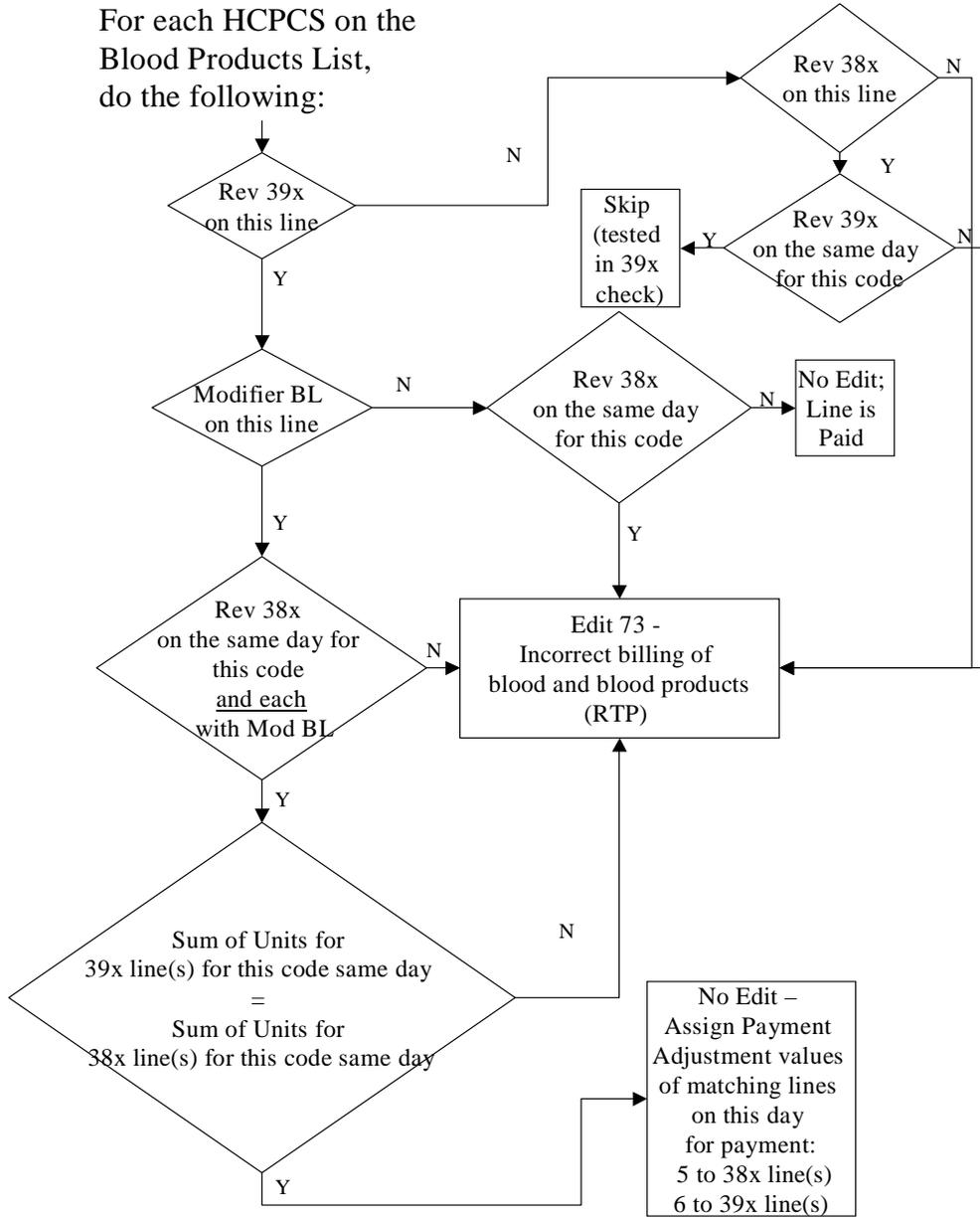
For each APC X subjected to Y maximum allowed units do the following (each day);



Appendix J

Billing for blood/blood products

For each HCPCS on the Blood Products List, do the following:



Appendix K OCE overview

1. If claim from/through dates span more than one day, subdivide the line items on the claim into separate days based on the calendar day of the line item service date.
2. Assign the default values to each line item in the APC return buffer.
The default values for the APC return buffer for variables not transferred from input are as follows:

Payment APC	00000
HCPCS APC	00000
Status indicator	A
Payment indicator	2
Discounting formula number	1
Line item denial or rejection flag	0
Packaging flag	0
Payment adjustment flag	0
Payment method flag	Assigned in steps 8, 17 and 18

3. If no HCPCS code is on a line item and the revenue code is from one of four specific lists, then assign the following values to the line item in the APC return buffer.

