Integrated OCE (IOCE)
CMS Specifications V15.3
Effective 10/01/2014

Contents

Introduction

This 'integrated' OCE program processes claims for outpatient institutional providers including hospitals that are subject to the Outpatient Prospective Payment System (OPPS) as well as hospitals that are NOT (Non-OPPS). The Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC) will identify the claim as 'OPPS' or 'Non-OPPS' by passing a flag to the OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

This version of the OCE processes claims consisting of multiple days of service. The OCE will perform three major functions:

Edit the data to identify errors and return a series of edit flags.
Assign an Ambulatory Payment Classification (APC) number for each service covered under OPPS, and return information to be used as input to an OPPS PRICER program.
Assign an Ambulatory Surgical Center (ASC) payment group for qualifying services on claims from certain Non-OPPS hospitals (bill type 83x) – in the PC program/interface only [v8.2 – v8.3 only].

Each claim will be represented by a collection of data, which will consist of all necessary demographic (header) data, plus all services provided (line items). It will be the user's responsibility to organize all applicable services into a single claim record, and pass them as a unit to the OCE. The OCE only functions on a single claim and does not have any cross claim capabilities. The OCE will accept up to 450 line items per claim. The OCE software is responsible for ordering line items by date of service.

The OCE not only identifies individual errors but also indicates what actions should be taken and the reasons why these actions are necessary. In order to accommodate this functionality, the OCE is structured to return lists of edit numbers. This structure facilitates the linkage between the actions being taken, the reasons for the actions and the information on the claim (e.g., a specific diagnosis) that caused the action.

In general, the 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 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 one calendar day, the OCE will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day.

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

The Control Block

Information is passed to the OCE by means of a control block of pointers. Table 1 contains the structure of the OCE control block. The shaded area separates input from return information. Multiple items are assumed to be in contiguous locations.

Pointer Name	Pointer Description	UB-04 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-9-CM diagnosis codes	70 a-c (Pt's rvdx) 67 (pdx) 67A-Q (sdx)	Up to 28	8 (7 for code, 1 for POA flag)	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First three listed diagnoses are considered 'patient's reasons for visit dx', fourth diagnosis is considered 'principal dx'
Ndxptr	Count of the number of diagnoses pointed to by *Dxptr*		1	4	Binary fullword count
Sgptr	Line item entries	42, 44-47	Up to 450	Table 2	
Nsgptr	Count of the number of Line item entries pointed to by Sgptr		1	4	Binary fullword count
Flagptr	Line item action flag Flag set by FI/MAC 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	11	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	18-28	Up to 11	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 (Pos 2-4)	1	3	Used to identify CMHC and claims pending under OPPS. 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)	56	1	13	Pass on to Pricer
OSCARProvptr	OSCAR Medicare provider number	57	1	6	Pass on to Pricer
PstatPtr	Patient status	17	1	2	UB-92 values
OppsPtr	Opps/Non-OPPS flag		1	1	1=OPPS, 2=Non-OPPS (A blank, zero or any other value is defaulted to 1)
OccPtr	Occurrence codes	31-34	Up to 10	2	For FI/MAC use
NOccptr	Count of number of occurrence codes		1	4	Binary fullword count
CodeTypePtr	Code Type indicator	-	1	1	0=ICD10 Dx; 9=ICD9 Dx; blank or any other value uses *From* date to determine Dx code type. (For future use).
Dxeditptr	Diagnosis edit return buffer		Up to 28	Table 3	Count specified in Ndxptr
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Mdeditptr	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
Rceditptr	Revenue code edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
APCptr	APC/ASC return buffer		Up to 450	Table 7	Count specified in Nsgptr
Claimptr	Claim return buffer		1	Table 5	
Wkptr	Work area pointer		1	1.25 MB	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by Wkptr		1	4	Binary fullword

Table 1: OCE Control block

The input for each line item contains the information described in Table 2.

Field	UB-04 Form Locator	Number	Size (bytes)	Comments
HCPCS procedure code	44	1	5	May be blank
HCPCS modifier	44	5 x 2	10	
Service date	45	1	8	Required for all lines
Revenue code	42	1	4	Required for all lines
Service units	46	1	9	A blank or zero value is defaulted to 1
Charge	47	1	10	Used by PRICER to determine outlier payments

Table 2: Line item input information

Edit Dispositions

There are currently 91 different edits in the OCE. The occurrence of an edit can result in one of six different dispositions.

Disposition	Description
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/MAC 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 cannot be resubmitted but can be appealed.

In the initial release of the OCE, many of the edits had a disposition of RTP in order to give providers time to adapt to OPPS. In subsequent releases of the OCE, the disposition of some edits may be 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 return to provider, the edit numbers of the three edits would be contained in the claim return to provider reason list. There is more space allocated in the reason lists 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.

Special processing conditions currently applied only to OPPS claims:

1) Partial hospitalizations are paid on a per diem basis; as level I or level II according to the number of services provided/coded. 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-a). 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. All other partial hospital services on the same day are packaged – SI changed to N. A composite adjustment flag identifies the PHP APC and all the packaged PHP services on the day; a different composite adjustment flag is assigned for each PHP day on the claim.

Effective 1/1/11, different PHP APCs, Level I and Level II, are assigned for hospital-based & for CMHC partial hospitalization programs.

If less than the minimum amount (number & type) of services required for PHP (level I) are reported for any day, the PHP day is denied (i.e., All PHP services on the day will be denied, no PHP APC will be assigned. Note: Any non-PHP services on the same day will be processed according to the usual OPPS rules). Lines that are denied or rejected are ignored in PHP processing. If mental health services that are not approved for the partial hospitalization program are submitted on a PHP claim (13x TOB with condition code 41 or TOB 76x), the claim is returned to the provider.

2) Reimbursement for a day of outpatient mental health services in a non-PH program is capped at the amount of the level II hospital-based partial hospital per diem. On a non-PHP claim, the OCE totals the payments for all the designated MH services with the same date of service; if the sum of the payments for the individual MH services exceeds the level II hospital-based partial hospital per-diem, the OCE assigns a special "Mental Health Service" composite payment APC to one of the line items that represent MH services. All other MH services for that day are packaged – SI changed from Q3 to N. A composite adjustment flag identifies the Mental Health Service composite APC and all the packaged MH services on the day that are related to that composite. (See Appendix C-b). The payment rate for the Mental Health Services composite APC is the same as that for the level II hospital-based partial hospitalization APC. Lines that are denied or rejected are ignored in the Daily Mental Health logic. Some mental health services are specific to partial hospitalization and are not payable outside of a PH program; if any of these codes is submitted on a 12x, or 13x TOB **without** condition code 41, the claim is returned to the provider.

3) 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 indicators 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.

4) Inpatient-only procedures that are on the separate-procedure list 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 OPPS rules.

5) 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 multiple 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). (v6.0 – v7.3 only)

6) The use of a device, or multiple devices, is necessary to the performance of certain outpatient procedures. If any of these procedures is submitted without a code for the required device(s), the claim is returned to the provider. Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code. Conversely, some devices are allowed only with certain procedures, whether or not the specific device is required. If any of these devices is submitted without a code for an allowed procedure, the claim is returned to the provider.

7) Observations may be paid separately if specific criteria are met; otherwise, the observation is packaged into other payable services on the same day. (See Appendix H-a) [v3.1- v8.3].
Observation is a packaged service; may be used to assign Extended Assessment and Management composite APCs, effective v9.0 (See Appendix K).

8) Direct referral from a physician in the community to hospital for observation care (G0379) may be used in the assignment of an extended assessment and management composite, packaged into T, V or critical care service procedure if present; otherwise, the direct referral is processed as a medical visit (see Appendix K-b). Code G0379 that has been denied or rejected will not be included in any subsequent special direct referral logic. The default SI (Q3) will be retained as the final SI.
Exception: If LIAF = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent direct referral logic and that logic will determine the final SI).

9) In some circumstances, in order for Medicare to correctly allocate payment for blood processing and storage, providers are required to submit two lines with different revenue codes for the same service when blood products are billed. One line is required with revenue code 39X and an identical line (same HCPCS, modifier and units) with revenue code 38X (see Appendix J). Revenue code 381 is reserved for billing packed red cells, and revenue code 382 for billing whole blood; if either of these revenue codes is submitted on a line with any other service, the claim is returned to the provider (HCPCS codes with descriptions that include packed red cells or whole blood may be billed with either revenue code).

10) Certain wound care services may be paid an APC rate or from the Physician Fee Schedule, depending on the circumstances under which the service was provided. The OCE will change the status indicator to A and remove the APC assignment when these codes are submitted with therapy revenue codes or therapy modifiers.

11) Providers must append modifier ‘FB’ to procedures that represent implantation of devices that are obtained at no cost to the provider; modifier ‘FC’ is appended if a replacement device is obtained at reduced cost. If there is an offset payment amount for the procedure with the modifier, and if there is a device present on the claim that is matched with that procedure on the offset procedure/device reduction crosswalk, the OCE will apply the appropriate payment adjustment flag (corresponding to the FB or FC modifier) to the procedure line. The OCE will also reduce the APC rate by the full offset amount (for FB), or by 50% of the offset amount (for FC) before determining the highest rate for multiple or terminated procedure discounting. If the modifier is used inappropriately (appended to procedure with SI other than S, T, X, V or Q3), the claim is returned to the provider. If both the FB and FC modifiers are appended to the same line, the FB modifier will take precedence and the full offset reduction will be applied (v10.0 - v14.3).

Effective 1/1/2014, if modifier FB or FC is reported on a claim with a device implantation procedure, the claim will be returned to the provider.

For a specified procedure pair (implantation of an implantable cardioverter defibrillator with pacing electrode (CRT-D)), 33249 and 33225 – the SIs for 33249 and 33225 will be changed from Q3 to the specified SI/APC for standard OPPS processing when they do not appear on the same claim with the same date of service. When

both procedures are submitted together on the same date of service, the primary procedure will be assigned to the standard APC for payment and the secondary procedure will be packaged.
Standard device requirements will apply to both procedures under all circumstances; however, modifier FB or FC on the secondary procedure will be ignored for offset reduction if the SI for the procedure is changed to N. (Device requirements changed; modifier FB/FC no longer used for offset reduction, effective v15.0).

Providers also must append modifier 'FB' to specified Nuclear Medicine procedures when the diagnostic radiopharmaceutical is received at no cost/full credit. The OCE will append the corresponding payment adjustment flag (#7) to the nuclear medicine procedure line as indication to Pricer to deduct the standard policy packaged offset amount from the APC rate. (Assignment of the discounting formula by OCE will not be affected; nuclear medicine procedures are non-type T). (v12.0 - v14.3).

12) Certain special HCPCS codes are always packaged when they appear with other specified services on the same day; however, they may be assigned to an APC and paid separately if there is none of the other specified service on the same day. Some codes are packaged in the presence of any payable code with status indicator of S, T, V or X (STVX-packaged, SI = Q1); other codes are packaged only in the presence of payable codes with status indicator T (T-packaged, SI = Q2). The OCE will change the SI from Q(#) to N for packaging, or to the SI and APC specified for the code when separately payable. If there are multiple STVX and/or T packaged HCPCS codes on a specific date and no service with which the codes would be packaged on the same date, the code assigned to the APC with the highest payment rate will be paid. All other codes are packaged. Units of service = 1is assigned to any line where an SI of Q1 or Q2 (S, T, V, X/T-packaged code) is changed to a separately payable SI and APC.
If any STVX-packaged or T-packaged independent bilateral or conditional bilateral code with modifier 50 is paid separately, the modifier will be ignored in assigning the discount formula.

STVX/T-packaged codes (Q1, Q2) that are denied or rejected will not be included in any subsequent special packaging logic. The default SI (Q1, Q2) will be retained as the final SI.
Exception: If LIAF = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent special packaging logic and that logic will determine the final SI).

Note: Effective 1/1/09, for the purposes of executing this packaging logic which is applied prior to the composite APC logic (see overview in Appendix M), codes with SI of Q3 (composite candidates) will be evaluated using the status indicator associated with their standard APC.
Note: Effective 10/1/09, codes with SI of S, T, V or X that have been denied or rejected, will be ignored in subsequent special S, T, V, X/T logic for packaging Q1 or Q2 codes. If no payable S, T, V or X code is present, the Q1 or Q2 code will be processed for separate payment.

13) Submission of the trauma response critical care code requires that the trauma revenue code (068x) and the critical care E&M code (99291) also be present on the claim for the same date of service. Otherwise, the trauma response critical care code will be rejected.

14) Certain codes may be grouped together for reimbursement as a "composite" APC when they occur together on the same claim with the same date of service (SI = Q3). When the composite criteria for a group are met, the primary code is assigned the composite APC and status indicator for payment; non-primary codes, and additional primary codes from the same composite group, are assigned status indicator N and packaged into the composite APC. Special composite adjustment flags identify each composite and all the packaged codes on the claim that are related to that composite. Multiple composites, from different composite groups, may be assigned to a claim for the same date. Terminated codes (modifier 52 or 73) are not included in the composite criteria. If the composite criteria are not met, each code is assigned an individual SI/APC for standard OPPS processing (see Appendix K). Some composites may have additional or different assignment criteria.
Lines that are denied or rejected are ignored in the composite criteria.

15) Certain nuclear medicine procedures are performed with specific radiolabeled products. If any specified nuclear medicine procedure is submitted without a code for one of the specified radiolabeled products on the same claim, the claim is returned to the provider (v9.0 – v14.3).

16) OPPS claims for managed care beneficiaries, as identified by the FI/MAC, will not be subject to line level deductible.

17) In order to allow the FI/MAC to process and pay for certain services on Hospice claims, any HCPCS code with status indicator M that is submitted with revenue code 657 on 81x or 82x bill types, will have the status indicator changed from M to A; the claim will not be returned to the provider.

Effective 10/1/2014, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis on hospice claims. Hospice claims submitted with a manifestation code as principal diagnosis will be returned to the provider (edit 86).

18) Certain ancillary services will be packaged if submitted on the same date of service as the critical care E&M code (99291). If code 99291 is present with any of the specified ancillary procedure codes, the OCE will change the SI of the ancillary procedure code from Q[#] to N for packaging. Exception: If code 99291 is present and modifier 59 is also present on any line with the same date of service, the specified ancillary codes will **not** be packaged - the SI will be changed to the standard SI & APC specified for the code.
If 99291 is not present on the same date of service, the SI for the ancillary procedure will be changed to the standard SI and APC specified for the code when separately payable.

Note: Critical care-packaged codes that previously had SI =Q1 (36600, 94762) will not be subject to the modifier 59 exception; also, they will have the usual STVX-packaged logic applied in the absence of 99291.

19) Deductible and co-insurance will be waived for certain preventive services (see Appendix G for the specified payment adjustment flag values and Appendix O for the list of preventive services), and for any services submitted with modifier Q3 on the line.
Deductible will be waived for all services coded in the CPT range 10000 – 69999, on any day/date of service when modifier PT is also present on a valid code in the same range on the claim. The OCE will set the specified payment adjustment flag on the line, except when any other payment adjustment flag is already applied to the same line (see Appendix G).

20) Certain claims will be returned to the provider if a specified add-on code is submitted without a code for a required primary procedure on the same date of service (edit 84).

