CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1913	**Date: September 6, 2017**
	Change Request 10116

Transmittal 1881, dated July 28, 2017, is being rescinded and replaced by Transmittal 1913, dated, September 6, 2017 to Remove BR 11, and reduce the number of condition codes in the attachment file Table 5: Claim Return Buffer to 10. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 13, 2017. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: FISS Integrated Outpatient Code Editor (IOCE) Claim and Return Buffer Interface Changes Related to OPPS 2018 Annual Updates

I. SUMMARY OF CHANGES: This CR implements the FISS interface Changes needed to receive the new fields for the Payer Only Condition Codes to be sent from the IOCE and for the IOCE to receive the Value Codes and amounts from the claim.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1913	Date: September 6, 2017	Change Request: 10116

Transmittal 1881, dated July 28, 2017, is being rescinded and replaced by Transmittal 1913, dated, September 6, 2017 to Remove BR 11, and reduce the number of condition codes in the attachment file Table 5: Claim Return Buffer to 10. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 13, 2017. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: FISS Integrated Outpatient Code Editor (IOCE) Claim and Return Buffer Interface Changes Related to OPPS 2018 Annual Updates

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: In preparation for the Outpatient Prospective Payment System (OPPS) 2018 annual update, the purpose of this CR is to notify FISS that the IOCE Claim and Return Buffer (that will be contained in the January 2018 IOCE specifications in Tables 1 and 5) will be modified as noted in attachment 1.

NOTES: There are no related changes to any of the information in Table 2 line item input of the IOCE specifications.

B. Policy: This notification provides the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10116.1	The Shared System Maintainer shall expand the IOCE Claim Input Buffer to accommodate up to thirty-six (36) Value Codes and amounts.					X				IOCE
10116.2	The Shared System Maintainer shall expand the IOCE					X				HIGLAS,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Claim Input Buffer to accommodate up to thirty (30) Condition Codes.									IOCE
10116.3	The Shared System Maintainer shall expand the IOCE Claim Input Buffer to accommodate up to thirty (30) Occurrence Codes.					X				IOCE
10116.4	The Shared System Maintainer shall remove from the IOCE Claim Input Buffer the following items: Count of the number of diagnoses pointed to by *Dxptr* Count of the number of Line item entries pointed to by Sgptr Count of the number of condition codes entered Count of number of occurrence codes Count of the number of value codes entered Code Type indicator					X				IOCE
10116.5	The Shared System Maintainer shall expand the IOCE Claim Return Buffer to accommodate 10 Payer Only Condition Codes.					X				IOCE
10116.6	The Shared System Maintainer shall receive up to 10 Payer Only Condition Codes in the IOCE Claim Return Buffer and ensure these become part of the claim record.					X				
10116.7	The Shared System Maintainer shall edit to prevent providers from submitting payer only condition codes in the payer only condition code range of M0-MZ. However, the Shared System Maintainer shall ensure that payer only condition codes appended to the claim record on the initial claim are also available on subsequent payer and provider adjustment claims.					X				
10116.8	The Shared System Maintainer shall not pass to the BCRC the Payer Only Condition Codes "M0" through "MZ".					X				BCRC
10116.9	The Shared System Maintainer shall expand the IOCE APC/ASC Return Buffer to accommodate one (1) Line level HCPCS modifier field and a filler field for future use.					X				IOCE
10116.10	The Shared System Maintainer shall receive one (1) Line level HCPCS modifier field in the IOCE					X				

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	APC/ASC Return Buffer and ensure this modifier becomes part of the claim record.									
10116.11	This business requirement has been deleted.					X				IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov , Yvonne Young, YVONNE.YOUNG@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Table 1: IOCE Control Block

Pointer Name	Pointer Description	UB-04 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for historical claims with From dates prior to 10/1/2015)	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 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 30	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 30	2	For MAC use
~~NOccptr~~	~~Count of number of occurrence codes~~		~~1~~	~~4~~	~~Binary fullword count~~
VCptr	Value codes and value code amounts	39-41	Up to 36	11	2-character Value Code followed by amount (nnnnnnn.nn*)
~~NVCptr~~	~~Count of the number of value codes entered~~		~~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.~~ ~~(Note: Deactivated as of 10/1/2015; the claim From Date is used to determine which diagnosis code set is applied.)~~

Dxeditptr	Diagnosis edit return buffer		Up to 28	Table 3	Diagnosis edits returned
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Procedure edits returned
Mdeditptr	Modifier edit return buffer		Up to 450	Table 3	Modifier edits returned
Dteditptr	Date edit return buffer		Up to 450	Table 3	Date edits returned
Rceditptr	Revenue code edit return buffer		Up to 450	Table 3	Revenue code edits returned
APCptr	APC/ASC return buffer		Up to 450	Table 7	APC detail returned
Claimptr	Claim return buffer		1	Table 5	Claim detail returned
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 5: Claim Return Buffer

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*, 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. * Edit 46 terminates processing only for those bill types where no other edits are applied (See Appendix F).
Num of line items	3	1	nnn	Input value from Nsgptr, or 450, whichever is less.
National provider identifier (NPI)	13	1	aaaaaaaaaaaaa	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- 90, 92, 94, 96-98, 99, 100, 101	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).