	N-list	E-list	B-list	F-list
HCPCS APC	00000	00000	00000	00000
Payment APC:	00000	00000	00000	00000
Status Indicator:	N	E	B	F
Payment Indicator	9	3	3	4
Packaging flag:	1	0	0	0

If there is no HCPCS code on a line, and the revenue center is not on any of the specified lists, assign default values as follows:

HCPCS APC	00000
Payment APC:	00000
Status Indicator:	Z
Payment Indicator	3
Packaging flag:	0

If the HCPCS code is invalid, or the revenue code is invalid and the HCPCS is blank, assign default values as follows:

HCPCS APC	00000
Payment APC:	00000
Status Indicator:	W
Payment Indicator	3
Packaging flag:	0

4. If applicable based on Appendix F, assign HCPCS APC in the APC return buffer for each line item that contains an applicable HCPCS code.
5. If procedure with status indicator "C" and modifier CA is present on a claim and patient status = 20, assign payment APC 375 to "C" procedure line and set the discounting factor to 1. Change SI to "N" and set the packaging flag to 1 for all other line items occurring on the same day as the line item with status indicator "C" and modifier CA. If multiple lines, or one line with multiple units, have SI = C and modifier CA, generate edit 60 for all lines with SI = C and modifier CA.
6. If edit 18 is present on a claim, generate edit 49 for all other line items occurring on the same day as the line item with edit 18, and set the line item denial or rejection flag to 1 for each of them. Go to step 14.

Appendix K OCE Overview (cont'd)

7. If all of the lines on the claim are incidental, and all of the line item action flags are zero, generate edit 27. Go to step 14.
8. If the line item action flag for a line item has a value of 2 or 3 then reset the values of the Payment APC and HCPCS APC to 00000, and set the payment method flag to 4. If the line item action flag for a line item has a value of 4, set the payment method flag to 0. Ignore line items with a line item action flag of 2, 3 or 4 in all subsequent steps.
9. If bill type is 13x and condition code = 41, or type of bill = 76x, apply partial hospitalization logic from Appendix C. Go to step 11.
10. If bill type is 12x, 13x or 14x without condition code 41 apply mental health logic from Appendix C.
11. If bill type is 13x apply observation logic from Appendix H.
If bill type is not 13x, and observation G codes (G0378, G0379) present, generate edit 53.
12. If code is on the “sometimes therapy” list, reassign the status indicator to A, APC 0 when there is a therapy revenue code or a therapy modifier on the line.
13. If the payment APC for a line item has not been assigned a value in step 9 thru 12, set payment APC in the APC return buffer for the line item equal to the HCPCS APC for the line item.
14. If edits 9, 13, 19, 20, 21, 28 39, 40, 45, 47, 49, 50, 53, 64, 65, 67, 68, 69 are present in the edit return buffer for a line item, the line item denial or rejection flag for the line item is set to 1.
15. Compute the discounting formula number based on Appendix D for each line item that has a status indicator of “T”, a modifier of 52, 73 or 50, or is a non type “T” bilateral procedure, or is a non-type “T” procedure with modifier 52 or 73. Note: If the SI or APC of a code is changed during claims processing, the newly assigned SI or APC is used in computing the discount formula. Line items that meet any of the following conditions are not included in the discounting logic.
 - Line item action flag is 2, 3, or 4
 - Line item rejection disposition or line item denial disposition in the APC return buffer is 1 and the line item action flag is not 1
 - Packaging flag is not 0 or 3
16. If the packaging flag has not been assigned a value of 1 or 2 in previous steps and the status indicator is “N”, then set the packaging flag for the line item to 1.
17. If the submitted charges for HCPCS surgical procedures (SI = T, or SI = S in code range 10000-69999) is less than \$1.01 for any line with a packaging flag of 0, then reset the packaging flag for that line to 3 when there are other surgical procedures on the claim with charges greater than \$1.00.
18. For all bill types where APCs are assigned, apply drug administration APC consolidation logic from appendix I.
19. Set the payment adjustment flag for a line item based on the criteria in Appendix G and Appendix J.
20. Set the payment method flag for a line item based on the criteria in Appendix E. If any payment method flag is set to a value that is greater than zero, reset the HCPCS and Payment APC values for that line to '00000'.
21. If the line item denial or rejection flag is 1 or 2 and the payment method flag has been set to 2 in the previous step, reset the payment method flag to 3.