21) Claims will be returned to the provider if the surgical procedure to insert the ocular telescope prosthesis is submitted without the code for the telescopic intraocular lens, or vice versa, on the same date of service (edit 85). Discontinued insertion procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing telescopic lens code. (v13.0 – v14.3)

22) Certain skin substitute products will be separately paid, based on their standard SI/APC assignment, only when billed with specified skin substitute application procedure codes. If one of the specified application procedure codes is not present on the same date of service as the skin substitute, the skin substitute product will be packaged (will have its status indicator changed to N). (v13.0 – v14.3).

Effective 1/1/2014 (v15.0), the submission of certain skin substitute application procedures require the reporting of a skin substitute product for the same day. Certain skin substitute application procedures and skin substitute products will be divided into two lists based on high or low cost. Claims containing a high cost skin substitute application procedure without any of the high cost skin substitute product codes, and conversely any low cost skin substitute application procedure without a low cost skin substitute product code for the same day, will be returned to the provider (edit 87).

23) Effective 1/1/2014 (v15.0), packaged laboratory codes (with status indicator of N) that are submitted on a claim with bill type 12x or 14x, or 13x when the L1 modifier is appended to a packaged laboratory code, will have the SI changed to A, and will not be subject to edit 27. If packaged laboratory codes are submitted on a claim with bill type 12x and condition code W2 is present, the laboratory codes remain packaged (status indicator N).

Special processing conditions for FQHC claims under PPS:

Effective for claims with From Dates on or after October 1, 2014, claims submitted through the IOCE with bill type 77x for Federally Qualified Health Clinics (FQHC) shall be processed under the FQHC PPS. FQHC claims shall be paid under a per encounter basis for qualified clinic visits. Any supporting ancillary services provided on the day of the FQHC visit shall be packaged into the encounter payment. If the FQHC claim contains multiple dates of service, each day is processed separately through the IOCE. Special output flag values shall be assigned during FQHC processing under the IOCE to facilitate identification of FQHC payment processing by the Pricer program. (See Table 7: APC Return Buffer and Appendix L: FQHC Criteria and Logic Flowchart for additional details).

The following criteria are used for processing FQHC PPS claims through the IOCE:

1) FQHC encounters require the reporting of both a unique FQHC payment HCPCS code (G0466, G0467, G0468, G0469 or G0470) indicating the type of visit (New or established medical visit, new or established mental health visit, or Initial Preventive Physical Exam/Annual Wellness Visit), and a qualifying visit HCPCS related to the services performed. FQHC claims that do not contain a required FQHC payment code shall be returned to the provider (edit 88). The FQHC payment code must be reported with revenue code 519, 52x or 900. FQHC payment codes reporting revenue codes other than those listed shall be returned to the provider (edit 90). FQHC claims that do not contain both the FQHC payment code and a qualifying visit code are also returned to the provider (edit 89). The FQHC payment code identifies the line where the Pricer program applies the FQHC encounter payment.

FQHC encounters for new patient visits or for the IPPE/AWV are identified by the IOCE for additional payment adjustment by the Pricer program. Only one FQHC payment code per day is identified for the new patient/IPPE/AWV payment adjustment.

If a mental health visit is provided on the same day as a medical clinic visit, both visits are recognized for FQHC encounter payments, providing the claim meets the criteria for payment of each visit, i.e. FQHC payment HCPCS codes are present for each visit, qualifying visit HCPCS codes are present, and appropriate revenue codes are reported.

Mental health visits reporting psychotherapy services that are add-on codes require the reporting of a primary service code. A subset of the primary service codes for psychotherapy are also considered qualifying visit codes under the FQHC PPS. In order to satisfy the criteria for a FQHC mental health visit reporting a psychotherapy add-on code, if a psychotherapy add-on code is present with a mental health FQHC payment code, the psychotherapy add-on code is paired to a qualifying visit code that represents a primary service for the psychotherapy add-on code. If the primary service code is missing from a claim containing a FQHC mental health visit with a psychotherapy add-on code, the claim shall be returned to the provider (edit 84). If there are multiple visits present for the day, once the criteria for a FQHC mental health visit with psychotherapy is satisfied for the add-on code, the paired qualifying visit code cannot be used as a qualifying visit code for other FQHC payment codes that may be present. However, the processing of psychotherapy add-on codes occurs after the assignment of any new patient, IPPE/AWV, or other medical visit processing; qualifying visit codes that are utilized for previous medical visit assignment are not available for pairing with the psychotherapy add-on code for FQHC mental health clinic visits.

If there is an additional FQHC payment code for an established medical or mental health visit reported on the same day with modifier 59, this would indicate that the visit is a subsequent, unrelated illness or injury provided on the same day as another FQHC visit. The subsequent visit may be eligible for FQHC encounter payment, provided the appropriate FQHC visit criteria are met for the established patient FQHC visit reported with modifier 59. Any additional FQHC visits reported on the same day, reported with or without modifier 59, are packaged.

A composite adjustment flag shall be assigned for lines reporting FQHC payment codes, identifying the type of FQHC visit(s) present for a date of service, whether for: 01) medical visit or IPPE/AWV, 02) mental health visit, or 03) a subsequent visit reported with modifier 59. The composite adjustment flag is used by the Pricer program to identify line item charges associated with each type of FQHC encounter. All FQHC payment codes are assigned a composite adjustment flag by the IOCE; the assignment of the composite adjustment flag has no bearing on whether or not the visit is eligible for separate FQHC encounter payment.

2) Preventive services under the FQHC PPS shall be packaged into the FQHC encounter payment; however, line items reporting preventive services are subject to a waiver of coinsurance payment. The IOCE shall identify to the Pricer program the FQHC packaged preventive services by way of a specific packaging flag value 6 (Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment).

3) Influenza and pneumococcal vaccines and associated vaccine administration services continue to be paid under reasonable cost through the cost report, and are not packaged into the FQHC encounter payment. If influenza and/or pneumococcal vaccine and vaccine administration is reported on the FQHC claim, the services are identified for the Pricer program as non-packaged services that are excluded from the FQHC encounter payment.

4) Telehealth facility fees continue to be paid by the Medicare physician fee schedule, and are not packaged into the FQHC encounter payment. If telehealth facility fees are reported on the FQHC claim, the service is processed through the IOCE and identified as a non-packaged service for the Pricer program in order to be processed for fee schedule payment.

5) Items or services that are not covered under the FQHC PPS shall be assigned a line item action flag value of 5 by the IOCE, and are excluded from FQHC encounter payment. Line items where the IOCE assigns line item action flag 5 are line item rejected (edit 91). Line items may also be passed into the IOCE with non-covered line item charges with line item action flag 5 previously assigned; these lines are not subject to edit 91.

FQHC non-covered items or services include durable medical equipment submitted with revenue code 29X, ambulance services submitted with revenue code 54X, laboratory services paid under the Clinical Lab Fee Schedule (excluding venipuncture, 36415, which is packaged), hospital-based care, group services and non-face-to-face services.

Special processing conditions applied only to Non-OPPS HOPD claims:

1) Bill type of 83x is consistent with the presence of an ASC procedure on the bill and a calculated ASC payment. The Integrated OCE will assign bill type flags to Non-OPPS HOPD claims (opps flag =2) indicating that the bill type should be 83x when there is an ASC procedure code present; and, should not be 83x when there is no ASC procedure present. (Note: Effective 1/1/08, ASC procedures are no longer identified in the IOCE; in the absence of ASC procedures, all non-OPPS claims are flagged as 'should not be 83x').

Some processing conditions apply to OPPS HOPD and to some Non-OPPS institutional claims:

Antigens, Vaccine Administration, Splints, and Casts

Vaccine administration, antigens, splints, and casts are paid under OPPS for hospitals. In certain situations, these services when provided by HHAs not under the Home Health PPS, and to hospice patients for the treatment of a non-terminal illness, are also paid under OPPS.
(See Appendix O for the specific list of HCPCS codes for reporting antigens, vaccine administration, splints and casts).

National Correct Coding Initiative (NCCI) Edits

The Integrated OCE generates NCCI edits for OPPS hospitals. All applicable NCCI edits are incorporated into the IOCE. 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, these NCCI edits also apply to ALL services billed, under bill types 22X, 23X, 34X, 74X, and 75X, by the following providers: Skilled Nursing Facilities (SNFs), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs), CORFs, and Home Health Agencies (HHAs).

The NCCI edits are applied to services submitted on a single claim, and on lines with the same date of service. NCCI edits address unacceptable code combinations based on coding rules, standards of medical practice, two services being mutually exclusive, or a variety of other reasons. In some cases, the edit is set to pay the higher-priced service, in other cases the lesser-priced service.

In some instances, both codes in a NCCI code pair may be allowed if an appropriate modifier is used that describes the circumstances when both services may be allowed. The code pairs that may be allowed with a modifier are identified with a modifier indicator of "1"; code pairs that are never allowed, whether or not a modifier is present, are identified with a modifier indicator of "0". (Modifiers that are recognized/used to describe allowable circumstances are: 24, 25, 27, 57, 58, 59, 78, 79, 91, E1-E4, F1-F9, FA, LC, LD, LM, LT, RI, RC, RT, T1-T9, and TA).

Version 20.3 of NCCI edits, with effective date of 10/01/2014, is included in the October, 2014 IOCE.

See Appendix F(a) and F(b) "OCE Edits Applied by Bill Type" for bill types that the IOCE will subject to these and other OCE edits.

All institutional outpatient claims, regardless of facility type, will go through the Integrated Outpatient Code Editor (IOCE)*; however, not all edits are performed for all sites of service or types of claim. Appendix F (a) contains OCE edits that apply for each bill type under OPPS processing; Appendix F (b) contains OCE edits that apply to claims from hospitals not subject to OPPS.
*__Note__: Effective for dates of service on or after 1/1/08 (v9.0), claims for 83x bill type will not go through the Integrated OCE.

The OPPS PRICER would compute the standard APC 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 APC payment calculations
APC value is not 00000
Payment indictor has a value of 1 or 5
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 or 1
Payment method flag is zero
Composite adjustment flag is zero

If payment adjustments are applicable to a line item (payment adjustment flag is not 0 or 1) then nonstandard calculations are necessary to compute payment for a line item (See Appendix G). The line item action flag is passed as input to the OCE as a means of allowing the FI/MAC to override a line item denial or rejection (used by FI/MAC to override OCE and have PRICER compute payment ignoring the line item rejection or denial) or allowing the FI/MAC to indicate that the line item should be denied or rejected even if there are no OCE edits present. The action flag is also used for handling external line item adjustments. For some sites of service (e.g., hospice) only some services are paid under OPPS.

The line item action flag also impacts the computation of the discounting factor in Appendix D. The Payment Method flag specifies for a particular site of service which of these services are paid under OPPS (See Appendix E). 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. Appendix M summarizes the process of filling in the APC return buffer.

If a claim spans more than one day, the 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 OCE deals with all multiple day claims issues by means of the return information. The PRICER does not need to be aware of the issues associated with multiple day claims. The PRICER 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.

General Programming Notes:

In composite processing, prime/non-prime lines that are denied or rejected (NCCI or other edits) will not be included in the composite criteria.

Edits that use status indicator (SI) in their criteria will use the final SI, after any special (SI = Q) processing that could change the SI. (Exception: edits that are stipulated in the overview to be performed before the special processing).

For codes where the default SI is a 'Q(#)', if special logic to change the SI is not performed because of the bill type or because the line is denied or rejected, the default SI will be carried through to the end of processing and will be returned as the final SI. **Exception**: If LIAF "1" is appended to a line with SI Q(#), the line item denial or rejection is ignored, the line is included in IOCE logic and the IOCE logic determines the final SI.

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.

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

Edit Return Buffers

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. The edit return buffers are described in Table 3

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	0,1-5, 86	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 28 diagnoses.
Procedure edit return buffer	3	30	0, 6, 8-9, 11-18, 20-21, 28, 30, 35, 37-38, 40, 42-45, 47, 49-50, 52-58, 60-64, 66 -74, 76-85, 87, 88, 89, 91	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	0,22,75	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 line item dates.	There is one 4x3 buffer for each of up to 450 line items.
Revenue center edit return buffer	3	5	0, 9[a] 41,48, 50[b], 65, 90	Three-digit code specifying the edits that applied to revenue centers.	There is one 5x3 buffer for each of up to 450 line items

Table 3: Edit Return Buffers

[a]Revenue codes 099x with SI of E when submitted without a HCPCS code (OPPS only)
[b]Revenue code 0637 with SI of E when submitted without a HCPCS code (OPPS & Non-OPPS)

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 the 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.

There are currently 91 different edits in the OCE, some of which are inactive for the current version of the program. Each edit is assigned a number. A description of the edits is contained in Table 4.

Edit #	Description	Non OPPS Hosp.	Disposition
1	Invalid diagnosis code	Y	RTP
2	Diagnosis and age conflict	Y	RTP
3[5]	Diagnosis and sex conflict	Y	RTP
4[4]	Medicare secondary payer alert **(v1.0-v1.1)**		Suspend
5[4]	E-diagnosis code cannot be used as principal diagnosis	Y	RTP
6	Invalid procedure code	Y	RTP
7	Procedure and age conflict **(Not activated)**		RTP
8[5]	Procedure and sex conflict	Y	RTP
9[6]	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion.	Y	Line item denial
10	Service submitted for denial (condition code 21)	Y	Claim denial
11	Service submitted for FI/MAC review (condition code 20)	Y	Suspend
12	Questionable covered service	Y	Suspend
13	Separate payment for services is not provided by Medicare **(v1.0 – v6.3)**		Line item reject
14	Code indicates a site of service not included in OPPS **(v1.0 – v6.3)**		Claim RTP
15	Service unit out of range for procedure [1]	Y	RTP
16	Multiple bilateral procedures without modifier 50 (see Appendix A) **(v1.0 – v6.2)**		RTP
17	Inappropriate specification of bilateral procedure (see Appendix A)	Y	RTP
18	Inpatient procedure [2]		Line item denial
19	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (combined with edit 20; **# deleted** v13.2, retroactive to earliest non-archived version)		Line item reject
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present		Line item reject
21	Medical visit on same day as a type "T" or "S" procedure without modifier 25 (see Appendix B)		RTP
22	Invalid modifier	Y	RTP
23	Invalid date	Y	RTP
24	Date out of OCE range	Y	Suspend
25	Invalid age	Y	RTP
26	Invalid sex	Y	RTP
27	Only incidental services reported [3]		Claim rejection
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Y	Line item reject
	(See Appendix C for logic for edits 29-36, and 63-64)		
29	Partial hospitalization service for non-mental health diagnosis		RTP
30	Insufficient services on day of partial hospitalization		Line item denial
31	Partial hospitalization on same day as ECT or type T procedure **(v1.0 – v6.3)**		Suspend
32	Partial hospitalization claim spans 3 or less days with insufficient services on a least one of the days **(v1.0 – v9.3)**		Suspend
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having partial hospitalization services **(v1.0 – v9.3)**		Suspend
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria **(v1.0 – v9.3)**		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 **(v1.0 – v6.3)**		Suspend
37	Terminated bilateral procedure or terminated procedure with units greater than one		RTP
38	Inconsistency between implanted device or administered substance and implantation or associated procedure		RTP
39	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (combined with edit 40; **# deleted** v13.2, retroactive to earliest non-archived version)		Line item reject
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present		Line item reject

Table 4: Description of edits/claim reasons (Part 1 of 2)

[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 exceed the code's limit, 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/ASC 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 patient's reason for visit diagnosis

[5] Sex conflict edits (#3 and #8) are bypassed if condition code 45 is present on the claim

[6] Edit 9 is not applied/is bypassed for code G0428 with SI = E.

