CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1872	**Date: December 11, 2009**
	Change Request 6761

SUBJECT: January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0

I. SUMMARY OF CHANGES: 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, and for 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. This Recurring Update Notification applies to Chapter 4, Section 40.1.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1872	Date: December 11, 2009	Change Request: 6761

SUBJECT: January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: This instruction informs the Fiscal Intermediaries (FIs), A/B MACs, and the Fiscal Intermediary Shared System (FISS) that the I/OCE was updated for January 1, 2010. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. Claims with dates of service prior to July 1, 2007, should be routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim. **The integration did not change the logic that is applied to outpatient bill types that previously passed through the OPPS OCE software. It merely expanded the software usage to include non-OPPS hospitals.**

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, and for 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. The I/OCE instructions are attached to this Change Request and will also be posted to http://www.cms.hhs.gov/OutpatientCodeEdit/.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6761.1	The Shared System Maintainer shall install the Integrated OCE (I/OCE) into their systems.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6761.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
5344	Notification of an Integrated Outpatient Code Editor (OCE) for the July 2007 Release

B. For all other recommendations and supporting information, use this space: N\A

V. CONTACTS

Pre-Implementation Contact(s):
Maria Durham at maria.durham@cms.hhs.gov.

For Policy related questions contact Marina Kushnirova at marina.kushnirova@cms.hhs.gov.

Post-Implementation Contact(s):
Regional Office(s) or the CMS Outpatient Code Editor Email at OCE_Integration@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers*:

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

B. ***For Medicare Administrative Contractors (MAC)*****:**
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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: (2)

Attachment A - I/OCE Specifications Version 11.0

Attachment B - Final Summary of Data Changes

Final

Summary of Data Changes

Integrated OCE v 11.0

Effective January 1, 2010

Table of Contents

DEFINITIONS

- A blank in a field indicates ‘no change’
- The “old” column describes the attribute prior to the change being made in the current update, which is indicated in the “new” column. If the effective date of the change is the same as the effective date of the new update, ‘old’ describes the attribute up to the last day of the previous quarter. If the effective date is retroactive, then ‘old’ describes the attribute for the same date in the previous release of the software.
- “Unassigned”, “Pre-defined” or “Placeholder” in APC or HCPCS descriptions indicates that the APC or HCPCS code is inactive. When the APC or HCPCS code is activated, it becomes valid for use in the OCE, and a new description appears in the “new description” column, with the appropriate effective date.
- Activation Date (ActivDate) indicates the mid-quarter date of FDA approval for a drug, or the mid-quarter date of a new or changed code resulting from a National Coverage Determination (NCD). The Activation Date is the date the code becomes valid for use in the OCE. If the Activation Date is blank, then the effective date takes precedence.
- Termination Date (TermDate) indicates the mid-quarter date when a code or change becomes inactive. A code is not valid for use in the OCE after its termination date.
- For codes with SI of “Q1, Q2, and Q3”, the APC assignment is the standard APC to which the code would be assigned if it is paid separately.

APC CHANGES

Added APCs

The following APC(s) were added to the IOCE, **effective 01-01-10**

APC	APCDesc	StatusIndicator
00102	Level II Pulmonary Treatment	S
00630	Level 5 Type B Emergency Visits	V
01254	Adenovirus vaccine, type 4	K
01255	Rotovirus vacc 3 dose, oral	K
01256	Brompheniramine maleate inj	K
01257	Enfuvirtide injection	K
01260	Nandrolone decanoate 100 MG	K
01263	Antithrombin iii injection	K
01266	Interferon alfacon-1 inj	K
01271	Cholera vaccine, injectable	K
01272	Acetylcysteine injection	K
01273	Dimecaprol injection	K
01274	Edetate calcium disodium inj	K
01275	Vivaglobin, inj	K
01276	Fondaparinux sodium	K
01277	Insulin for insulin pump use	K
01279	Factor VIII (porcine)	K
01282	Gamma globulin 2 CC inj	K
01283	Gamma globulin 3 CC inj	K
01284	Gamma globulin 5 CC inj	K
01285	Nandrolone decanoate 50 MG	K
01286	Nandrolone decanoate 200 MG	K
01288	Visualization adjunct	K
01289	AbobotulinumtoxintypeA	K
01290	Human fibrinogen conc inj	G
01291	Rilonacept injection	K
01292	Cyclosporine oral 100 mg	K
01293	Bladder calculi irrig sol	K
01294	Cyclosporine oral 25 mg	K
01295	Sm 153 lexidronam	K
01296	Degarelix injection	G
01297	Ferumoxytol, non-esrd	G
01298	Cosyntropin cortrosyn inj	K
01299	Gadofosveset trisodium inj	G
09144	Encephalitis vaccine, sc	K
09254	Injection, lacosamide	K
09255	Paliperidone palmitate inj	G
09256	Dexamethasone intravitreal	G