Appendix L

Summary of Modifications

The modifications of the OCE/APC for the April 2006 release (V7.1) are summarized in the attached table.

Readers should also read through the specifications and note the highlighted sections, which also indicate change from the prior release of the software.

Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

	Mod. Type	Effective Date	Edit	
1.	Logic	4/1/06	37	Implement terminated procedure discounting (50%) for all procedures (type T and non-type T) with modifiers 52 and 73; see Appendix D.
2.	Logic	10/1/05		Modify appendix F to rescind application of edit 62 to bill types 22x and 23x (edit 28 will continue to be applied).
3.	Logic	8/1/00	48	Modify appendix F to bypass edit 48 for rev codes 0500, 0509, 0583, 0660-0663, 0669, 0931 and 0932

4	Content			Make HCPCS/APC/SI changes, as specified by CMS.
5	Content	4/1/06	19,20, 39,40	Implement version 12.0 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911). or Drug Admin (96400-96450; 96542-96549; 90780,90781)
6	Content	8/1/00	17	Remove Inherent Bilateral indicator in the OCE for codes 92002, 92004, 92012 and 92014.
7	Content	4/1/05	71	Update procedure/device edit requirements as specified by CMS
8	Content	8/1/00	65	Add rev codes 0500, 0509, 0583, 0660-0663, 0669, 0931 and 0932 to the list of valid revenue codes; not recognized by Medicare
9	Content	1/1/06		Add 90471 and 90472 to the list of codes designated as “vaccines” (see appendix F footnote)
10	Content	1/1/06		Remove 90740, 90743, 90744, 90746, 90747 and G0010 from the list of codes designated as “vaccines”.
11	Doc	1/1/06		Change description for SI “F” to: Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines”

FINAL
Summary of Data Changes
OCE/APC v7.1
Effective April 1, 2006

Table of Contents

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DEFINITIONS

- A blank in a field indicates 'no change'
- The "old" column describes the attribute prior to the change being made in the current update, which is indicated in the "new" column. If the effective date of the change is the same as the effective date of the new update, 'old' describes the attribute up to the last day of the previous quarter. If the effective date is retroactive, then 'old' describes the attribute for the same date in the previous release of the software.
- "Unassigned", "Pre-defined" or "Placeholder" in APC or HCPCS descriptions indicates that the APC or HCPCS code is inactive. When the APC or HCPCS code is activated, it becomes valid for use in the OCE, and a new description appears in the "new description" column, with the appropriate effective date.
- Activation Date (ActivDate) indicates the mid-quarter date of FDA approval for a drug, or the mid-quarter date of a new or changed code resulting from a National Coverage Determination (NCD). The Activation Date is the date the code becomes valid for use in the OCE. If the Activation Date is blank, then the effective date takes precedence.
- Termination Date (TermDate) indicates the mid-quarter date when a code or change becomes inactive. A code is not valid for use in the OCE after its termination date.