Edit	Description	Non OPPS Hosp.	Disposition
41	Invalid revenue code	**Y**	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 reject
46	Partial hospitalization condition code 41 not approved for type of bill	Y*	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 under any Medicare outpatient benefit, based on statutory exclusion	Y	RTP
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 or 85x	Y*	Line item reject
54	Multiple codes for the same service	Y	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	Composite E/M condition not met for 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 (**Edit deleted** in v11.2, retroactive to date of establishment or earliest non-archived version).		RTP
60	Use of modifier CA with more than one procedure not allowed		RTP
61	Service can only be billed to the DMERC	Y	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) **(v1.0 – v13.3)**		RTP
64	AT service not payable outside the partial hospitalization program (See Appendix C) **(v1.0 – v13.3)**		Line item reject
65	Revenue code not recognized by Medicare	Y	Line item reject
66	Code requires manual pricing		Suspend
67	Service provided prior to FDA approval	Y	Line item denial
68	Service provided prior to date of National Coverage Determination (NCD) approval	Y	Line item denial
69	Service provided outside approval period	Y	Line item denial
70	CA modifier requires patient status code 20		RTP
71	Claim lacks required device code		RTP
72	Service not billable to the Fiscal Intermediary/Medicare Administrative Contractor	Y	RTP
73	Incorrect billing of blood and blood products		RTP
74	Units greater than one for bilateral procedure billed with modifier 50	Y*	RTP
75	Incorrect billing of modifier FB or FC		RTP
76	Trauma response critical care code without revenue code 068x and CPT 99291		Line item reject
77	Claim lacks allowed procedure code		RTP
78	Claim lacks required radiolabeled product **(v9.0 – v14.3)**		RTP
79	Incorrect billing of revenue code with HCPCS code		RTP
80	Mental health code not approved for partial hospitalization program		RTP
81	Mental health service not payable outside the partial hospitalization program		RTP
82	Charge exceeds token charge ($1.01)		RTP
83	Service provided on or after effective date of NCD non-coverage	Y	Line item denial
84	Claim lacks required primary code		RTP
85	Claim lacks required device code or required procedure code **(v13.0 – v14.3)**		RTP
86	Manifestation code not allowed as principal diagnosis		RTP
87	Skin substitute application procedure without appropriate skin substitute product code		RTP
88	FQHC payment code not reported for FQHC claim		RTP
89	FQHC claim lacks required qualifying visit code		RTP
90	Incorrect revenue code reported for FQHC payment code		RTP
91	Item or service not covered under FQHC PPS		Line item reject

Table 4: Description of edits/claim reasons (Part 2 of 2)

* Non-OPPS hospital bill types allowed for edit condition

Y = edits apply to Non-OPPS hospital claims

The claim return buffer described in Table 5 summarizes the edits that occurred on the claim.

Item	Bytes	Number	Values	Description
Claim processed flag	1	1	0-3, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, 46[a], TOB 83x or other invalid bill type). 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 cannot run - the environment cannot 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	aaaaaaaaaaaa	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 4) 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 4) 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, 21-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 50, 52, 54-56, 58, 60-63, 70-75, 77-82 , 84-87, 88, 89, 90	Three-digit code specifying edits (see Table 4) that caused the claim to be returned to provider.
Claim suspension reasons	3	16	4, 11, 12, 24, 31 -34, 36, 57, 66	Three-digit code specifying the edits that caused the claim to be suspended (see Table 4).
Line item rejection reasons	3	12	13, 20, 28, 40, 45, 47, 53, 64, 65, 76, 91	Three-digit code specifying the edits that caused the line item to be rejected (See Table 4).
Line item denied reasons	3	6	9, 18, 30, 49, 67-69, 83	Three-digit code specifying the edits that caused the line item to be denied (see Table 4).
APC/ASC return buffer flag	1	1	0-1	0 - No services paid under OPPS. APC/ASC return buffer filled in with default values and ASC group number (See App F). 1 - One or more services paid under OPPS. APC/ASC return buffer filled in with APC.
VersionUsed	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. *A blank, zero or any other value is defaulted to 1
Non-OPPS bill type flag	1	1	1-2	Assigned by OCE based on presence/absence of ASC code 1 = Bill type should be 83x (v8.2 - v8.3 only; ASC list & 83x TOB removed v9.0) 2 = Bill type should not be 83x

Table 5: Claim Return Buffer

[a]Edit 46 terminates processing only for those bill types where no other edits are applied (See App.F)

Note: Table 6, a complex table which summarizes the edit return buffers, claim disposition and claim reasons, has been removed; this information is available in tables 3, 4 and 5.

Table 7 describes the APC/ASC return buffer. The APC/ASC return buffer contains the APC for each line item along with the relevant information for computing OPPS payment for OPPS hospital claims. Two APC numbers are returned in the APC/ASC fields: HCPCS APC and payment APC. Except when specified otherwise (e.g., partial hospitalization, mental health, observation logic, codes with SI of Q(#), etc.), the HCPCS APC and the payment APC are always the same. The APC/ASC return buffer contains the information that will be passed to the OPPS PRICER. The APC is only returned for claims from HOPDs that are subject to OPPS, and for the special conditions specified in Appendix F-a.

The APC/ASC return buffer for the PC program interface also contains the ASC payment groups for procedures on certain Non-OPPS hospital claims. The ASC group number is returned in the payment APC/ASC field, the HCPCS ASC field is zero-filled [v8.2 – v8.3 only].

Name	**Size (bytes)**	**Values**	**Description**
HCPCS procedure code	5	Alpha	For potential future use by Pricer. Transfer from input
Payment APC/ASC*	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, and other procedure claims, the payment APC may be different than the APC assigned to the HCPCS code. ASC group for the HCPCS code.
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status indicator**	2	Alpha [Right justified, blank filled]	A - Services not paid under OPPS; paid under fee schedule or other payment system. 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 J - New drug or new biological pass-through [1] K - Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals L – Flu/PPV vaccines M – Service not billable to the FI/MAC N - Items and Services packaged into APC rates P - Partial hospitalization service Q - Packaged services subject to separate payment based on payment criteria [2] Q1 – STVX-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC R – Blood and blood products S - Procedure or service, not discounted when multiple T - Procedure or service, multiple reduction applies U – Brachytherapy sources V - Clinic or emergency department visit W – Invalid HCPCS or Invalid revenue code with blank HCPCS X - Ancillary service Y – Non-implantable DME Z – Valid revenue code with blank HCPCS and no other SI assigned
Payment indicator**	2	Numeric (1- nn) [Right justified, blank filled].	1 - Paid standard hospital OPPS amount (status indicators K, R, S, T, U, V, X) 2 - Services not paid under OPPS; paid under fee schedule or other payment system (SI A) 3 - Not paid (Q, Q1, Q2, Q3, M, W,Y, E), or not paid under OPPS (B, C, Z) 4 - Paid at reasonable cost (status indicator F, L) 5 – Paid standard amount for pass-through drug or biological (status indicator G) 6 – Payment based on charge adjusted to cost (status indicator H) 7 – Additional payment for new drug or new biological (status indicator J)[1] 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)) 10 – Paid FQHC encounter payment 11 – Not paid or not included under FQHC encounter payment 12 – No additional payment, included in payment for FQHC encounter 13 - Paid FQHC encounter payment for New patient or IPPE/AWV
Discounting formula number**	1	1-9	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 (procedure edit return buffer for line item contains a 9, 13, 18, 20, 28, 30, 40, 45, 47 ,49, 53, 64, 65, 67, 68, 69, 76, 83, 91) 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).

Table 7: APC/ASC Return Buffer (Part 1 of 2)

Name	Size (bytes)	Values	Description
Packaging flag**	1	0-6	0 - Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of PH per diem or daily mental health service per diem (v1.0-v93 only)[3] 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01) 4 – Packaged as part of drug administration APC payment (v6.0 – v7.3 only) 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment
Payment adjustment flag**	2	0- 10, 91-99 [Right justified, blank filled]	0 - No payment adjustment 1 – Paid standard amount for pass-through drug or biological (status indicator G) 2 – Payment based on charge adjusted to cost (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 7 - Item provided without cost to provider[5] 8 – Item provided with partial credit to provider[5] 9 – Deductible/co-insurance not applicable 10 – Co-insurance not applicable 91 – 99 Each composite APC present, same value for prime and non-prime codes (v 9.0 – v9.3 only)[4].
Payment Method Flag**	1	0-5	0 - OPPS pricer determines payment for service 1 - Service not paid based on coverage or billing rules 2 - Service is not subject to OPPS 3 - Service is not subject to OPPS, and has an OCE line item denial or rejection 4 - Line item is denied or rejected by FI/MAC; OCE not applied to line item 5 – Payment for service determined under FQHC PPS
Service units	9	1-x	Transferred from input, for Pricer. For the line items assigned APCs 33, 172, 173 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 (v6.0 – v7.3 only)]
Charge	10	nnnnnnnnn	Transferred from input, for Pricer; COBOL pic 9(8)v99
Line item action flag**	1	0-5	Transferred from input to Pricer, and can impact selection of discounting formula (AppxD). 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. 5 - Non-covered service excluded from payment under FQHC PPS.
Composite Adjustment Flag**	2	Alphanumeric	00 – Not a composite 01 – ZZ: First thru the nth composite APC present; same composite flag identifies the prime and non-prime codes in each composite APC group. For FQHC PPS claims (bill type 77x) only, the following values are defined for composite adjustment flag[6]: 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC clinic visit, medical or mental health (modifier 59 reported)

Table 7: APC/ASC Return Buffer (Part 2 of 2)

[1] Status indicator J was replaced by status indicator G starting in April, 2002 (V3.0)
[2] Status indicator Q was replaced by status indicators Q(#) in January, 2009 (v10.0)
[3] Packaging flag 2 was replaced by the composite adjustment flag starting in January, 2009 (v10.0)
[4] Payment adjustment flag values 91 thru 99 discontinued 1/1/09, replaced by the composite adjustment flag (v10.0)
[5] Payment adjustment flag values 7 & 8 discontinued effective January, 2014 (v15.0)
[6] Values defined for composite adjustment flag that are used only for FQHC PPS processing are output on claims with bill type 77x without condition code 65; no composite APCs are assigned (v15.3).
***** ASC # returned **only** for TOB 83x, on the PC version output report, for v8.2 & v8.3
****** Not activated for claims with Opps flag = 2 (blanks are returned in the APC/ASC Return Buffer)

Appendix A (OPPS & Non-OPPS)
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 without a 50 modifier	Return claim to provider	16
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 with a 50 modifier	Return claim to provider	17

There is a list of codes that are considered inherently bilateral even if a modifier of 50 is not present. The following edit applies 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. **Exception**: If modifier 76 or 77 is submitted on the second and subsequent line(s) or unit(s).	Return claim to provider	17***

There are two lists of codes, one is considered conditionally bilateral and the other independently bilateral if a modifier 50 is present. The following edit applies to these bilateral procedures (effective 10/1/06). [OPPS claims only]

Condition	Action	Edit
The bilateral code occurs with modifier 50 and more than one unit of service on the same line. **Modifications for TOB 85x with RC 96x, 97x, 98x** (v9.0): a) Sum up units for multiple lines with the same HCPCS and same revenue code on the same day, if some or all the lines have modifier 50. b) Exclude any lines that have any other modifier, other than 50, present.	Return claim to provider	74

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.

** Exception: For codes with SI of V that are also on the Inherent Bilateral list, condition code 'G0' will take precedence over the bilateral edit; these claims will not receive edit 17 nor be returned to provider.

*** Exception: Edit 17 is not applied to Non-OPPS TOB 85x

Appendix B (OPPS Only)
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 the claim will be returned to the provider.

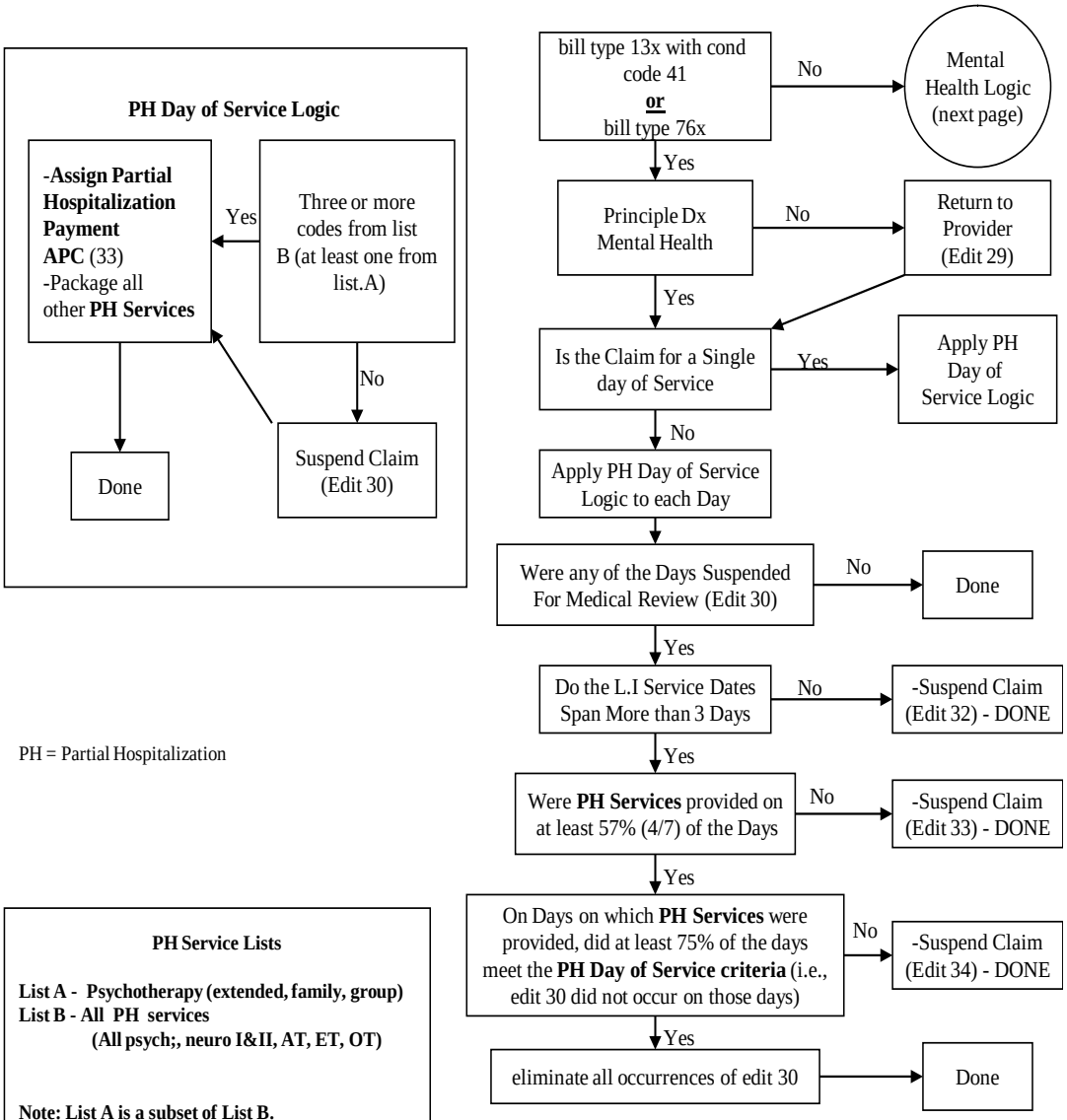
If there are multiple E&M codes on the same day, on the same claim the rules associated with multiple medical visits are shown in the following table.