Deleted APCs

The following APC(s) were deleted from the IOCE, **effective 01-01-10**

APC	APCDesc
00222	Level II Implantation of Neurostimulator
00681	Knee Arthroplasty
00682	Level V Debridement & Destruction
00702	Sm 153 lexidronm
00750	Dolasetron mesylate
00763	Dolasetron mesylate oral
00764	Granisetron hcl injection
00765	Granisetron hcl 1 mg oral
00768	Ondansetron hcl injection
00769	Ondansetron hcl 8 mg oral
00804	Vivaglobin, inj
00855	Vinorelbine tartrate inj
00863	Paclitaxel injection
00883	Fondaparinux sodium
00888	Cyclosporine oral
00898	Gamma globulin 2 CC inj
00899	Gamma globulin 3 CC inj
00906	RSV-ivig
00919	Gamma globulin 5 CC inj
00999	Edetate calcium disodium inj
01186	Acetylcysteine injection
01189	Foscarnet sodium injection
01206	Dimecaprol injection
01208	Factor VIII (porcine)
01211	Oxytetracycline injection
01212	Diphtheria antitoxin
01217	Penicillin g benzathine inj
01218	Triflupromazine hcl inj
01219	Dtap-ipv vacc 4-6 yr im
01223	Pentobarbital sodium inj
01224	Sincalide injection
01227	Urea injection
01228	Hyaluronidase recombinant
01230	Nabilone oral
01231	Plicamycin (mithramycin) inj
01703	Ovine, 1000 USP units
07015	Oral busulfan
09047	Itraconazole injection
09216	Abarelix injection
09219	Mycophenolic acid
09354	Veritas collagen matrix, cm2
09355	Neuromatrix nerve cuff, cm

APC Description Changes

The following APC(s) had description changes, **effective 01-01-10**

APC	Old Description	New Description
00039	Level I Implantation of Neurostimulator	Level I Implantation of Neurostimulator Generator
00078	Level II Pulmonary Treatment	Level III Pulmonary Treatment
00096	Non-Invasive Vascular Studies	Level II Noninvasive Physiologic Studies
00097	Cardiac and Ambulatory Blood Pressure Monitoring	Level I Noninvasive Physiologic Studies
00269	Level II Echocardiogram Without Contrast Except Transesophageal	Level II Echocardiogram Without Contrast
00270	Transesophageal Echocardiogram Without Contrast	Level III Echocardiogram Without Contrast
00315	Level III Implantation of Neurostimulator	Level II Implantation of Neurostimulator Generator
00333	Computed Tomography without Contrast followed by Contrast)	Computed Tomography without Contrast followed by Contrast
00337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast f	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
00616	Level 5 Emergency Visits	Level 5 Type A Emergency Visits
00676	Thrombolysis and Thrombectomy	Thrombolysis and Other Device Revisions
00697	Level I Echocardiogram Without Contrast Except Transesophageal	Level I Echocardiogram Without Contrast
00835	Inj cosyntropin	Cosyntropin injection NOS
00874	Synvisc inj per dose	Synvisc or synvisc-one
00902	Botulinum toxin a per unit	Injection, onabotulinumtoxinA
01268	Xyntha, inj	Xyntha inj
09018	Botulinum toxin type B	Inj, rimabotulinumtoxinB
09245	Injection, romiplostim	Romiplostim injection
09246	Inj, gadoxetate disodium	Gadoxetate disodium inj
09249	Inj, certolizumab pegol	Certolizumab pegol inj
09251	Inj, C1 esterase inhibitor	C1 esterase inhibitor inj
09252	Injection, plerixafor	Plerixafor injection
09253	Injection, temozolomide	Temozolomide injection
09359	Implnt,bone void filler-putty	Implnt,bon void filler-putty
09362	Implnt,bone void filler-strip	Implnt,bon void filler-strip

APC Status Indicator Changes

The following APC(s) had Status Indicator changes, **effective 01-01-10**

APC	Old SI	New SI
00097	X	S
00701	H	K
00825	G	K

APC	Old SI	New SI
00951	G	K
01064	H	K
01150	H	K
01168	G	K
01643	H	K
01645	H	K
01675	H	K
01676	H	K
09236	G	K

HCPCS/CPT PROCEDURE CODE CHANGES

Added HCPCS/CPT Procedure Codes

The following new HCPCS/CPT code(s) were added to the IOCE, **effective 07-01-09**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
90470	Immune admin H1N1 im/nasal	E	00000	28	20090928	
G9141	Influenza A H1N1,admin w cou	S	00350		20090901	
G9142	Influenza A H1N1, vaccine	E	00000	28	20090901	
G9143	Warfarin respon genetic test	M	00000	72	20090803	