APC CHANGES

Added APCs

The following Apc(s) were added to the OCE/APC, **effective 07-01-05**

APC	APCDesc	StatusIndicator
01634	Td vaccine no prsrv >= 7 im	K

The following Apc(s) were added to the OCE/APC, **effective 04-01-06**

APC	APCDesc	StatusIndicator
09227	Injection, micafungin sodium	G
09228	Injection, tigecycline	G

APC Description Changes

The following Apc(s) had description changes, **effective 01-01-06**

APC	Old Description	New Description
00061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excludin	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve
00306	Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic e	Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation
00333	Computerized Axial Tomography and Computerized Angiography without Contrast foll	Computerized Axial Tomography and Computerized Angiography without Contrast followed by Contrast

HCPCS/CPT PROCEDURE CODE CHANGES

Added HCPCS/CPT Procedure Codes

The following new HCPCS/CPT code(s) were added to the OCE/APC, **effective 07-01-05**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
90714	Td vaccine no prsrv >= 7 im	K	01634			

The following new HCPCS/CPT code(s) were added to the OCE/APC, **effective 01-01-06**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
E1239	Ped power wheelchair NOS	Y	00000	61		
G0252	PET imaging initial dx	E	00000	9		
G8054	Falls assess not docum 12 mo	M	00000	72		
G9050	Oncology work-up evaluation	M	00000	72		
G9051	Oncology tx decision-mgmt	M	00000	72		
G9052	Onc surveillance for disease	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
G9053	Onc expectant management pt	M	00000	72		
G9054	Onc supervision palliative	M	00000	72		
G9055	Onc visit unspecified NOS	M	00000	72		
G9056	Onc prac mgmt adheres guide	M	00000	72		
G9057	Onc pract mgmt differs trial	M	00000	72		
G9058	Onc prac mgmt disagree w/gui	M	00000	72		
G9059	Onc prac mgmt pt opt alterna	M	00000	72		
G9060	Onc prac mgmt dif pt comorb	M	00000	72		
G9061	Onc prac cond noadd by guide	M	00000	72		
G9062	Onc prac guide differs nos	M	00000	72		
G9063	Onc dx nsclc stgI no progres	M	00000	72		
G9064	Onc dx nsclc stg2 no progres	M	00000	72		
G9065	Onc dx nsclc stg3A no progre	M	00000	72		
G9066	Onc dx nsclc stg3B-4 metasta	M	00000	72		
G9067	Onc dx nsclc dx unknown nos	M	00000	72		
G9068	Onc dx sclc/nsclc limited	M	00000	72		
G9069	Onc dx sclc/nsclc ext at dx	M	00000	72		
G9070	Onc dx sclc/nsclc ext unknwn	M	00000	72		
G9071	Onc dx brst stg1-2B HR, no p	M	00000	72		
G9072	Onc dx brst stg1-2 no progre	M	00000	72		
G9073	Onc dx brst stg3- HR, no pro	M	00000	72		
G9074	Onc dx brst stg3- no progres	M	00000	72		
G9075	Onc dx brst metastatic/ recur	M	00000	72		
G9076	Onc dx brst unknown NOS	M	00000	72		
G9077	Onc dx prostate T1no progres	M	00000	72		
G9078	Onc dx prostate T2no progres	M	00000	72		
G9079	Onc dx prostate T3b-T4noprog	M	00000	72		
G9080	Onc dx prostate w/rise PSA	M	00000	72		
G9081	Onc dx prostate mets no cast	M	00000	72		
G9082	Onc dx prostate castrate met	M	00000	72		
G9083	Onc dx prostate unknown NOS	M	00000	72		
G9084	Onc dx colon t1-3,n1-2,no pr	M	00000	72		
G9085	Onc dx colon T4, N0 w/o prog	M	00000	72		
G9086	Onc dx colon T1-4 no dx prog	M	00000	72		
G9087	Onc dx colon metas evid dx	M	00000	72		
G9088	Onc dx colon metas no evid d	M	00000	72		
G9089	Onc dx colon extent unknown	M	00000	72		
G9090	Onc dx rectal T1-2 no progr	M	00000	72		
G9091	Onc dx rectal T3 N0 no prog	M	00000	72		
G9092	Onc dx rectal T1-3,N1-2noprg	M	00000	72		
G9093	Onc dx rectal T4,N,M0 no prg	M	00000	72		
G9094	Onc dx rectal M1 w/mets prog	M	00000	72		
G9095	Onc dx rectal extent unknwn	M	00000	72		
G9096	Onc dx esophag T1-T3 noprog	M	00000	72		
G9097	Onc dx esophageal T4 no prog	M	00000	72		
G9098	Onc dx esophageal mets recur	M	00000	72		
G9099	Onc dx esophageal unknown	M	00000	72		
G9100	Onc dx gastric no recurrence	M	00000	72		
G9101	Onc dx gastric p R1-R2noprog	M	00000	72		
G9102	Onc dx gastric unresectable	M	00000	72		
G9103	Onc dx gastric recurrent	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
G9104	Onc dx gastric unknown NOS	M	00000	72		
G9105	Onc dx pancreatc p R0 res no	M	00000	72		
G9106	Onc dx pancreatc p R1/R2 no	M	00000	72		
G9107	Onc dx pancreatic unresectab	M	00000	72		
G9108	Onc dx pancreatic unknwn NOS	M	00000	72		
G9109	Onc dx head/neck T1-T2no prg	M	00000	72		
G9110	Onc dx head/neck T3-4 noprog	M	00000	72		
G9111	Onc dx head/neck M1 mets rec	M	00000	72		
G9112	Onc dx head/neck ext unknown	M	00000	72		
G9113	Onc dx ovarian stg1A-B no pr	M	00000	72		
G9114	Onc dx ovarian stg1A-B or 2	M	00000	72		
G9115	Onc dx ovarian stg3/4 noprog	M	00000	72		
G9116	Onc dx ovarian recurrence	M	00000	72		
G9117	Onc dx ovarian unknown NOS	M	00000	72		
G9118	Onc NHLstg 1-2 no relap no	M	00000	72		
G9119	Onc dx NHL stg 3-4 not relap	M	00000	72		
G9120	Onc dx NHL trans to lg Bcell	M	00000	72		
G9121	Onc dx NHL relapse/refractor	M	00000	72		
G9122	Onc dx NHL stg unknown	M	00000	72		
G9123	Onc dx CML chronic phase	M	00000	72		
G9124	Onc dx CML acceler phase	M	00000	72		
G9125	Onc dx CML blast phase	M	00000	72		
G9126	Onc dx CML remission	M	00000	72		
G9127	Onc dx CML dx status unknown	M	00000	72		
G9128	Onc dx multi myeloma stage I	M	00000	72		
G9129	Onc dx mult myeloma stg2 hig	M	00000	72		
G9130	Onc dx multi myeloma unknown	M	00000	72		