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).

* For codes with SI of V that are also on the Inherent Bilateral list, condition code 'G0' will take precedence over the bilateral edit to allow multiple medical visits on the same day.

Appendix C-a (OPPS Only)
Partial Hospitalization Logic (v1.0 – v9.3)

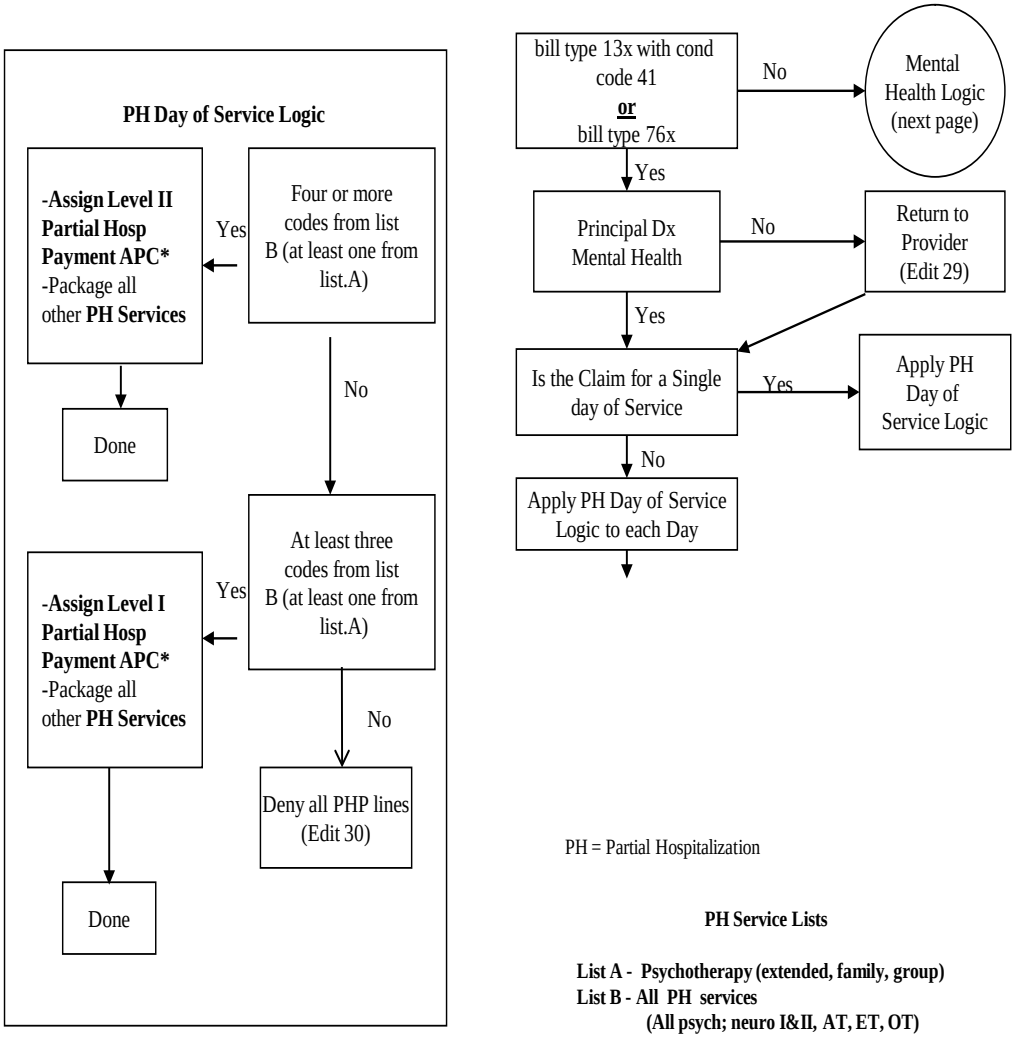


+ Multiple occurrences of services from list A or B are treated as separate units in determining whether 3 or more PH services are present..

Assign Partial Hospitalization Payment APC
For any day that has a PH service, the first listed line item from the following hierarchical list (List A, other codes in list B) 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 **partial hospital service** (List B), the SI is changed to N and packaging flag is set to 2
For ALL lines with a partial hospital service (List B), the HCPCS APC is set to 0 (effective **1/1/08**)
Note: If mental health services which are not approved for the partial hospitalization program are submitted on a 13x TOB with CC41, or on a 76x TOB, the claim is returned to the provider (edit 80).

Appendix C-a (cont'd)
Partial Hospitalization Logic (effective v10.0)



PH = Partial Hospitalization

PH Service Lists

List A - Psychotherapy (extended, family, group)
List B - All PH services
(All psych; neuro I&II, AT, ET, OT)
List C – Add-on codes not counted toward APC

Note: Lists A & C are subsets of List B.
(See Appendix N for the lists of PH services.)

+ Multiple occurrences of services from list A or B are treated as separate units in determining whether 3 or more PH services are present..

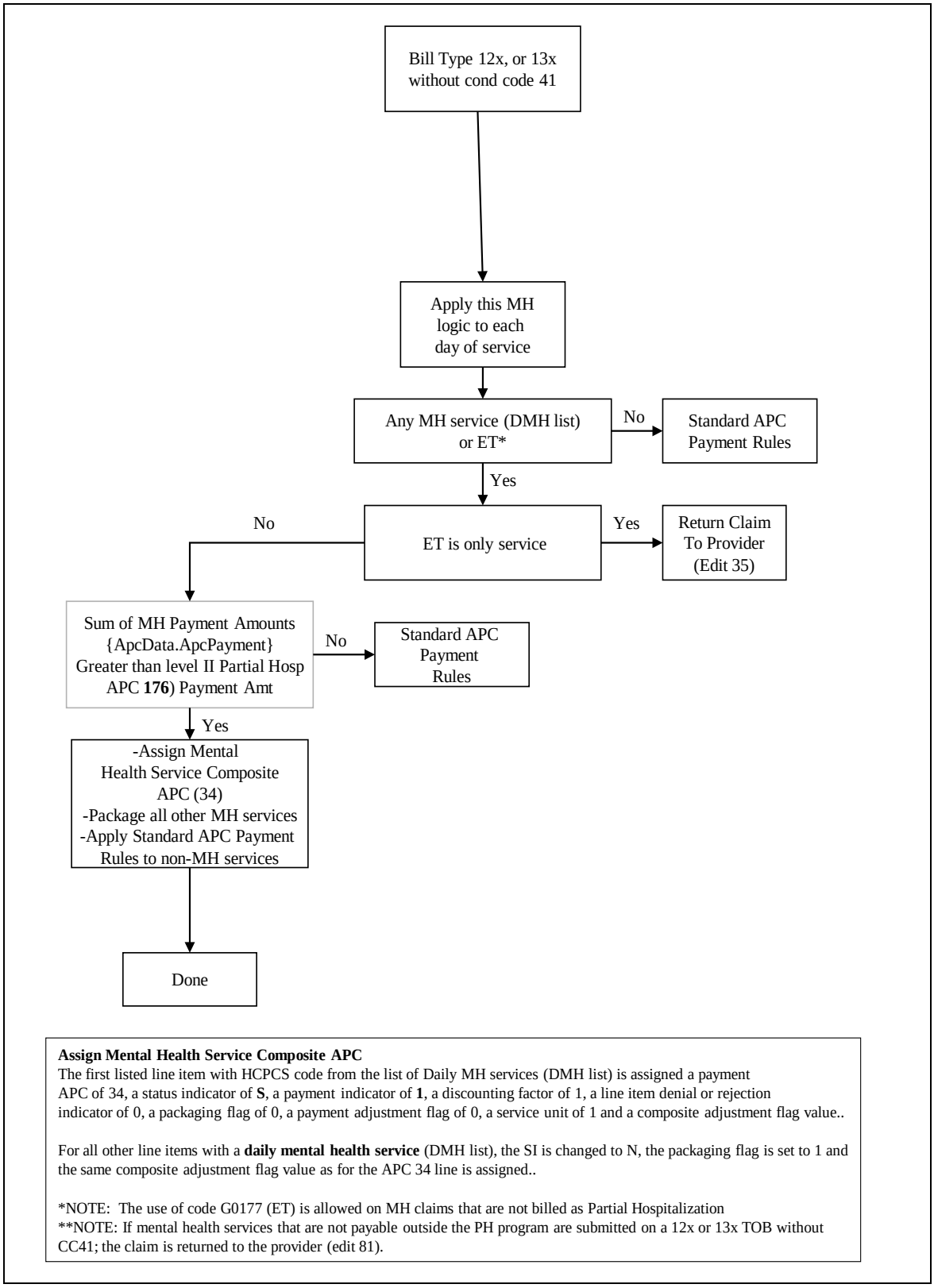
***Assign Partial Hospitalization Payment APC according to bill type:**
For bill type 13x w/cc41: APC 176 = Level II; APC 175 = Level I (effective 1/1/11)
For bill type 76x: APC 173 = Level II; APC 172 = Level I (effective 1/1/11)

For any day that meets the criteria for level II or level I PHP APC, the first listed line item from the following hierarchical list (List A, other codes in list B excluding list C codes) is assigned the PHP payment APC, 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, a service unit of 1 and a composite adjustment flag value.

For all other line items with a **partial hospital service** (List B) on the day, the SI is changed to N, the packaging flag is set to 1 and the same composite adjustment flag value as for the PHP APC, is assigned.

For ALL lines with a partial hospital service (List B), the HCPCS APC is set to 0 (effective **1/1/08**)
Note: If mental health services which are not approved for the partial hospitalization program are submitted on a 13x TOB with CC41, or on a 76x TOB, the claim is returned to the provider (edit 80).

Appendix C-b (cont'd)
Mental Health Logic



Assign Mental Health Service Composite APC
The first listed line item with HCPCS code from the list of Daily MH services (DMH list) is assigned a payment APC of 34, a status indicator of **S**, a payment indicator of **1**, 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, a service unit of 1 and a composite adjustment flag value..

For all other line items with a **daily mental health service** (DMH list), the SI is changed to N, the packaging flag is set to 1 and the same composite adjustment flag value as for the APC 34 line is assigned..

*NOTE: The use of code G0177 (ET) is allowed on MH claims that are not billed as Partial Hospitalization
**NOTE: If mental health services that are not payable outside the PH program are submitted on a 12x or 13x TOB without CC41; the claim is returned to the provider (edit 81).

Appendix D
Computation of Discounting Fraction (OPPS Only)

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 should not occur, and have the discounting factor set so as to result in the equivalent of a single procedure. Claims submitted with terminated bilateral procedures or terminated procedure with units greater than one 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 non-bilateral procedures 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:

All line items with SI other than "T" are subject to terminated procedure discounting when modifier 52 or 73 is present.

There are nine 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
9. 2D/U

Where

D = discounting fraction (currently 0.5)
U = number of units
T = terminated procedure discount (currently 0.5)

***Note**: Effective 1/1/08 (v9.0), formula #6 and formula #7 discontinued; replaced by formula #3 and new formula #9.

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

Discount formulas applied to type "T" procedures:

Payment Amount	Modifier 52 or 73	Modifier 50**	Conditional or Independent Bilateral	Inherent or Non Bilateral
Highest	No	No	2	2
Highest	Yes	No	3	3
Highest	No	Yes	4	2
Highest	Yes	Yes	3	3
Not Highest	No	No	5	5
Not Highest	Yes	No	3	3
Not Highest	No	Yes	9	5
Not Highest	Yes	Yes	3	3

Discount formulas applied to non-type "T" procedures:

Payment Amount	Modifier 52 or 73	Modifier 50**	Conditional or Independent Bilateral	Inherent or Non Bilateral
Highest	No	No	1	1
Highest	Yes	No	3	3
Highest	No	Yes	8*	1
Highest	Yes	Yes	3	3
Not Highest	No	No	1	1
Not Highest	Yes	No	3	3
Not Highest	No	Yes	8*	1
Not Highest	Yes	Yes	3	3

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (**T**) and any applicable offset, will be applied prior to selecting the type T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset will be applied first, before the terminated procedure discount.

*If not terminated, non-type T Conditional bilateral procedures with modifier 50 will be assigned discount formula #8 effective 10/1/08; non-type T Independent bilateral procedures with modifier 50 will be assigned to formula #8.

**If modifier 50 is present on an independent or conditional bilateral line that has a composite APC or a separately paid STVX/T-packaged procedure, the modifier is ignored in assigning the discount formula.

Effective 1/1/08 (v9.0), formula #6 and formula #7 discontinued; replaced by formula #3 and new formula #9.

Appendix E (a)
Logic for Assigning Payment Method Flag Values to Status Indicators by Bill Type [OPPS flag = 1]

Payment Method Flag (PMF) Values

0 - OPPS Pricer determines payment for service
1 - Service is not paid based on coverage or billing rules
2 - Service is not subject to OPPS
3 - Service is not subject to OPPS, and has an OCE line item denial or rejection
4 - Line item is denied or rejected by FI; OCE not applied to line item
5 - Payment for service determined under FQHC PPS

Type Of Bill	PMF = 0	PMF = 1	PMF = 2	Comments
HOPD 13x w or w/o Condition Code 41	G, H, J, K, N, P, R, S, T, U, V, X	C, E, B, M, Q, Q1, Q2, Q3, W, Y, Z	A, F, L	
HOPD 12x, 14x with CC41	Not set	Not set	Not set	PMF is not set, edit 46 is generated, claim processed flag is set to 1 and no further processing occurs.
HOPD 12x, 14x Without CC 41	G, H, J, K, N, P, R, S, T, U, V, X	C, E, B, M, Q, Q1, Q2, Q3, W, Y, Z	A, F, L	
CMHC 76x	PH services (any SI/code on PH list) & Non-PH w/SI = N	Non-PH & non-Telehealth service: A, B, C, E, F, G, H, J, K, L, M, R, S, T, U, V, X, Q, Q1, Q2, Q3, W, Y, Z	Telehealth (Q3014)	
CORF 75x	Vaccine [v1-6.3] (any SI/code on the vaccine list)	C,E,M, W, Y, Z	A, B, F, G, H, J, K, L, N, P, Q, Q#, R, S, T, U, V, X	
Home Health 34x	Vaccine, Antigen, Splint, Cast (any SI/code on specified lists)	Not vaccine, Antigen, splint, cast: C, E, M, W, Y, Z	Not vaccine, Antigen, splint, cast: A, B, F, G, H, J, K, L, N, P, Q, Q#, R, S, T, U, V, X	
RNHC (43x) RHC (71x) FQHC (73x/77x)		C, E, M, W, Y, Z	A, B, F, G, H, J, K, L, N, P, Q, Q#, R, S, T, U, V, X	
Any 'OPPS' bill type not listed above, with Condition Code 07.	Antigen, splint, cast: (any SI/code on specified lists)	Not antigen, splint, cast: C, E, M, W, Y, Z	Not antigen, splint, cast: A, B, F, G, H, J, K, L, N, P, Q, Q#, R, S, T, U, V, X	
Any 'OPPS' bill type not listed above, without Condition Code 07.		C, E, M, W, Y, Z	A, B, F, G, H, J, K, L, N, P, Q, Q#, R, S, T, U, V, X	

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 above, 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).
7. Effective 10/1/2014, if the bill type is 77X and CC 65 is not present, all lines are assigned PMF = 5, regardless of SI assignment.