The following new HCPCS/CPT code(s) were added to the IOCE, **effective 01-01-10**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
0203T	Unattend sleep study w/time	S	00213			
0204T	Unattended sleep study	S	00213			
0205T	Inirs each vessel add-on	N	00000			
0206T	Remote algorithm analys ecg	Q1	00340			
0207T	Clear eyelid gland w/heat	S	00230			
0208T	Automated audiometry air	X	00035			
0209T	Auto audiometry air/bone	X	00035			
0210T	Auto audiometry sp thresh	X	00035			
0211T	Auto audiometry sp thresh	X	00035			
0212T	Comprehen auto audiometry	X	00364			
0213T	Us facet jt inj cerv/t 1 lev	T	00207			
0214T	Us facet jt inj cerv/t 2 lev	T	00204			
0215T	Us facet jt inj cerv/t 3 lev	T	00204			
0216T	Us facet jt inj ls 1 level	T	00207			
0217T	Us facet jt inj ls 2 level	T	00204			
0218T	Us facet jt inj ls 3 level	T	00204			
0219T	Fuse spine facet jt cerv	C	00000			
0220T	Fuse spine facet jt thor	C	00000			
0221T	Fuse spine facet jt lumbar	T	00050			
0222T	Fuse spine facet jt add seg	T	00050			
0545F	Follow up care plan mdd docd	E	00000	28		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
1200F	Seizure type(s)+ frq docd	E	00000	28		
1205F	EPI etiol synd rvwd and docd	E	00000	28		
14301	Skin tissue rearrangement	T	00137			
14302	Skin tissue rearrange add-on	T	00137			
2060F	Pt talk eval hlthwkr re mdd	E	00000	28		
21011	Exc face les sc < 2 cm	T	00020			
21012	Exc face les sc = 2 cm	T	00020			
21013	Exc face tum deep < 2 cm	T	00020			
21014	Exc face tum deep = 2 cm	T	00020			
21016	Resect face tum = 2 cm	T	00022			
21552	Exc neck les sc = 3 cm	T	00022			
21554	Exc neck tum deep = 5 cm	T	00022			
21558	Resect neck tum = 5 cm	T	00022			
21931	Exc back les sc = 3 cm	T	00022			
21932	Exc back tum deep < 5 cm	T	00021			
21933	Exc back tum deep = 5 cm	T	00022			
21936	Resect back tum = 5 cm	T	00022			
22901	Exc back tum deep = 5 cm	T	00022			
22902	Exc abd les sc < 3 cm	T	00021			
22903	Exc abd les sc > 3 cm	T	00022			
22904	Resect abd tum < 5 cm	T	00021			
22905	Resect abd tum > 5 cm	T	00022			
23071	Exc shoulder les sc > 3 cm	T	00022			
23073	Exc shoulder tum deep > 5 cm	T	00022			
23078	Resect shoulder tum > 5 cm	T	00022			
24071	Exc arm/elbow les sc = 3 cm	T	00022			
24073	Ex arm/elbow tum deep > 5 cm	T	00022			
24079	Resect arm/elbow tum > 5 cm	T	00022			
25071	Exc forearm les sc > 3 cm	T	00022			
25073	Exc forearm tum deep = 3 cm	T	00022			
25078	Resect forearm/wrist tum=3cm	T	00022			
26111	Exc hand les sc > 1.5 cm	T	00022			
26113	Exc hand tum deep > 1.5 cm	T	00022			
26118	Exc hand tum ra > 3 cm	T	00022			
27043	Exc hip pelvis les sc > 3 cm	T	00022			
27045	Exc hip/pelv tum deep > 5 cm	T	00022			
27059	Resect hip/pelv tum > 5 cm	T	00022			
27337	Exc thigh/knee les sc > 3 cm	T	00022			
27339	Exc thigh/knee tum deep >5cm	T	00022			
27364	Resect thigh/knee tum >5 cm	T	00022			
27616	Resect leg/ankle tum > 5 cm	T	00022			
27632	Exc leg/ankle les sc > 3 cm	T	00022			
27634	Exc leg/ankle tum deep >5 cm	T	00022			
28039	Exc foot/toe tum sc > 1.5 cm	T	00022			
28041	Exc foot/toe tum deep >1.5cm	T	00022			
28047	Resect foot/toe tumor > 3 cm	T	00022			
29581	Apply multlay comprs lwr leg	S	00058			
3008F	Body mass index docd	E	00000	28		
3015F	Cerv cancer screen docd	E	00000	28		
3038F	Pulm fx w/in 12 mon b/4 surg	E	00000	28		
31626	Bronchoscopy w/markers	T	00076			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
31627	Navigational bronchoscopy	N	00000			
32552	Remove lung catheter	S	00078			
32553	Ins mark thor for rt perq	X	00310			
32561	Lyse chest fibrin init day	T	00070			
32562	Lyse chest fibrin subq day	T	00070			
3293F	Abo rh blood typing docd	E	00000	28		
3294F	Grp b strep screening docd	E	00000	28		
3323F	Clin node stgng docdb/4 surg	M	00000	72		
3324F	Mri ct scan ord rvwd rqstd	E	00000	28		
3328F	Prfrmnc docd 2 wks b/4 surg	E	00000	28		
33782	Nikaidoh proc	C	00000			
33783	Nikaidoh proc w/ostia implt	C	00000			
33981	Replace vad pump ext	C	00000			
33982	Replace vad intra w/o bp	C	00000			
33983	Replace vad intra w/bp	C	00000			
36147	Access av dial grft for eval	T	00676			
36148	Access av dial grft for proc	N	00000			
3650F	Eeg ordered rvwd reqstd	E	00000	28		
37761	Ligate leg veins open	T	00092			
4004F	Pt tobacco use done rcvd tlk	E	00000	28		
4063F	Antidepres rxthxpy not rxd	E	00000	28		
4255F	Anesth >= 60 min as docd	M	00000	72		