The following new HCPCS/CPT code(s) were added to the OCE/APC, effective 04-01-06

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
C9227	Injection, micafungin sodium	G	09227	55		
C9228	Injection, tigecycline	G	09228	55		
S0345	HOME ECG MONITRNG GLOBAL 24H	E	00000	28		
S0346	HOME ECG MONITRNG TECH 24H	E	00000	28		
S0347	HOME ECG MONITRNG PROF 24HR	E	00000	28		

Deleted HCPCS/CPT Procedure Codes

The following HCPCS/CPT code(s) were deleted from the OCE/APC, effective 01-01-06

HCPCS	CodeDesc
A4555	Disposable underpad small
E0590	Dispensing fee dme neb drug
G9021	Chemo assess nausea vomit L1
G9022	Chemo assess nausea vomit L2
G9023	Chemo assess nausea vomit L3
G9024	Chemo assess nausea vomit L4
G9025	Chemo assessment pain level1
G9026	Chemo assessment pain level2
G9027	Chemo assessment pain level3

HCPCS	CodeDesc
G9028	Chemo assessment pain level4
G9029	Chemo assess for fatigue L1
G9030	Chemo assess for fatigue L2
G9031	Chemo assess for fatigue L3
G9032	Chemo assess for fatigue L4

The following HCPCS/CPT code(s) were deleted from the OCE/APC, **effective 04-01-06**

HCPCS	CodeDesc
S0133	Histerlin implant
S2362	Kyphoplasty, first vertebra
S2363	Kyphoplasty, each addl
S3701	NMP-22 assay
S8093	CT angiography coronary
S8260	Oral orthotic for treatment