Appendix E(b) [OPPS flag = 2] **[Not activated]**.
Logic for Assigning Non-OPPS Hospital Payment Method Flag Values

[PMF values not returned on claims with OPPS flag = 2]

Bill type	Status Indicator	PMF
HOPD (12x, 13x, 14x) CAH (85x) ASC (83x w OPPS flag = 2	C, E,M, W, Y, Z	1
HOPD (12x, 13x, 14x) CAH (85x) ASC (83x w OPPS flag = 2	A, B, F, G, H, K, L, N, P, Q, Q1, Q2, Q3, R, S, T, U, V, X	2

Appendix F(a) – OCE Edits Applied by Bill Type [OPPS flag =1]

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12x or 14x with condition code 41	46	Buffer not completed
2	12x or 14x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52-54, 56-58, 60-79, 81-85, 87.	Buffer completed
3	13xwith condition code 41	1-9, 11-18, 20-23, 25-28, 29-34, 37, 38, 40 - 45, 47-50, 52, 54, 56-58, 60-62, 65-80, 82–85, 87.	Buffer completed
4	13x without condition code 41	1-9, 11-18, 20-23, 25-28, 35- 38, 40-45, 47- 50, 52, 54, 56-58, 60-79, 81, 82 – 85, 87.	Buffer completed
5	76x (CMHC)	1-9, 11-13, 15, 18, 23, 25, 26, 29-34, 38, 41, 43-45, 47-50, 53-55, 61, 65, 69, 71-73, 75, 77- 80, 82, 84, 85, 87.	Buffer completed
6	34x (HHA) with Vaccine, Antigens, Splints or Casts	1- 9, 11-13, 15, 18, 20, 25-26, 28, 38, 40, 41, 43-45, 47, 49-50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87.	Buffer completed
7	34x (HHA) without Vaccine, Antigens, Splints or Casts	1-9, 11-13, 20, 25, 26, 40-41, 44, 50, 53-55, 65, 69.	Buffer not completed
8	75x (CORF) with Vaccine (PPS) [v1-6.3]	1-9, 11-13, 15, 18, 20, 25, 26, 38, 40-41, 43-45, 47-50, 53-55, 61, 62, 65, 69, 71-73, 75, 77 -79, 82, 84, 85, 87.	Buffer completed
9	43x (RNHCI)	25, 26, 41, 44, 46, 55, 65.	Buffer not completed
10	71x (RHC), 73x/77x (FQHC, [v11.1 – 15.2])	1-5, 25, 26, 41, 61, 65, 72.	Buffer not completed
11	Any bill type except 12x, 13x, 14x, 34x, 43x, 71x, 73x/77x, 76x, with CC 07, with Antigen, Splint or Cast	1-9, 11-13, 18, 23, 25, 26, 28, 38, 41, 43-45, 47, 49, 50, 53-55, 62, 65, 69, 71, 73, 75, 77 -79, 82, 84, 85, 87.	Buffer completed
12	75x (CORF)	1-9, 11-13, 15, 20, 23, 25, 26, 40, 41, 44, 48, 50, 53-55, 61, 65, 69, 72.	Buffer not completed
13	22X, 23X (SNF), 24X	1-9, 11-13, 20, 23, 25, 26, 28, 40-41, 44, 50, 53, 54, 55, 61, 62, 65, 69, 72.	Buffer not completed
14	32X, 33X (HHA)	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53-55, 65, 69.	Buffer not completed
15	72X (ESRD)	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53, 54, 55, 61, 65, 69, 72.	Buffer not completed
16	74X (OPT)	1-9, 11-13, 20, 25, 26, 40-41, 44, 48, 50, 53, 54, 55, 61, 65, 69, 72.	Buffer not completed
17	81X (Hospice), 82X	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53, 54, 55, 61, 65, 69, 72, 86	Buffer not completed
18	77X (FQHC PPS) [v15.3]	1- 6, 25, 26, 41, 65, 72, 84, 88, 89, 90, 91	Buffer not completed

FLOW CHART ROWS ARE IN HIERARCHICAL ORDER.

Notes:

1) Edit 10, and edits 23 and 24 for From/Through dates, are not dependent on Appendix F.
2) If edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates and processing continues.
3) Edit 22 is bypassed if revenue code is 540.
4) Edit 77 is not applicable to bill type 12x (rows #1 and #2).
5) Bypass edit 48 if revenue code is 100x, 210x, 310x, 0500, 0509, 0521, 0522, 0524, 0525, 0527, 0528, 0583, 0637, 0660-0663, 0669, 0905-0907, 0931, 0932, 0948, 099x.
6) In V1.0 to V3.2, "vaccines" included all vaccines paid by APC; from V4.0 forward, "vaccines" includes Hepatitis B vaccines only, plus Flu, H1N1 and PPV administration.
7) Bypass diagnosis edits (1-5) for bill types 32x and 33x (HHA) &12x (inpt/B) if **From** date is before October 1 and **Through** date is on or after October 1. And for bill types 322 & 332 if **From** date is between 9/26 and 9/30, inclusive. Note: Bill type 33X is deleted as of 10/1/2013.
8) Bill type 24x deleted, effective 10/1/2005.
9) NCCI edits (20, and 40) applied to bill types 22x, 23x, 34x, 74x and 75x effective 1/1/06.
10) Edit 28 applied to bill type 22x and 23x effective 10/1/2005.
11) Effective 4/1/2006, MH edits (35, 36, 63, 64 and 81) not applicable to TOB 14x.
12) If TOB is 81x or 82x and RC = 657, bypass edit 72 for any HCPCS code with SI =M (& change the SI from M to A).
13) Change TOB for FQHC from 73x to 77x, effective 4/1/2010.
14) Psychiatric add-on codes trigger edit 84 only on PHP claims (TOB 13x w/CC41 & 76x).
15) Edit 86 applied to bill types 81x and 82x only, effective 10/01/2013.
16) Bypass edit 27 for bill types 12x or 14x (row #2), or 13x with modifier L1 reported for laboratory services, when claims containing packaged laboratory codes have the SI changed to A (effective 1/1/2014).
17) Effective 10/1/2014, the list of edits for bill type 77x is modified for applicability under the FQHC PPS. Edit 88 is not applicable for claims with bill type 770 (no payment claim).

Appendix F(b) – OCE Edits Applied by Non-OPPS Hospital Bill Type [OPPS flag = 2]

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12X or 14X with condition code 41, and OPPS flag = 2	46	Buffer not completed
2	12X or 14X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 53, 54, 61, 65, 67-69, 72, 83.	Buffer not completed
3	13X with condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 83.	Buffer not completed
4	13X without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 83.	Buffer not completed
5	85X, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 22, 23, 25, 26, 28, 41, 50, 54, 61, 65, 67-69, 72, 74, 83.	Buffer not completed
6	83X, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 22, 23, 25, 26, 28, 41, 50, 53, 54, 61, 65, 67-69, 72, 83.	Buffer completed

FLOW CHART ROWS ARE IN HIERARCHICAL ORDER.

Notes:

1) Edit 10, and edits 23 and 24 for **From/Through** dates, are not dependent on Appendix F.
2) If edit 23 is not applied, the lowest service (or **From**) date is substituted for invalid dates and processing continues.
3) Edit 22 is bypassed if revenue code is 540
4) Bypass edit 72 if bill type is 85X and HCPCS with SI = M is submitted with revenue code 096x, 097x or 098x.
5) 83X bill type is invalid for IOCE effective for dates of service on or after 1/1/08 (IOCE v9.0).

Appendix G [OPPS Only]
Payment Adjustment Flag Values

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[5] as 'deductible not applicable' or condition code "MA" is present on the claim.	4
Blood product with modifier BL on RC 38X line[2]	5
Blood product with modifier BL on RC 39X line[2]	6
Item provided without cost to provider[6]	7
Item provided with partial credit to provider[6]	8
Deductible/co-insurance not applicable[4]	9
Co-insurance not applicable	10
First thru ninth composite APC present – prime & non-prime	91 - 99[3] (v9.0-v9.3)
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)
[3]PAF 91-99 were replaced by the Composite Adjustment Flag, 1/1/09 (v10.0).
[4] Apply to preventive services (see Appendix O) & lines with modifier Q3 (Live kidney donor and related services).
[5]Codes may be flagged in the database or by program logic.
[6]PAF 7 & 8 deactivated 1/1/2014 (v15.0).

Appendix H [OPPS Only]

OCE Observation Criteria (v3.0 – v8.3)

Note: **Appendix H is not applicable to claims for dates of service after 1/1/2008. See Appendix K for rules governing payment for observation after 1/1/2008 .**

OCE Observation Rules (v3.0 – v8.3) [4/1/02 – 12/31/07]:

Code G0378 is used to identify all outpatient observations, regardless of the reason for observation (diagnosis) or the duration of the service.

Code G0379 is used to identify direct referral from a physician's office to observation care, regardless of the reason for observation.

Code G0378 has default Status Indicator "Q" and default APC 0
If the criteria are met for payable observation, the SI is changed to "S" and APC 339 is assigned.
If the criteria for payable observation are not met, the SI is changed to "N".

Code G0379 has default Status Indicator "Q" and default APC 0
If associated with a payable observation (payable G0378 present on the same day), the SI for G0379 is changed to "N".
If the observation on the same day is not payable, the SI is changed to "V" and APC 604 is assigned.
If there is no G0378 on the same day, the claim is returned to the provider.

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 (or 85x).

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.

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 referral from physician's office).
E/M or C/C visit is required the day before or day of observation; Direct referral is required on the day of observation.

If an observation cannot be paired with an E/M or C/C visit or Direct referral, the observation is packaged.

E/M or C/C visit or Direct referral on the same day as observation takes precedence over E/M or C/C visit on the day before observation.

E/M, C/C visit or Direct referral that have been denied or rejected, either externally or by OCE edits, are ignored.

Both the associated E/M or C/C visit (APCs 604-616, 617) and the observation are paid separately if the criteria are met for separately payable observation.

If a "T" procedure occurs on the day of or the day before observation, the observation is packaged.

Multiple observations on a claim are paid separately if the required criteria are met for each one.

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.

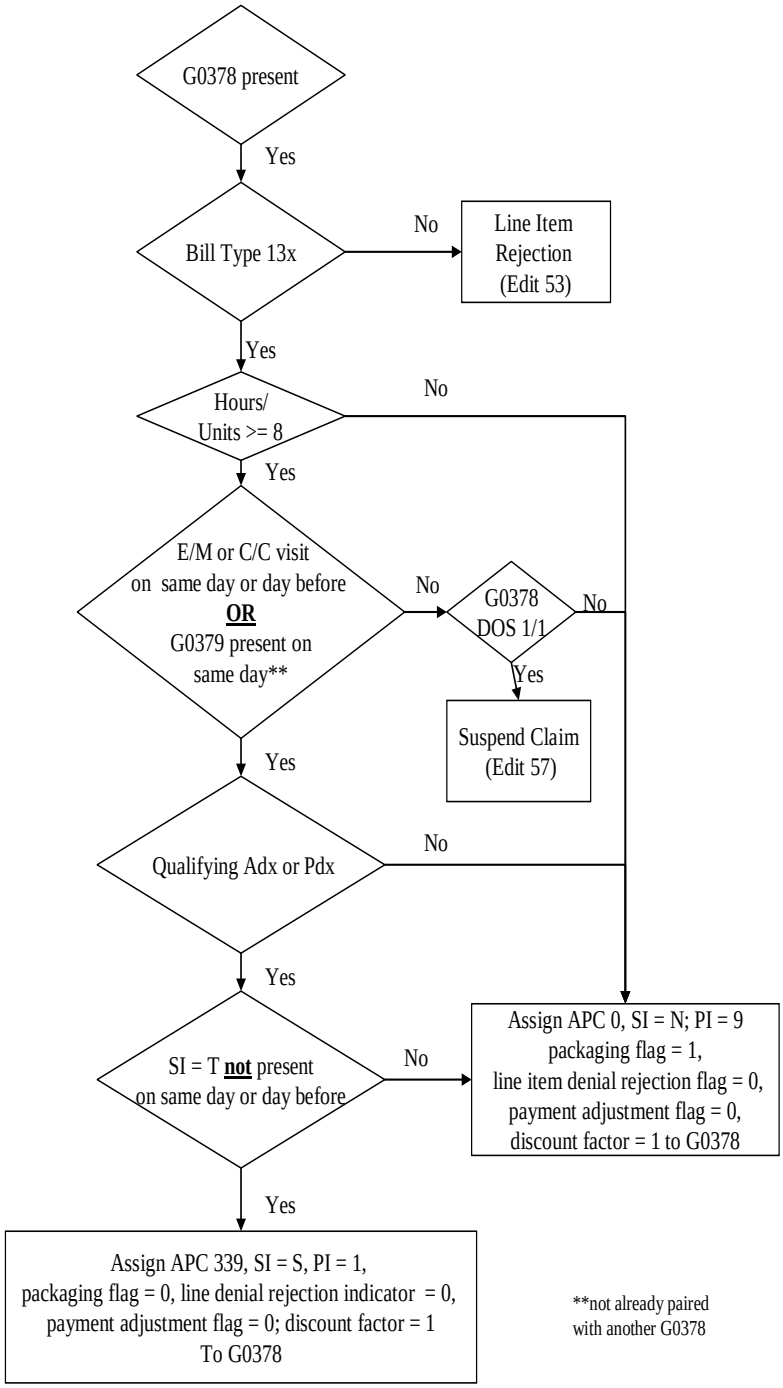
Observation date is assumed to be the date admitted for observation

The diagnoses (patient's reason for visit or principal) required for the separately payable observation criteria are:

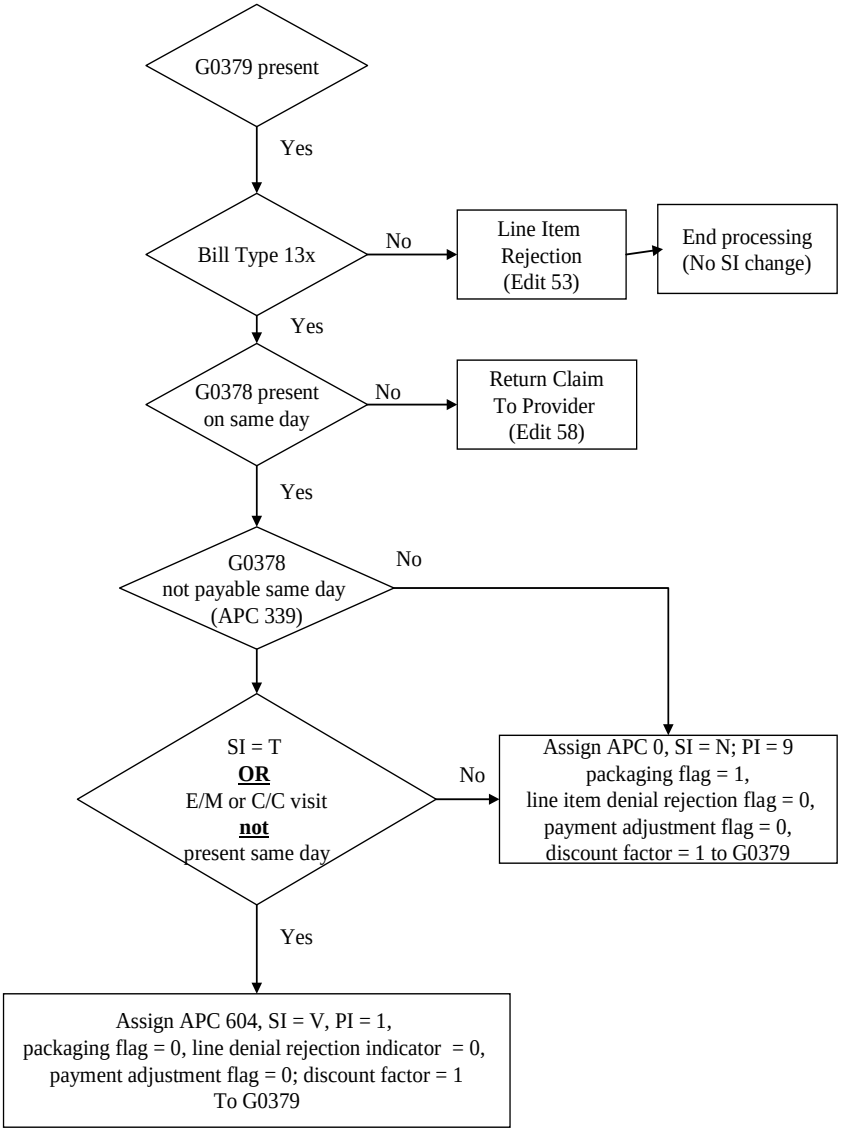
Chest Pain	Asthma	CHF
4110, 1, 81, 89	49301, 02, 11, 12, 21, 22, 91, 92	3918, 39891
4130, 1, 9		40201, 11, 91
78605, 50, 51, 52, 59		40401, 03, 11, 13, 91, 93
		4280, 1, 9, 20-23, 30-33, 40-43