4256F	Anesth < 60 min as docd	M	00000	72		
43281	Lap paraesophag hern repair	C	00000			
43282	Lap paraesoph her rpr w/mesh	C	00000			
4330F	Cnslng epi spec sfty issues	E	00000	28		
4340F	Cnslng chldbrng+ women epi	E	00000	28		
43775	Lap sleeve gastrectomy	C	00000			
45171	Exc rect tum transanal part	T	00155			
45172	Exc rect tum transanal full	T	00149			
46707	Repair anorectal fist w/plug	T	00150			
49411	Ins mark abd/pel for rt perq	X	00310			
51727	Cystometrogram w/up	T	00156			
51728	Cystometrogram w/vp	T	00156			
51729	Cystometrogram w/vp&up	T	00156			
5200F	Eval appros surg thxpy epi	E	00000	28		
53855	Insert prost urethral stent	T	00164			
57426	Revise prosth vag graft lap	T	00193			
6070F	Pt asked/cnsld aed effects	E	00000	28		
63661	Remove spine eltrd perq aray	T	00687			
63662	Remove spine eltrd plate	T	00687			
63663	Revise spine eltrd perq aray	T	00687			
63664	Revise spine eltrd plate	T	00687			
64490	Inj paravert f jnt c/t 1 lev	T	00207			
64491	Inj paravert f jnt c/t 2 lev	T	00204			
64492	Inj paravert f jnt c/t 3 lev	T	00204			
64493	Inj paravert f jnt l/s 1 lev	T	00207			
64494	Inj paravert f jnt l/s 2 lev	T	00204			
64495	Inj paravert f jnt l/s 3 lev	T	00204			
74261	Ct colonography, w/o dye	Q3	00332			
74262	Ct colonography, w/dye	Q3	00283			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
74263	Ct colonography, screen	E	00000	9		
75565	Card mri vel flw map add-on	N	00000			
75571	Ct hrt w/o dye w/ca test	X	00340			
75572	Ct hrt w/3d image	S	00383			
75573	Ct hrt w/3d image, congen	S	00383			
75574	Ct angio hrt w/3d image	S	00383			
75791	Av dialysis shunt imaging	Q2	00676			
77338	Design mlc device for imrt	X	00303			
78451	Ht muscle image spect, sing	S	00377			
78452	Ht muscle image spect, mult	S	00377			
78453	Ht muscle image,planar,sing	S	00377			
78454	Ht musc image, planar, mult	S	00377			
83987	Exhaled breath condensate	A	00000			
84145	Procalcitonin (pct)	A	00000			
84431	Thromboxane, urine	A	00000			
86305	Human epididymis protein 4	A	00000			
86352	Cell function assay w/stim	A	00000			
86780	Treponema pallidum	A	00000			
86825	Hla x-match, non-cytotoxic	A	00000			
86826	Hla x-match, non-cyt add-on	A	00000			
87150	Dna/rna, amplified probe	A	00000			
87153	Dna/rna sequencing	A	00000			
87493	C diff amplified probe	A	00000			
88387	Tiss exam molecular study	N	00000			
88388	Tiss ex molecul study add-on	N	00000			
88738	Hgb quant transcutaneous	A	00000			
89398	Unlisted reprod med lab proc	X	00342			
90644	HIB/men/tt vaccine, im	E	00000	9		
92540	Basic vestibular evaluation	X	00660			
92550	Tympanometry & reflex thresh	X	00364			
92570	Acoustic immittance testing	X	00364			
93750	Interrogation vad, in person	S	00692			
94011	Up to 2 yrs old, spirometry	X	00368			
94012	= 2 yrs, spiromtry w/dilator	X	00368			
94013	= 2 yrs, lung volumes	X	00369			
95905	Motor/sens nrve conduct test	S	00215			
A4264	Intratubal occlusion device	E	00000	28		
A4336	Urethral insert	A	00000			
A4360	Disposable ext urethral dev	A	00000			
A4456	Adhesive remover, wipes	A	00000			
A4466	Elastic garment/covering	E	00000	28		
A9581	Gadoxetate disodium inj	G	09246			
A9582	Iodine I-123 iobenguane	G	09247			
A9583	Gadofosveset trisodium inj	G	01299			
A9604	Sm 153 lexidronam	K	01295			
C9254	Injection, lacosamide	K	09254	55		
C9255	Paliperidone palmitate inj	G	09255	55		
C9256	Dexamethasone intravitreal	G	09256	55		
C9257	Bevacizumab injection	K	01281	55		
E0433	Portable liquid oxygen sys	Y	00000	61		
E1036	Patient transfer system >300	Y	00000	61		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
G0420	Ed svc CKD ind per session	A	00000			
G0421	Ed svc CKD grp per session	A	00000			
G0422	Intens cardiac rehab w/exerc	S	00095			
G0423	Intens cardiac rehab no exer	S	00095			
G0424	Pulmonary rehab w exer	S	00102			
G0425	Inpt telehealth consult 30m	C	00000			
G0426	Inpt telehealth consult 50m	C	00000			
G0427	Inpt telehealth con 70/>m	C	00000			
G0430	Drug screen multi class	A	00000			
G0431	Drug screen single class	A	00000			
G8545	HepC measures grp	M	00000	72		
G8546	CAP measures grp	M	00000	72		
G8547	IVD measures grp	M	00000	72		
G8548	HF measures grp	M	00000	72		
G8549	HepC MG qual act perform	M	00000	72		
G8550	CAP MG qual act perform	M	00000	72		
G8551	HF MG qual act perform	M	00000	72		
G8552	IVD MG qual act perform	M	00000	72		