Item	Bytes	Number	Values	Description
Line item rejection reasons	3	12	13, 20, 28, 40, 45, 47, 53, 64, 65, 76, 91, 93, 95	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 IOCE based on presence/absence of ASC code 1 = Bill type should be 83x (v8.2 - v8.3 only; ASC list and 83x TOB removed v9.0) 2 = Bill type should not be 83x
Payer Value Code and Payer Value Code Amount	11	10	2-character Value Code (QN-QW) followed by amount (nnnnnnn.nn*)	Assigned by IOCE based on criteria for APC payment offset. *Decimal in Payer Value Code amount is implied. QN – First APC device offset QO – Second APC device offset QP – *Reserved for future use* QQ - Terminated procedure with pass-through device QR – First APC pass-through drug or biological offset QS – Second APC pass-through drug or biological offset QT – Third APC pass-through drug or biological offset QU – Condition for device credit present *QV – QW (Reserved for future use)* Note: If offset conditions do not exist, the value code label (QN-QW) is blank; the amount is zero-filled.
Payer Condition Code	2	**10**	2-character Condition Code	2-character Payer only Condition Code Assigned by IOCE. MP – PHP claim contains initial admit week MQ – PHP claim contains final discharge week

Table 7: APC/ASC Return Buffer

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 [v8.2 – v8.3 only].
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status Indicator**	2	Alpha	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* E1 – Non-allowed item or service E2 - Items and services for which pricing information and claims data are not available 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* J1 – Hospital Part B services paid through a comprehensive APC J2 – Hospital Part B services that may be paid through a comprehensive APC K – Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals L – Flu/PPV vaccines M – Service not billable to the MAC N – Items and Services packaged into APC rates P – Partial hospitalization service Q – Packaged services subject to separate payment based on payment criteria* Q1 – STV-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC Q4 – Conditionally packaged laboratory services 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)	1 – Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V, X) 2 – Services not paid by OPPS Pricer; paid under fee schedule or other payment system (status indicator A, G, K) 3 – Not paid (Q, Q1, Q2, Q3, Q4, 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)* 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, G0177 or G0129) 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 14 – Grandfathered tribal FQHC encounter payment
Discounting Formula Number**	1	1-9	(See Appendix D for formula values)
Line Item Denial or Rejection Flag**	1	0-3	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, 93) 2 – The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/1/2002 - v3.0) 3 - Line item not denied or rejected; identified for informational alert only
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-v9.3 only) 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-nn [Right justified, blank filled]	0 – No payment adjustment 1 – Paid standard amount for pass-through drug or biological 2 – Payment based on charge adjusted to cost 3 – Additional payment for new drug or new biological applies to APC 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 8 – Item provided with partial credit to provider 9 – Deductible/co-insurance not applicable 10 – Co-insurance not applicable 11 – Multiple service units reduced to one by OCE processing; payment based on single payment rate 12 – Offset for first device pass-through 13 – Offset for second device pass-through 14 – PAMA Section 218 reduction on CT scan 15 – Reserved for future use 16 – Terminated procedure with pass-through device 17 – Condition for device credit present 18 – Offset for first pass-through drug or biological 19 – Offset for second pass-through drug or biological 20 – Offset for third pass-through drug or biological 21 – CAA Section 502(b) reduction on film X-ray 91 – 99 Each composite APC present, same value for prime and non-prime codes (v 9.0 – v9.3 only)
Method Flag**	1	0-9	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 MAC; OCE not applied to line item 5 – Payment for service determined under FQHC PPS 6 – CMHC outlier limitation reached 7 - Section 603 service with no reduction in OPPS Pricer

			8 - Section 603 service with PFS reduction applied in OPPS Pricer 9 - CMHC outlier limitation bypassed
Service Units	9	1-x	Transferred from input, for Pricer. For line items assigned to APCs for daily mental health, PHP, composite APC or comprehensive APC, the service units are assigned a value of one by the IOCE even if the input service units were greater than one, and payment adjustment flag 11 is provided (v16.1). Service units are also assigned to one for payable conditionally packaged lines (SI = Q1, Q2) and FQHC payment codes; payment adjustment flag 11 is provided (v16.2). Input service units also may be reduced for some Drug administration APCs, based on Appendix I (v6.0 – v7.3 only).
Charge	10	nnnnnnnnnn	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 (Appendix D). 0 – OCE line item denial or rejection is not ignored 1 – OCE line item denial or rejection is ignored 2 – External line item denial. Line item is denied even if no OCE edits 3 – External line item rejection. Line item is rejected even if no OCE edits 4 – External line item adjustment. Technical charge rules apply 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. Specific Composite Adjustment Flag values designated for certain conditions: For FQHC PPS claims (bill type 77x) only, the following values are defined for composite adjustment flag: 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC medical clinic visit (modifier 59 reported)
HCPCS Modifier	2	Alphanumeric	Assigned by IOCE for final payment determination.
Filler	2	Alphanumeric	Filler