1. The APCs required for the observation criteria to identify E/M or C/C visits are 604- 616, 617.

Appendix H-a (cont'd)
OCE Observation Flowchart (v3.0 – v8.3)

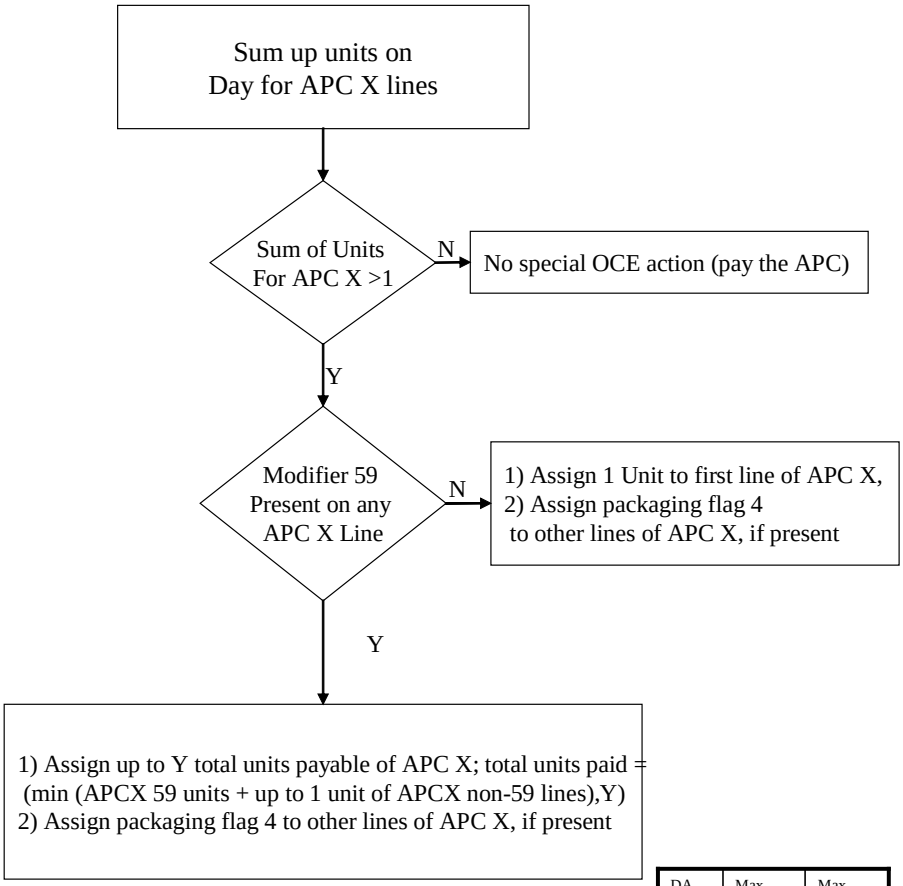


Appendix H-b (cont'd)
Direct Referral Logic (v3.0 – v8.3)



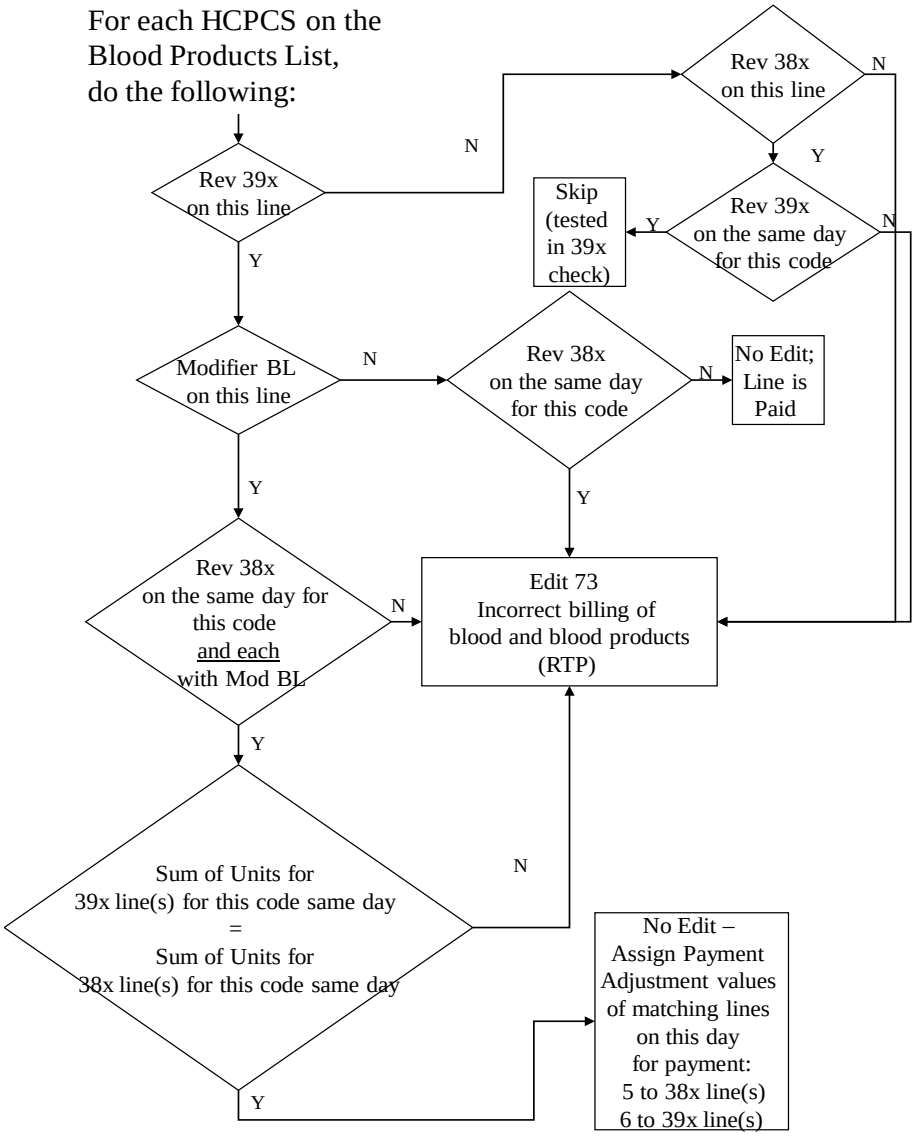
Appendix I [OPPS Only]
Drug Administration (v6.0 – v7.3 only)

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



DA APC	Max APC units without modifier 59	Max APC units with modifier 59
116	1	2
117	1	2
120	1	4

Appendix J [OPPS Only]
Billing for blood/blood products



Note: If revenue code 381 is used with HCPCS other than packed red cells, or revenue code 382 with HCPCS other than whole blood, the claim will be returned to the provider (edit 79).

Appendix K
Composite APC Assignment Logic

LDR prostate brachytherapy composite APC assignment criteria:

1. If a 'prime' code is present with at least one non-prime code from the same composite on the same date of service, assign the composite APC and related status indicator to the prime code; assign status indicator N to the non-primary code(s) present.
    a. Assign units of service = 1 to the line with the composite APC
    b. If there is more than one prime code present, assign the composite APC to the prime code with the lowest numerical value and assign status indicator N to the additional prime code(s) on the same day.
    c. Assign the indicated composite adjustment flag to the composite and all component codes present.
2. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.
3. Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.
4. Procedures that are packaged (SI changed to 'N' in an earlier processing step) are not included in the composite assignment logic.

The component codes for the composite APC assignments are:

LDR Prostate brachytherapy composite

Prime/Group A code	Non-prime/Group B codes	Composite APC
55875	77778	8001

Electrophysiology/ablation composite APC assignment criteria:

1. If there is a single code present from group C, **or** one 'prime' code (group A) and at least one non-prime code (group B) on the same date of service, assign the composite APC and related status indicator to the group C code, or to the prime code & assign status indicator N to the non-primary code(s) present.
    a. Assign units of service = 1 to the line with the composite APC
    b. If multiple codes from group C are present, assign the composite APC to the code with the lowest numerical value and assign status indicator N to additional group C codes on the same day.
    c. If there is more than one prime code present, assign the composite APC to the prime code with the lowest numerical value and assign status indicator N to the additional prime code(s) on the same day.
    d. If the criteria for APC assignment are met with a code from group C as well as from groups A&B, assign the composite APC to the group C code and assign SI of N to the codes from groups A&B.
    e. If there is one or more codes from group C present with one or more codes from **either** group A **or** group B; assign the composite APC to the group C code and assign the standard APC and related SI to any separate group A **or** group B codes present.
    f. Assign the indicated composite adjustment flag to the composite and all component codes present.
2. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component group A and group B codes present.
3. Terminated codes (modifier 52 or 73 present) in group C are assigned to the composite APC; terminated codes in groups A and B are ignored in composite APC assignment

4. Procedures that are packaged (SI changed to ‘N’ in an earlier processing step) are not included in the composite assignment logic.

Electrophysiology/ablation composite

Prime/Group A codes	Non-prime/Group B codes	Group C	Composite APC
93619 93620	93650	93653 93654 93656	8000

Appendix K (cont'd)
Composite APC Assignment Logic

Code G0378 is used to identify all outpatient observation services, regardless of the reason for observation (diagnosis), the duration of the service or whether the criteria for the EAM composites are met.

Code G0379 is used to identify direct referral from a physician in the community to hospital for observation care, regardless of the reason for observation (diagnosis).

EAM 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 (or 85x).

Extended Assessment and Management Composite APC rules:

a) If the criteria for the composite APC are met, the composite APC and its associated SI are assigned to the prime code (visit or critical care).

b) Only one extended assessment and management APC is assigned per claim.

c) If the criteria are met for a level I and a level II extended assessment and management APC, assignment of the level II composite takes precedence. (Level I and Level II EAM APCs deleted effective 1/1/2014).

d) If multiple qualifying prime codes (visit or C/C) appear on the day of or day before G0378, assign the composite APC to the prime code with the highest separately paid payment rate; assign the standard APC to any/all other visit codes present.

e) Visits not paid under an extended assessment and management composite are paid separately.

Exception: Code G0379 is always packaged if there is an extended assessment and management APC on the claim.

f) The SI for G0378 is always N.

g) Extended assessment and management composite APCs have SI = V if paid.

h) The logic for extended assessment and management is performed only for bill type 13x, with or without condition code 41.

i) Hours/units of service for observation (G0378) must be at least 8 or the composite APC is not assigned.

j) If a "T" procedure occurs on the day of or day before observation, the composite APC is not assigned.

k) Assign units of service = 1 to the line with the composite APC.

l) Assign the composite adjustment flag to the visit line with the composite APC and to the G0378.

m) If the composite APC assignment criteria are not met, apply regular APC logic for separately paid items, special logic for G0379 and the SI for G0378 = N.

Level II Extended Assessment and Management criteria: **(Level II EAM APC deleted effective 1/1/2014).**

a) If there is at least one of a specified list of critical care or emergency room visit codes on the day of or day before observation (G0378), assign the composite APC and related SI to the critical care or emergency visit code.

b) Additional emergency or critical care visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.

Prime/List A codes	Non-prime/List B code	Composite APC
99284, 99285, 99291 G0384	G0378	8003

Level I Extended Assessment and Management criteria: (Level I EAM APC deleted effective 1/1/2014).

a) If there is at least one of a specified list of prime clinic visit codes on the day of or day before observation (G0378), or code G0379 is present on the same day as G0378, assign the composite APC and related status indicator to the clinic visit or direct referral code.

b) Additional clinic visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.

c) Additional G0379, **on the same claim**, are assigned SI = N.

Prime /List A codes	Non-prime/List B code	Composite APC
99205, 99215, G0379	G0378	8002

Extended Assessment and Management criteria: (EAM APC effective 1/1/2014, v15.0).

a) If there is at least one of a specified list of critical care or emergency room or clinic visit codes on the day of or day before observation (G0378), or code G0379 is present on the same day as G0378, assign the composite APC and related status indicator to the critical care, emergency department, clinic visit or direct referral code.

b) Additional critical care, emergency or clinic visit codes (whether or not on the prime list) are assigned to their standard APCs for separately paid items.

c) Additional G0379, **on the same claim**, are assigned SI = N.

Prime /List A codes	Non-prime/List B code	Composite APC
99284, 99285, 99291, G0384, G0463, G0379	G0378	8009

Separate Direct Referral (G0379) Processing Logic

(See Appendix K-b for flowchart):

a) Code G0378 must be present on the same day

b) No SI = T, E/M, or C/C visit on the same day

c) Code G0379 may be paid under the composite 8009, paid under APC 633, or packaged with SI = N.