G8553	1 Rx via qualified eRx sys	M	00000	72		
G8556	Ref to doc otolog eval	M	00000	72		
G8557	Pt inelig ref otolog eval	M	00000	72		
G8558	No ref to doc otolog eval	M	00000	72		
G8559	Pt ref doc oto eval	M	00000	72		
G8560	Pt hx act drain prev 90 days	M	00000	72		
G8561	Pt inelig for ref oto eval	M	00000	72		
G8562	Pt no hx act drain 90 d	M	00000	72		
G8563	Pt no ref oto reas no spec	M	00000	72		
G8564	Pt ref oto eval	M	00000	72		
G8565	Ver doc hear loss	M	00000	72		
G8566	Pt inelig ref oto eval	M	00000	72		
G8567	Pt no doc hear loss	M	00000	72		
G8568	Pt no ref otolo no spec	M	00000	72		
G8569	Prol intubation req	M	00000	72		
G8570	No prol intub req	M	00000	72		
G8571	Ster wd ifx 30 d postop	M	00000	72		
G8572	No ster wd ifx	M	00000	72		
G8573	Stk/CVA CABG	M	00000	72		
G8574	No strk/CVA CABG	M	00000	72		
G8575	Postop ren insuf	M	00000	72		
G8576	No postop ren insuf	M	00000	72		
G8577	Reop req bld grft oth	M	00000	72		
G8578	No reop req bld grft oth	M	00000	72		
G8579	Antplt med disch	M	00000	72		
G8580	Antplt med contraind	M	00000	72		
G8581	no antplt med disch	M	00000	72		
G8582	Bblock disch	M	00000	72		
G8583	Bblock contraind	M	00000	72		
G8584	No bblock disch	M	00000	72		
G8585	Antilipid treat disch	M	00000	72		
G8586	Antlip disch contra	M	00000	72		
G8587	No antlipid treat disch	M	00000	72		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
G8588	Sys BP <140	M	00000	72		
G8589	Sys BP >= 140	M	00000	72		
G8590	Dia BP < 90	M	00000	72		
G8591	Dia BP >= 90	M	00000	72		
G8592	No BP measure	M	00000	72		
G8593	Lipid pn results	M	00000	72		
G8594	No lipid prof perf	M	00000	72		
G8595	Ldl < 100	M	00000	72		
G8596	No LDL perf	M	00000	72		
G8597	Ldl >= 100	M	00000	72		
G8598	Asp therp used	M	00000	72		
G8599	No asp therp used	M	00000	72		
G8600	tPA initi w/in 3 hrs	M	00000	72		
G8601	No elig tPA init w/in 3 hrs	M	00000	72		
G8602	No tPA init w/in 3 hrs	M	00000	72		
G8603	Spok lang comp score	M	00000	72		
G8604	No high score spok lang	M	00000	72		
G8605	No spok lang comp score	M	00000	72		
G8606	Attention score	M	00000	72		
G8607	No high score attention	M	00000	72		
G8608	No attention score	M	00000	72		
G8609	Memory score	M	00000	72		
G8610	No high score memory	M	00000	72		
G8611	No memory score	M	00000	72		
G8612	Moto speech score	M	00000	72		
G8613	No high score moto speech	M	00000	72		
G8614	No moto speech score	M	00000	72		
G8615	Reading score	M	00000	72		
G8616	No high score reading	M	00000	72		
G8617	No reading score	M	00000	72		
G8618	Spok lang exp score	M	00000	72		
G8619	No high score spok lang exp	M	00000	72		
G8620	No spok lang exp score	M	00000	72		
G8621	Writing score	M	00000	72		
G8622	No high score writing	M	00000	72		
G8623	No writing score	M	00000	72		
G8624	Swallowing score	M	00000	72		
G8625	No high score swallowing	M	00000	72		
G8626	No swallowing score	M	00000	72		
G8627	Surg proc w/in 30 days	M	00000	72		
G8628	No surg proc w/in 30 days	M	00000	72		
J0461	Atropine sulfate injection	N	00000			
J0559	PenG benzathine/procaine inj	N	00000			
J0586	AbobotulinumtoxinA	K	01289			
J0598	C1 esterase inhibitor inj	G	09251			
J0718	Certolizumab pegol inj	G	09249			
J0833	Cosyntropin injection NOS	K	00835			
J0834	Cosyntropin cortrosyn inj	K	01298			
J1680	Human fibrinogen conc inj	G	01290			
J2562	Plerixafor injection	G	09252			
J2793	Rilonacept injection	K	01291			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
J2796	Romiplostim injection	G	09245			
J7185	Xyntha inj	K	01268			
J7325	Synvisc or Synvisc-One	K	00874			
J9155	Degarelix injection	G	01296			
J9171	Docetaxel injection	K	00823			
J9328	Temozolomide injection	G	09253			
L2861	Torsion mechanism knee/ankle	E	00000	28		
L3891	Torsion mechanism wrist/elbo	E	00000	28		
L5973	Ank-foot sys dors-plant flex	A	00000			
L8031	Breast prosthesis w adhesive	A	00000			
L8032	Reusable nipple prosthesis	A	00000			
L8627	CID ext speech process repl	A	00000			
L8628	CID ext controller repl	A	00000			
L8629	CID transmit coil and cable	A	00000			
L8692	Non-osseointegrated snd proc	E	00000	50		
Q0138	Ferumoxytol, non-esrd	G	01297			
Q0139	Ferumoxytol, esrd use	A	00000			
Q0506	Lith-ion batt elec/pneum VAD	A	00000			
Q4074	Iloprost non-comp unit dose	Y	00000	61		
Q9968	Visualization adjunct	K	01288			
S0280	Medical home, initial plan	E	00000	28		
S0281	Medical home, maintenance	E	00000	28		