HCPCS Description Changes

The following code descriptions were changed, **effective 01-01-06**

HCPCS	Old Description	New Description
0001F	Blood pressure, measured	Heart failure composite
0005F	Tobacco use txmnt, pharmacol	Osteoarthritis composite
15170	Cell graft trunk/arms/legs	Acell graft trunk/arms/legs
15171	Cell graft t/arm/leg add-on	Acell graft t/arm/leg add-on
33768	Cavopulmonary Shunting	Cavopulmonary shunting
C1767	Generator, neurostim, imp	Generator, neuro non-recharg
C1900	Lead coronary venous	Lead, coronary venous
C9399	Unclass drugs/biologicals	Unclassified drugs or biolog
C9716	RF Energy to Anus	Radiofrequency energy to anu
G0314	ESRD relate svcs 4+mo 12-19	ESRD related svcs 4+ mo 12-19
G0364	Bone marrow aspirate & biops	Bone marrow aspirate & biopsy
G8019	Diabetic pt w/LDL > 100mg/dl	Diabetic pt w/LDL >= 100mg/dl
G8020	Diab pt w/LDL <= 100mg/dl	Diab pt w/LDL < 100mg/dl
G8023	DM pt w BP > 140/80	DM pt w BP >= 140/80
G8033	AMI-CAD pt on Bblocker	PMI-CAD pt on Bblocker
G8034	AMI-CAD pt not on Bblocker	PMI-CAD pt not on Bblocker
G8035	AMI-CAD pt inelig Bblocker	PMI-CAD pt inelig Bblocker
G9019	Oseltamivir phosphate 75mg	Oseltamivir phosphate 75mg
G9033	Amantadine HCL, oral, brand	Amantadine HCL oral brand
G9034	Zanamivir powder via inhaler	Zanamivir, inh pwdr, brand
J7640	Formoterol injection	Formoterol injection
K0606	AED garment w/elec analysis	AED garment w elec analysis
Q3020	ALS nonemer trans no ALS se	ALS nonemer trans no ALS ser

The following code descriptions were changed, **effective 04-01-06**

HCPCS	Old Description	New Description
S0143	Aztreonam inh sol gram	Aztreonam, inh sol gram
S0146	Peg interferon alfa-2B/10	Peg interferon alfa-2b/10
S0625	Digital screening retinal	Digital screening retina

HCPCS Changes- APC, Status Indicator and/or Edit Assignments

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-04** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
Q4054	Darbepoetin alfa, esrd use			B	A	62	N/A
Q4055	Epoetin alfa, esrd use			B	A	62	N/A

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
63075	Neck spine disk surgery	00000	00208	C	T		
A0800	Amb trans 7pm-7am			B	E	62	28
J0882	Darbepoetin alfa, esrd use			B	A	62	N/A
J0886	Epoetin alfa, esrd			B	A	62	N/A
Q0512	Px sup fee anti-can sub pres			M	B	72	62
Q3019	ALS emer trans no ALS serv			A	E	N/A	28
Q3020	ALS nonemer trans no ALS ser			A	E	N/A	28

Edit Assignments

The following code(s) were removed from the inherently bilateral list, **effective 08-01-00**

HCPCS
92002
92004
92012
92014

Procedure/ Device Pair Changes

The following procedure/device code pair requirements were added, **effective 04-01-05**

Proc	Device1
61626	C1769

The following procedure/device code pair requirements were added, **effective 10-01-05**

Proc	Device1
50688	C2617
63650	C1897
63655	C1897
64553	C1897
64555	C1897
64560	C1897
64561	C1897
64565	C1897
64573	C1897

Proc	Device1
64575	C1897
64577	C1897
64580	C1897
64581	C1897

The following procedure/device code pair requirements were added, **effective 01-01-06**

Proc	Device1
93624	C1893

The following procedure/device code pair requirements were removed, **effective 10-01-05**

Proc	Device1
36870	C1757
37204	C1887

REVENUE CODES

Added Revenue Codes

The following revenue code(s) were added to the list of valid revenue codes, **effective 08-01-00**

RevenueCode
0500
0509
0583
0660
0661
0662
0663
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