Critical Care Packaging

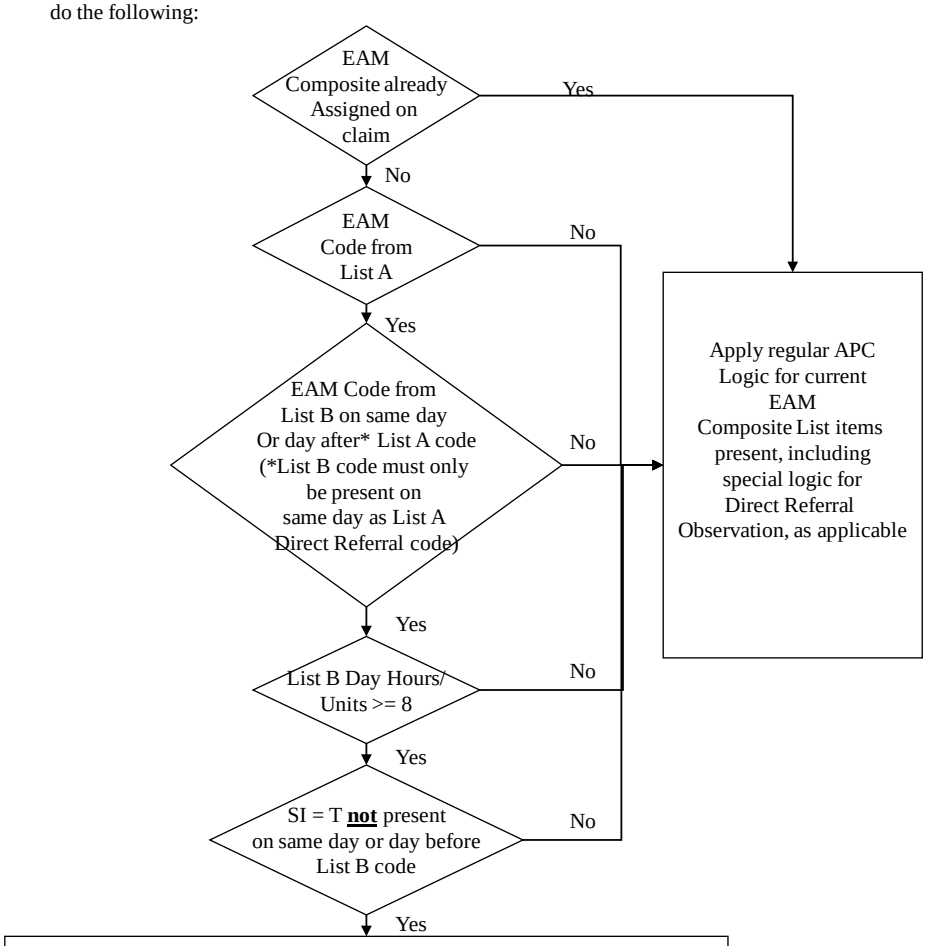
A specified list of ancillary procedure codes that are packaged when submitted on the same date of service as the critical care E&M code (99291) will have the default SI of Q3; however, they are not required components of any composite APCs and are not used to assign any composite APCs. The Q3 status indicator will be changed to N when 99291 is present; otherwise, it will be changed to the standard SI and APC for the specified code. The composite adjustment flag will not be assigned nor any special composite logic applied.

Implantable Cardioverter Defibrillator and Pacing Electrode.

Codes 33249 and 33225 have default SI of Q3, however, they are not components of a composite APC. When submitted together on the same date of service, the SI for 33249 will be changed to the standard SI/APC for payment and the SI for 33225 will be changed to N. The composite adjustment flag will not be assigned, but 33249 and 33225 will be paid as a single, composite service. For all other processing, the SI for both codes will be changed to the standard SI/APC.

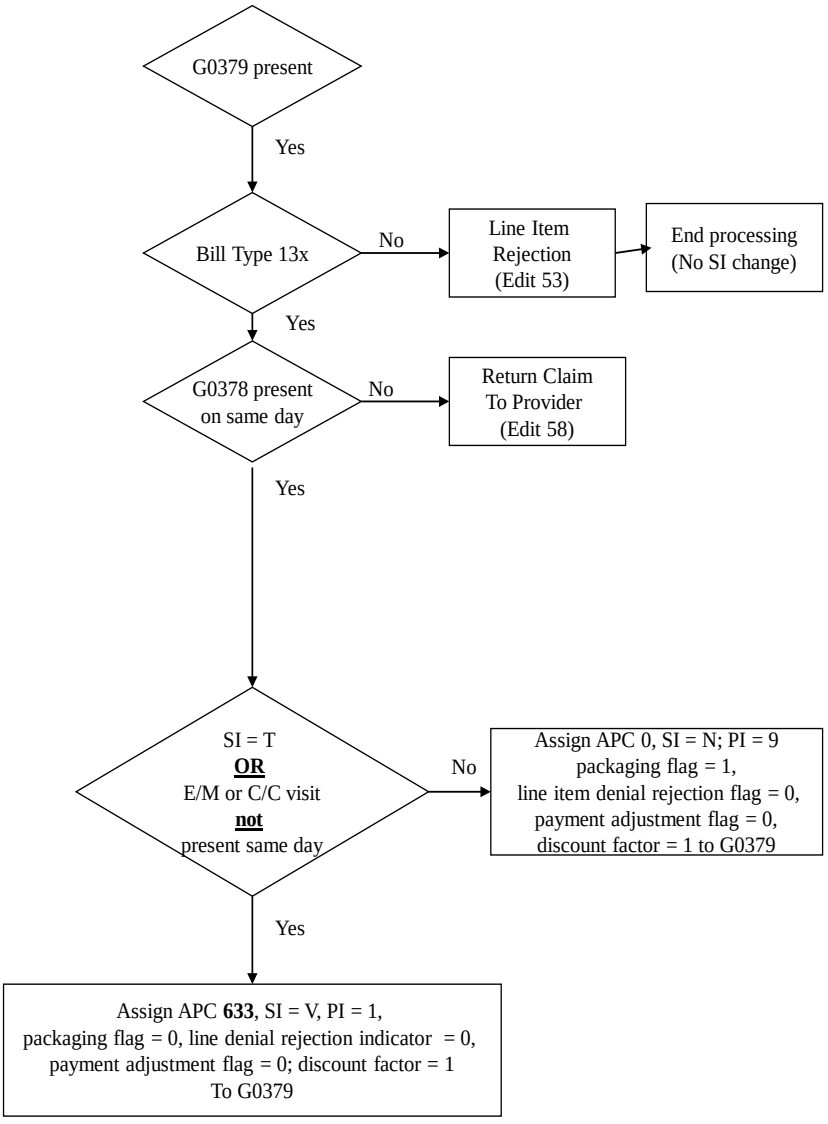
Appendix K-a
Extended Assessment & Management Flowchart
[Effective v9.0]

For each Extended Assessment and Management (EAM) Composite APC,
(Level II first, then Level I – **Level I & Level II EAM APCs effective v9.0 – v14.3 only)**
do the following:



Appendix K-b
Direct Referral Logic (v9.0)

If there is no Extended Assessment & Management APC assigned on the claim:



Appendix K (cont'd)

Multiple Imaging Composite Assignment Rules & Criteria:

1. Multiple imaging composite APCs are assigned for three 'families' of imaging procedures – ultrasound, computed tomography and computed tomographic angiography (CT/CTA), and magnetic resonance imaging and magnetic resonance angiography (MRI/MRA).
2. Within two of the imaging families, imaging composite APCs are further assigned based on procedures performed with contrast and procedures performed without contrast. There is currently a total of five multiple imaging composite APCs.
3. If multiple imaging procedures from the same family are performed on the same DOS, a multiple imaging composite APC is assigned to the first eligible code encountered; all other eligible imaging procedures from the same family on the same day are packaged (the status indicator is changed to N).
4. Multiple lines or multiple units of the same imaging procedure will count to assign the composite APC; independent or conditional bilateral imaging procedures with modifier 50 will count as 2 units.
5. If multiple imaging procedures within the CT/CTA family, or the MRI/MRA family are performed with contrast and without contrast during the same session (same DOS), the 'with contrast' composite APC is assigned.
6. Imaging procedures that are terminated (modifier 52 or 73 present), are not included in the multiple imaging composite assignment logic; standard imaging APC is assigned to the line(s) with modifier 52 or 73 (SI changed from Q3 to separately payable SI and APC).
7. Imaging procedures that are packaged (SI changed from Q# to N in an earlier processing step) are not included in the multiple imaging composite assignment logic.
8. If the imaging composite APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.

Family 1 – Ultrasound:

1. Ultrasound Composite (APC 8004)

APC Number	Codes
8004	76604, 76700, 76705, 76770, 76775, 76776, 76831, 76856, 76857, 76870

Family 2 – CT/CTA with and without contrast*:

1. CT and CTA without Contrast Composite (APC 8005)

APC	Codes
8005	70450, 70480, 70486, 70490, 71250, 72125, 72128, 72131, 72192, 73200, 73700, 74150, 74176, 74261.

2. CT and CTA with Contrast Composite (APC 8006)

APC	Codes
8006	70460, 70470, 70481, 70482, 70487, 70488, 70491, 70492, 70496, 70498, 71260, 71270, 71275, 72126, 72127, 72129, 72130, 72132, 72133, 72191, 72193, 72194, 73201, 73202, 73206, 73701, 73702, 73706, 74160, 74170, 74175, 74177, 74178, 74262, 75635.

Family 3 – MRI/MRA with and without contrast*:

1. MRI and MRA without Contrast Composite (APC 8007)

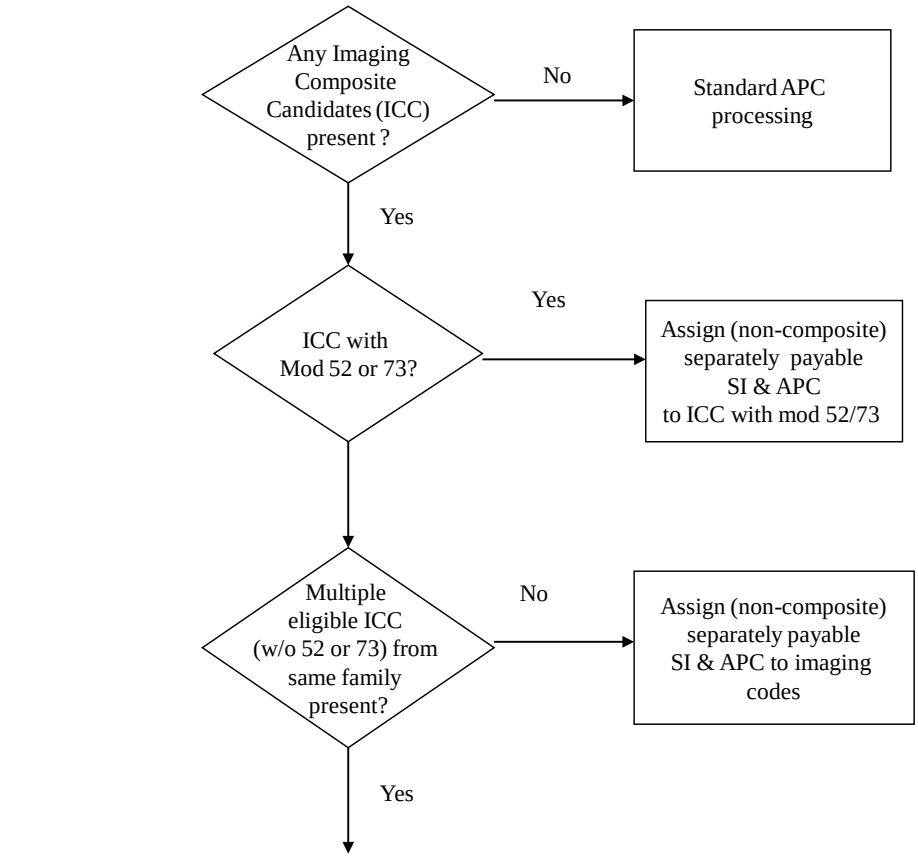
APC	Codes
8007	70336, 70540, 70544, 70547, 70551, 70554, 71550, 72141, 72146, 72148, 72195, 73218, 73221, 73718, 73721, 74181, 75557, 75559, C8901, C8904, C8907, C8910, C8913, C8919, C8932, C8935.

2. MRI and MRA with Contrast Composite (APC 8008)

APC	Codes
8008	70542, 70543, 70545, 70546, 70548, 70549, 70552, 70553, 71551, 71552, 72142, 72147, 72149, 72156, 72157, 72158, 72196, 72197, 73219, 73220, 73222, 73223, 73719, 73720, 73722, 73723, 74182, 74183, 75561, 75563, C8900, C8902, C8903, C8905, C8906, C8908, C8909, C8911, C8912, C8914, C8918, C8920, C8931, C8933, C8934, C8936.

*If a 'without contrast' procedure is performed on the same day as a 'with contrast' procedure from the same family, the 'with contrast' composite APC is assigned.

Appendix K-c
Multiple Imaging Composite Flowchart
[Effective v10.0]



Assign Multiple Imaging Composite APC:
(see appendix K for the lists of eligible candidates for each imaging family/composite APC):

For the first code encountered in the composite family – assign the composite APC, SI , PI; packaging flag = 0, composite adjustment flag = (01- xx), discount factor = 1, units output= 1

For all other eligible codes from the same family present – change the SI from Q3 to N, assign packaging flag = 1, same composite adjustment flag.

Note: If there are a mix of eligible imaging candidates with & without contrast from the same imaging family, the 'with contrast' composite APC is assigned.

Appendix L
FQHC (Federally Qualified Health Clinic) PPS Criteria Overview (v15.3)

1. FQHC processing occurs for claims with From Dates on or after 10/01/2014, bill type = 77x and Condition Code 65 is absent. Processing occurs for each date of service if the claim contains multiple dates.

2. A FQHC payment code reported with revenue code 519, 52x or 900 is required for FQHC PPS claims. If a FQHC payment code is not found, the claim is returned to the provider. If the correct revenue code is not found for the FQHC payment code, the claim is returned to the provider. Payable FQHC payment code lines are flagged with Payment Indicator (PI) = 10, unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported, PI = 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. If multiple visits are reported, only one new patient FQHC payment HCPCS is assigned PI = 13 per day. Any additional FQHC payment codes present for the same day are assigned PI = 10.

Specific revenue code to FQHC payment code requirements are as follows:
a. Medical visit codes G0466, G0467 and G0468 require revenue code 52x or 519
b. Mental health visit codes G0469 and G0470 require revenue code 900 or 519

3. A qualifying visit HCPCS code is also required. If the qualifying visit code from the list below is not found with the required FQHC payment code, the claim is returned to the provider. Qualifying visit codes are flagged with PI = 12 and are packaged with Packaging Flag = 5.

FQHC Payment Code	Qualifying Visit Codes
G0466: FQHC visit, new patient	92002, 92004, 97802, 99201**, 99202**, 99203**, 99204**, 99205**, 99324**, 99325**, 99326**, 99327**, 99328**, 99341**, 99342**, 99343**, 99344**, 99345**, 99381, 99382, 99383, 99384, 99385, 99386, 99387, G0101, G0102, G0108, G0117, G0118, G0436, G0437, G0442, G0443, G0444, G0445, G0446, G0447
G0467: FQHC visit, established patient	92012, 92014, 97802, 97803, 99211**, 99212**, 99213**, 99214**, 99215**, 99304**, 99305**, 99306**, 99307**, 99308**, 99309**, 99310**, 99315**, 99316**, 99318**, 99334**, 99335**, 99336**, 99337**, 99347**, 99348**, 99349**, 99350**, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99495, 99496, G0101, G0102, G0108, G0117, G0118, G0270, G0436, G0437, G0442, G0443, G0444, G0445, G0446, G0447, M0064
G0468: FQHC visit, IPPE/AWV	G0402, G0438, G0439
G0469: FQHC visit, mental health, new patient	90791, 90792, 90832, 90833*, 90834, 90836*, 90837, 90838*, 90839, 90845
G0470: FQHC visit, mental health, established patient	90791, 90792, 90832, 90833*, 90834, 90836*, 90837, 90838*, 90839, 90845

* Psychotherapy add-on code requiring primary procedure code
** Primary procedure codes for psychotherapy add-on codes

4. Multiple visits reported for the same day are processed for FQHC encounter payment up to a maximum of three visits, with the FQHC payment codes marked for FQHC encounter payment (PI = 10 or PI = 13 for new patient or IPPE/AWV), provided all criteria are met for each visit: one medical clinic visit, one mental health clinic visit and one additional subsequent established patient visit for an unrelated illness or injury reported with modifier 59. Any additional visits reported on the same day are packaged (Packaging Flag = 5).

FQHC payment codes are processed in the following hierarchical order when multiple visits are present for the same day: G0468, G0466, G0467, G0469, G0470.

Units of service reported greater than 1 for a line with a qualifying FQHC payment code are assigned units of service = 1.