Deleted HCPCS/CPT Procedure Codes

The following HCPCS/CPT code(s) were deleted from the IOCE, **effective 01-01-10**

HCPCS	CodeDesc
0062T	Rep intradisc annulus;1 lev
0063T	Rep intradisc annulus;>1lev
0064T	Spectroscop eval expired gas
0066T	Ct colonography;screen
0067T	Ct colonography;dx
0068T	Interp/rept heart sound
0069T	Analysis only heart sound
0070T	Interp only heart sound
0077T	Cereb therm perfusion probe
0084T	Temp prostate urethral stent
0086T	L ventricle fill pressure
0087T	Sperm eval hyaluronan
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on

HCPCS	CodeDesc
01632	Anesth, surgery of shoulder
0170T	Anorectal fistula plug rpr
0194T	Procalcitonin (pct)
1127F	New episode for condition
1128F	Subs episode for condition
14300	Skin tissue rearrangement
23221	Partial removal of humerus
23222	Partial removal of humerus
24151	Extensive humerus surgery
24153	Extensive radius surgery
26255	Extensive hand surgery
26261	Extensive finger surgery
27079	Extensive hip surgery
29220	Strapping of low back
36145	Artery to vein shunt
36834	Repair A-V aneurysm
45170	Excision of rectal lesion
46210	Removal of anal crypt
46211	Removal of anal crypts
46937	Cryotherapy of rectal lesion
46938	Cryotherapy of rectal lesion
51772	Urethra pressure profile
51795	Urine voiding pressure study
63660	Revise/remove neuroelectrode
64470	Inj paravertebral c/t
64472	Inj paravertebral c/t add-on
64475	Inj paravertebral l/s
64476	Inj paravertebral l/s add-on
75558	Cardiac mri flow/velocity
75560	Cardiac mri flow/vel/stress
75562	Card mri flow/vel w/dye
75564	Ht mri w/flo/vel/strs & dye
75790	Visualize A-V shunt
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78478	Heart wall motion add-on
78480	Heart function add-on
82307	Assay of vitamin D
86781	Treponema pallidum, confirm
90379	Rsv ig, iv
92569	Acoustic reflex decay test
99185	Regional hypothermia
99186	Total body hypothermia
A4365	Adhesive remover wipes
A6200	Compos drsg <=16 no border
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no border
A6542	Gc stocking custom made
A6543	Gc stocking lymphedema

HCPCS	CodeDesc
A9535	Injection, methylene blue
A9605	Sm 153 lexidronm
C9245	Injection, romiplostim
C9246	Inj, gadoxetate disodium
C9247	Inj, iobenguane, I-123, dx
C9249	Inj, certolizumab pegol
C9251	Inj, C1 esterase inhibitor
C9252	Injection, plerixafor
C9253	Injection, temozolomide
E1340	Repair for DME, per 15 min
E2223	Valve replacement only each
E2393	Valve, pneumatic tire tube
E2399	Noc interface
G0392	AV fistula or graft arterial
G0393	AV fistula or graft venous
G8503	Doc proph antibx w/in 1 hr
G8504	Doc ord pro antbx w/in 1 hr
G8505	No doc proph antibx w/in 1hr
G8512	Pain sev quant present
G8513	ABI meas & doc
G8514	PT inelig; ABI measure
G8515	No ABI measurement
G8516	Scrn fal rsk >2 fal or w/inj
G8517	Scrn fall rsk; <2 falls
G8521	Antplt recd 48 hrs & disch
G8522	Pt inelig; antiplt therapy
G8523	Antplt not recd reas no spec
G8527	Doc ord antimic prophy
G8528	Pt inelig; proph antibiot
G8529	No doc ord antimic prophy
G8533	Partic in clin data base reg
J0460	Atropine sulfate injection
J0530	Penicillin g benzathine inj
J0540	Penicillin g benzathine inj
J0550	Penicillin g benzathine inj
J0835	Inj cosyntropin per 0.25 MG
J1565	RSV-ivig
J7322	Synvisc inj per dose
J9170	Docetaxel injection
L0210	Thoracic rib belt
L1800	Knee orthoses elas w stays
L1815	Elastic with condylar pads
L1825	Ko elastic knee cap
L1901	Prefab ankle orthosis
L2770	Low ext orthosis per bar/jnt
L3651	Prefab shoulder orthosis
L3652	Prefab dbl shoulder orthosis
L3700	Elbow orthoses elas w stays
L3701	Prefab elbow orthosis
L3909	Prefab wrist orthosis
L3911	Prefab hand finger orthosis

HCPCS	CodeDesc
L6639	Heavy duty elbow feature
Q2023	Xyntha, inj
Q2024	Bevacizumab injection
Q4080	Iloprost non-comp unit dose
S0345	Home ecg monitrng global 24h
S0346	Home ecg monitrng tech 24hr
S0347	Home ecg monitrng prof 24hr
S0605	Digital rectal examination,

HCPCS Description Changes

The following code descriptions were changed, **effective 01-01-07**

HCPCS	Old Description	New Description
1040F	Dsm-IV info mdd doc'd	Dsm-ivtm info mdd docd

The following code descriptions were changed, **effective 10-01-09**

HCPCS	Old Description	New Description
G9141	Influenza A H1N1, admin w co	Influenza A H1N1,admin w cou

The following code descriptions were changed, **effective 01-01-10**

HCPCS	Old Description	New Description
1060F	Doc perm/cont/parox atr. fib	Doc perm/cont/parox atr fib
1100F	Ptfalls assess-doc'd ge2+/yr	Ptfalls assess-docd ge2+/yr
1101F	Pt falls assess-doc'd le1/yr	Pt falls assess-docd le1/yr
16036	Escharotomy; add'l incision	Escharotomy; addl incision
2030F	H2O stat doc'd, normal	H2o stat docd, normal
2031F	H2O stat doc'd, dehydrated	H2o stat docd, dehydrated
21015	Resection of facial tumor	Resect face tum < 2 cm
21555	Remove lesion, neck/chest	Exc neck les sc < 3 cm
21556	Remove lesion, neck/chest	Exc neck tum deep < 5 cm
21557	Remove tumor, neck/chest	Resect neck tum < 5 cm
21930	Remove lesion, back or flank	Exc back les sc < 3 cm
21935	Remove tumor, back	Resect back tum < 5 cm
22522	Percut vertebroplasty add'l	Percut vertebroplasty addl
22534	Lat thor/lumb, add'l seg	Lat thor/lumb, addl seg
22900	Remove abdominal wall lesion	Exc back tum deep < 5 cm
23075	Removal of shoulder lesion	Exc shoulder les sc < 3 cm
23076	Removal of shoulder lesion	Exc shoulder tum deep < 5 cm
23077	Remove tumor of shoulder	Resect shoulder tum < 5 cm
23200	Removal of collar bone	Resect clavicle tumor
23210	Removal of shoulder blade	Resect scapula tumor
23220	Partial removal of humerus	Resect prox humerus tumor
24075	Remove arm/elbow lesion	Exc arm/elbow les sc < 3 cm
24076	Remove arm/elbow lesion	Ex arm/elbow tum deep < 5 cm

HCPCS	Old Description	New Description
24077	Remove tumor of arm/elbow	Resect arm/elbow tum < 5 cm
24150	Extensive humerus surgery	Resect distal humerus tumor
24152	Extensive radius surgery	Resect radius tumor
25075	Removal forearm lesion subcu	Exc forearm les sc < 3 cm
25076	Removal forearm lesion deep	Exc forearm tum deep < 3 cm
25077	Remove tumor, forearm/wrist	Resect forearm/wrist tum<3cm
25170	Extensive forearm surgery	Resect radius/ulnar tumor
26115	Removal hand lesion subcut	Exc hand les sc < 1.5 cm
26116	Removal hand lesion, deep	Exc hand tum deep < 1.5 cm
26117	Remove tumor, hand/finger	Exc hand tum ra < 3 cm
26260	Extensive finger surgery	Resect prox finger tumor
26262	Partial removal of finger	Resect distal finger tumor
27047	Remove hip/pelvis lesion	Exc hip/pelvis les sc < 3 cm
27048	Remove hip/pelvis lesion	Exc hip/pelv tum deep < 5 cm
27049	Remove tumor, hip/pelvis	Resect hip/pelv tum < 5 cm
27075	Extensive hip surgery	Resect hip tumor
27076	Extensive hip surgery	Resect hip tum incl acetabul
27077	Extensive hip surgery	Resect hip tum w/innom bone
27078	Extensive hip surgery	Rsect hip tum incl femur
27327	Removal of thigh lesion	Exc thigh/knee les sc < 3 cm
27328	Removal of thigh lesion	Exc thigh/knee tum deep <5cm
27329	Remove tumor, thigh/knee	Resect thigh/knee tum < 5 cm
27365	Extensive leg surgery	Resect femur/knee tumor
27615	Remove tumor, lower leg	Resect leg/ankle tum < 5 cm
27618	Remove lower leg lesion	Exc leg/ankle tum < 3 cm
27619	Remove lower leg lesion	Exc leg/ankle tum deep <5 cm
27645	Extensive lower leg surgery	Resect tibia tumor
27646	Extensive lower leg surgery	Resect fibula tumor
27647	Extensive ankle/heel surgery	Resect talus/calcaneus tum
28043	Excision of foot lesion	Exc foot/toe tum sc < 1.5 cm
28045	Excision of foot lesion	Exc foot/toe tum deep <1.5cm
28046	Resection of tumor, foot	Resect foot/toe tumor < 3 cm
28171	Extensive foot surgery	Resect tarsal tumor
28173	Extensive foot surgery	Resect metatarsal tumor
28175	Extensive foot surgery	Resect phalanx of toe tumor
3022F	Lvef =40% systolic	Lvef >=40% systolic
3027F	Spirom fev/fvc=70%/ w/o copd	Spirom fev/fvc>=70%/w/o copd
3035F	O2 saturation =88% /pa0 =55	O2 saturation<=88% /pao<=55
3042F	Fev= 40% predicted value	Fev>=40% predicted value
3050F	Ldl-c = 130 mg/dl	Ldl-c >= 130 mg/dl
3073F	Pre-surg eye measures doc'd	Pre-surg eye measures docd
3077F	Syst bp = 140 mm hg6 it	Syst bp >= 140 mm hg6 it
30802	Cauterization, inner nose	Ablate inf turbinate submuc
3080F	Diast bp = 90 mm hg	Diast bp >= 90 mm hg
3093F	Doc new diag 1st/addl. mdd	Doc new diag 1st/addl mdd
3095F	Central dexa results doc'd	Central dexa results docd
3110F	Pres/absn hmrhg/lesion doc'd	Doc pres/absn hmrhg/lesion
3112F	Ct/mri brain done gt24 hrs	Ct/Mri brain done gt 24 hrs
3132F	Doc ref. upper gi endoscopy	Doc ref upper gi endoscopy
3140F	Upper gi endo shows barrtt's	Upper gi endo shows barrtts
3141F	Upper gi endo not barrtt's	Upper gi endo not barrtts