5. A composite adjustment flag is assigned to each FQHC payment code, indicating for the Pricer program the type of FQHC visit(s) that is/are present. A value of 01 is assigned to FQHC payment codes representing new or established medical visits or the IPPE/AWV, a value of 02 is assigned to FQHC payment codes representing new or established

mental health visits, and a value of 03 is assigned for subsequent visits for established patients, reported with modifier 59.

6. If a psychotherapy add-on code is reported for a mental health clinic visit, the look-up of the primary procedure code for the add-on code is performed after the assignment criteria for the qualifying FQHC visits. If multiple visits are reported for the day, the add-on criteria is satisfied only when a primary procedure code is available that has not been previously utilized by another payable FQHC visit.

7. Preventive services are packaged under FQHC PPS, however, a special Packaging Flag value of 6 is assigned to identify that the preventive service is not to be included in any coinsurance calculation. The PI value for preventive services is 12.

8. Flu/PPV vaccine and administration services continue to be paid under reasonable cost and are not packaged under FQHC PPS; PI = 11.

9. Telehealth facility services reported with HCPCS code Q3014 and revenue code 78x are not packaged under FQHC PPS and continue to be paid by fee schedule; PI = 2.

10. Services that are excluded and not covered under FQHC PPS are line item rejected (DME, ambulance, laboratory and other non-covered services). Non-covered lines are assigned Line Item Action flag 5 and PI = 3 by the IOCE. If line items with non-covered charges are passed into the IOCE with Line Item Action flag 5 previously assigned, these lines are not line item rejected.

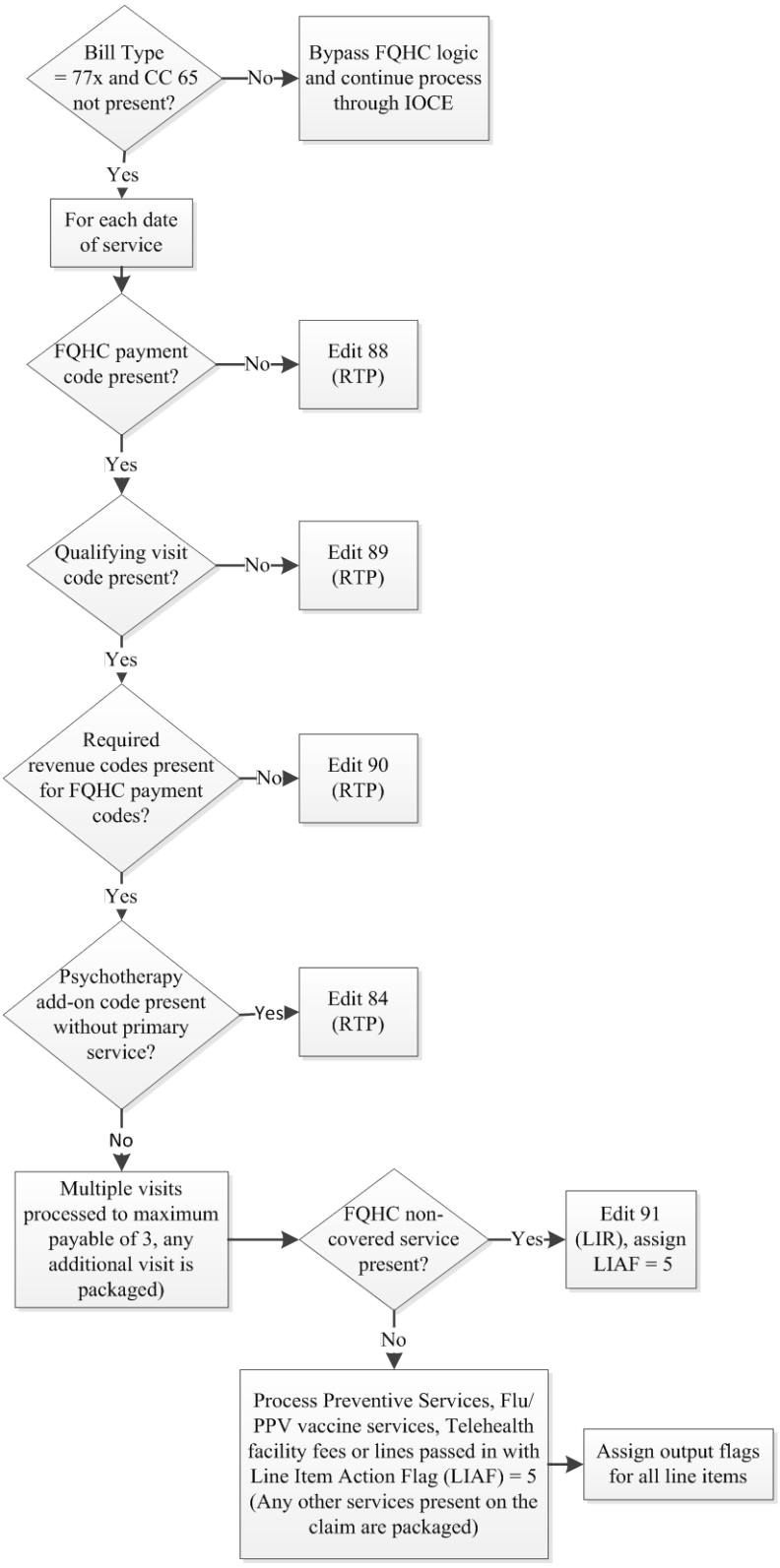
11. Any additional services reported on the claim for the same day that are not part of the aforementioned criteria are packaged. This includes the qualifying visit codes. All packaged services that are not packaged preventive services are assigned Packaging Flag = 5 and PI = 12.

12. The APC Buffer is not completed for bill type 77x; although the APC = 0 and default values for the SI and PI are assigned for each HCPCS code, these values are ignored, and resulting values for the PI may change as a result of FQHC processing.

13. Refer to Appendix F(a) for a list of edits applied to FQHC PPS claims.

14. Values output from the IOCE for FQHC claims which are specifically used by the Pricer program for payment purposes are Payment Method flag, Payment Indicator, Packaging flag, Composite Adjustment Flag and Line Item Action flag. Refer to Table 7 (APC Return Buffer) for a list of applicable flag output values.

Appendix L (continued)
FQHC Logic Flowchart (v15.3)



FQHC Processing Logic

Appendix M
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.

For claims with OPPS flag = "1":

2. Assign the default values to each line item in the APC/ASC return buffer.
   The default values for the APC return buffer for variables not transferred from input, or not pre-assigned, are as follows:

Payment APC/ASC	00000
HCPCS APC	00000
Status indicator	W
Payment indicator	3
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, 25 and 26
Composite adjustment flag	00

3. If no HCPCS code is on a line 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.

Line item	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/ASC return buffer for each line item that contains an applicable HCPCS code.

5. Effective with v15.0, for each line with a laboratory procedure HCPCS with SI = N that is submitted with bill type 12x (without condition code W2), 13x for laboratory services reported with modifier L1 or 14x, change the SI to A and set the packaging flag to 0.

Appendix M
OCE Overview (cont'd)

6. 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.
7. 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 21.
8. Effective for 10/1/2014 with v15.3, if the bill type is 77x and Condition Code 65 is not present, the claim processes through the FQHC PPS logic, and applicable edits are performed. Go to step 28.
9. 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 19.
10. 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.
11. Perform edits that are not based on the status indicator.
12. If bill type is 13x and condition code = 41, or type of bill = 76x, apply partial hospitalization logic from Appendix C. Go to step 12.
13. If bill type is 12x or 13x without condition code 41, apply mental health logic from Appendix C-b.
14. Apply special packaging logic (T-packaged (SI of Q2); followed by STVX-packaged (SI of Q1); followed by critical care-packaged (specified list of ancillary procedures)).
15. Apply general composite logic from Appendix K (APCs 8000, 8001). (Note: If any composite candidate has its SI changed to N in step 12 or any other previous step, do not use the packaged item to fulfill the composite criteria).
16. Apply Multiple Imaging composite logic from Appendix K (APC 8004 – 8008). (Note: If any composite candidate has its SI changed to N in step 12 or any other previous step, do not use the packaged item to fulfill the composite criteria).
17. If bill type is 13x, apply Extended Assessment and Management composite logic from Appendix K and Direct Referral for Observation logic from Appendix K-b. (Note: If any composite candidate has its SI changed to N in step 12 or any other previous step, do not use the packaged item to fulfill the composite criteria).
18. 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.
19. Apply special skin substitute logic (Change the SI/APC for the skin substitute to N/ APC 0 if there is none of the specified application procedures on the same date of service). (v13.1 – v14.3).
20. Perform all remaining edits that are driven by the status indicator.
21. If the payment APC for a line item has not been assigned a value in step 9 thru 18, set payment APC in the APC return buffer for the line item equal to the HCPCS APC for the line item.
22. If edits 9, 13, 20, 28, 30, 40, 45, 47, 49, 53, 64, 65, 67, 68, 69, 76, 83 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.

Appendix M
OCE Overview (cont'd)

23. 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" 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/ASC return buffer is 1 and the line item action flag is not 1
    Packaging flag is not 0 or 3

24. 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.
25. 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.
26. For all bill types where APCs are assigned, apply drug administration APC consolidation logic from appendix I. (v6.0 – v7.3 only).
27. Set the payment adjustment flag for a line item based on the criteria in Appendix G and Appendix J, and apply logic to assign Payment Adjustment flag based on the presence of PT modifier.
28. Set the payment method flag for a line item based on the criteria in Appendix E(a). 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'.
29. 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.

For claims with OPPS flag = "2":

1. Set Non-OPPS bill type flag as applicable, based on the presence or absence of ASC procedures.

Appendix N
Summary of Modifications

The modifications of the IOCE for the October 2014 release (V15.3) are summarized in the table below.
Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software.

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

#	Type	Effective Date	Edits Affected	Modification
1.	Logic	10/1/2014	24	Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this October 2014 release is 1/1/2008).
2.	Logic	**01/01/2008**	8	Add code 52630 to the male-only procedure list, retroactive to the earliest version of the program.
3.	Logic	10/1/2014	-	Add logic for processing claims with bill type 77x that do not contain Condition Code 65 under new FQHC PPS logic (see page 10 and new Appendix L).
4.	Logic	10/1/2014	-	Add new values to the following output fields returned in the APC Return Buffer (see Table 7) in support of FQHC processing: a) Payment Indicator: 10 – Paid FQHC encounter payment 11 – Not paid or not included under FQHC encounter payment 12 – No additional payment, included in payment for FQHC encounter 13 – Paid FQHC encounter payment for new patient or IPPE/AWV b) Packaging Flag: 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment, not subject to coinsurance payment c) Payment Method Flag 5 – Payment for service determined under FQHC PPS d) Line Item Action Flag 5 - Non-covered service excluded from payment under FQHC PPS e) Composite Adjustment Flag 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC clinic visit, medical or mental health (modifier 59 reported) Note: The values defined above for Composite Adjustment flag are used only for FQHC claims with bill type 77x when CC 65 is not present.
5.	Logic	10/1/2014	88	New edit 88 - FQHC payment code not reported for FQHC claim (RTP) Criteria: FQHC payment code not reported for a claim with bill type 77x and without Condition Code 65 Note: If the bill type is 770 (No payment claim), edit 88 is not applicable.
6.	Logic	10/1/2014	89	New edit 89 - FQHC claim lacks required qualifying visit code (RTP) Criteria: FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS.
7.	Logic	10/1/2014	90	New edit 90 - Incorrect revenue code reported for FQHC payment code (RTP) Criteria: FQHC payment code not reported with revenue code 519, 52X or 900.
8.	Logic	10/1/2014	91	New edit 91 - Item or service not covered under FQHC PPS (LIR) Criteria: A service considered to be non-covered under FQHC PPS is reported.
9.	Logic	10/1/2014	6, 84	Add edit 6 (Invalid procedure code) and edit 84 (Claim lacks required primary code) to the list of edits to be applied for FQHC PPS claims.
10.	Logic	10/1/2014	-	Update Appendix F(a) OCE Edits Applied by Bill Type table, to include a new row for edits applicable for FQHC (bill type 77x) effective 10/1/2014. Modified row10 to document the previous bill type 77x applicable versions.
11.	Logic	10/1/2014	-	Update Appendix E(a) Logic for Assigning Payment Method Flag Values to Status Indicators by Bill type to add new Payment Method Flag value of 5.
12.	Content	10/1/2014	-	Make HCPCS/APC/SI changes as specified by CMS (data change files).
13.	Content	10/1/2014	20, 40	Implement version **20.3** of the NCCI (as modified for applicable institutional providers).
14.	Content	**7/1/2014**	87	Updated skin substitute product list (Appendix O, List E) to move Q4137 from low cost to high

#	Type	Effective Date	Edits Affected	Modification
				cost (List A to List B).
15.	Content	10/1/2014	87	Updated skin substitute product list (Appendix O, List E) to move Q4138 and Q4140 from low cost to high cost (List A to List B).
16.	Content	**1/1/2012**	-	Remove the Deductible/CoInsurance N/A flag from HCPCS code G0448, which was erroneously flagged in the program, retroactively to 1/1/2012.
17.	Doc	10/1/2014	-	Add new Appendix L (FQHC Processing Logic and Flowchart) and rename OCE Overview to Appendix M, rename the Summary of Modifications to Appendix N, and rename the Code Lists to Appendix O.
18.	Other	10/1/2014	-	Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS web site.
19.	Other	10/1/2014	-	Deliver quarterly software update & all related documentation and files to users via electronic means.

Appendix O

Code Lists Referenced in this Document

A. HCPCS Codes for Reporting Antigens, Vaccine Administration, Splints, and Casts

Category	Code
Antigens	95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, 95180, 95199
Vaccine Administration	90471, 90472, 90473, 90474, G0008, G0009, G0010
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

B. Partial Hospitalization Services

PHP List A	90832, 90834, 90837, 90845, 90846, 90847, 90865, 90880, G0410, G0411
PHP List B	90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90846, 90847, 90865, 90880, 96101, 96102, 96103, 96116, 96118, 96119, 96120, G0129, G0176, G0177, G0410, G0411
PHP List C*	90785, 90833, 90836, 90838

*Add-on codes that are not counted in meeting the numerical requirement for APC assignment.

C. Preventive Services

Deductible/co-insurance not applicable	76977, 77078, 77080, 77081, G0008, G0009, G0010, G0101, G0104, G0105, G0121, G0130, G0389, G0402, G0436, G0437, G0442, G0443, G0444, G0445, G0446, G0447, Q0091
Deductible not applicable	G0106, G0120

D. HCPCS Codes for Skin Substitute Procedures (v13.0 – v14.3)

Skin substitute	C9358, C9360, C9363, Q4101 – Q4108, Q4110 – Q4116, Q4118, Q4119, Q4121-Q4128, Q4131 - Q4136
Skin substitute application	15271 – 15278

E. HCPCS Codes for Skin Substitute Procedures (v15.0)

List	Skin substitute application	Skin substitute product
List A	C5271, C5272, C5273, C5274, C5275, C5276 C5277, C5278	C9358, C9360, C9363, Q4100, Q4102 – Q4105, Q4108, Q4111, Q4115, Q4117, Q4119 - Q4120, Q4123, Q4124, Q4128, Q4129, Q4135, Q4136, Q4141 – Q4143, Q4146
List B	15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278	Q4101, Q4106, Q4107, Q4110, Q4116, Q4121, Q4122, Q4125 – Q4127, Q4131 – Q4134, Q4137, Q4138, Q4140, Q4147, Q4148