HCPCS	Old Description	New Description
31632	Bronchoscopy/lung bx, add'l	Bronchoscopy/lung bx, addl
31633	Bronchoscopy/needle bx add'l	Bronchoscopy/needle bx addl
3218F	RNA tstng hep C doc'd-done	Rna tstng hep c docd-done
32560	Treat lung lining chemically	Treat pleurodesis w/agent
3281F	Hgb lvl <11 g/dl	Hgb lvl < 11 g/dl
3284F	IOP down >15% of pre-svc lvl	IOP down>=15% of pre-svc lvl
3288F	Fall risk assessment doc'd	Fall risk assessment docd
33216	Insert lead pace-defib, one	Insert 1 electrode pm-defib
33217	Insert lead pace-defib, dual	Insert 2 electrode pm-defib
33223	Revise pocket, pacing-defib	Revise pocket for defib
3372F	AJCC brst cncr stage 1 +docd	Ajcc brst cncr stage 1+docd
3374F	AJCC brst cncr stage 1 +docd	Ajcc brst cncr stage 1+docd
34826	Endovasc exten prosth, add'l	Endovasc exten prosth, addl
3492F	History CD4+cell count <350	History cd4+ cell count <350
3493F	No hist CD4+cell cnt <350	No hist cd4+cell cnt<350
3495F	CD4+cell cnt 200-499 cells	Cd4+cell cnt 200-499 cells
3496F	CD4+ cell count >=500 cells	Cd4+ cell count =500 cells
3500F	CD4 +cell cnt/% docd as done	Cd4+cell cnt/% docd as done
3570F	Rprt bone scint x-refw/x-ray	Rprt bone scint xref w xray
37760	Ligation, leg veins, open	Ligate leg veins radical
4005F	Pharm thx for op rx'd	Pharm thx for op rxd
4055F	Pt. rcvng periton dialysis	Pt rcvng periton dialysis
4056F	Approp. oral rehyd. recomm'd	Approp oral rehyd recommd
4062F	Pt referral psych doc'd	Pt referral psych docd
4067F	Pt referral for ECT doc'd	Pt referral for ect docd
4070F	Dvt prophylx recv'd day 2	Dvt prophylx recvd day 2
4084F	Aspirin recv'd w/in 24 hrs	Aspirin recvd w/in 24 hrs
4100F	Biphos thxpy vein ord/rec'vd	Biphos thxpy vein ord/recvd
4110F	Int. mam art used for cabg	Int mam art used for cabg
4120F	Antibiot rx'd/given	Antibiot rxd/given
4124F	Antibiot not rx'd/given	Antibiot not rxd/given
4165F	3d-crt/imrt received	3d-crt/imrt) received
4172F	Pt. not rcvng esa thxpy	Pt not rcvng esa thxpy
4181F	Conformal rad'n thxpy rcv'd	Conformal radn thxpy rcvd
4194F	Pt rcvng>10mg daily predniso	Pt rec>=10mg prednison qd
4274F	Flu immuno admin'd rcvd	Flu immuno admind rcvd
4275F	Hep B vac inj admin/rcvd	Hep b vac inj admin/ rcvd
46220	Removal of anal tag	Excise anal ext tag/papilla
46250	Hemorrhoidectomy	Remove ext hem groups = 2
46255	Hemorrhoidectomy	Remove int/ext hem 1 group
46257	Remove hemorrhoids & fissure	Remove in/ex hem grp & fiss
46258	Remove hemorrhoids & fistula	Remove in/ex hem grp w/fistu
46260	Hemorrhoidectomy	Remove in/ex hem groups = 2
46261	Remove hemorrhoids & fissure	Remove in/ex hem grps & fiss
46262	Remove hemorrhoids & fistula	Remove in/ex hem grps w/fist
46270	Removal of anal fistula	Remove anal fist subq
46275	Removal of anal fistula	Remove anal fist inter
46280	Removal of anal fistula	Remove anal fist complex
46285	Removal of anal fistula	Remove anal fist 2 stage
46945	Ligation of hemorrhoids	Remove by ligat int hem grp
46946	Ligation of hemorrhoids	Remove by ligat int hem grps

HCPCS	Old Description	New Description
50200	Biopsy of kidney	Renal biopsy perq
50205	Biopsy of kidney	Renal biopsy open
5050F	Plan 2 main Dr. by 1 month	Plan 2 main dr by 1 month
61868	Implant neuroelectrde, add'l	Implant neuroelectrde, addl
63043	Laminotomy, add'l cervical	Laminotomy, addl cervical
63044	Laminotomy, add'l lumbar	Laminotomy, addl lumbar
72291	Perq vertebroplasty, fluor	Perq verte/sacroplsty, fluor
72292	Perq vertebroplasty, ct	Perq verte/sacroplsty, ct
76802	Ob us < 14 wks, add'l fetus	Ob us < 14 wks, addl fetus
78290	Meckel's divert exam	Meckels divert exam
82306	Assay of vitamin D	Vitamin d, 25 hydroxy
82652	Assay of dihydroxyvitamin d	Vit d 1, 25-dihydroxy
82784	Assay of gammaglobulin igm	Assay, iga/igd/igg/igm each
82785	Assay of gammaglobulin ige	Assay of ige
83519	Immunoassay, nonantibody	Ria nonantibody
83520	Immunoassay, RIA	Immunoassay quant nos nonab
83986	Assay of body fluid acidity	Assay ph body fluid nos
86592	Blood serology, qualitative	Syphilis test non-trep qual
86593	Blood serology, quantitative	Syphilis test non-trep quant
87149	Culture type, nucleic acid	Dna/rna direct probe
88045	Coroner's autopsy (necropsy)	Coroners autopsy (necropsy)
88312	Special stains	Special stains group 1
88313	Special stains	Special stains group 2
88314	Histochemical stain	Histochemical stain add-on
88332	Path consult intraop, add'l	Path consult intraop, addl
90378	Rsv ig, im, 50mg	Rsv, mab, im, 50mg
90663	Flu vacc pandemic	Flu vacc pandemic H1N1
90669	Pneumococcal vacc, ped <5	Pneumococcal vacc, 7 val im
93701	Bioimpedance, thoracic	Bioimpedance, cv analysis
95806	Sleep study, unattended	Sleep study unatt&resp efft
95967	Meg, evoked, each add'l	Meg, evoked, each addl
96570	Photodynamic tx, 30 min	Photodynmc tx, 30 min add-on
99292	Critical care, add'l 30 min	Critical care, addl 30 min
99358	Prolonged serv, w/o contact	Prolong service w/o contact
99359	Prolonged serv, w/o contact	Prolong serv w/o contact add
A6022	Collagen drsg>6<=48 sq in	Collagen drsg>16<=48 sq in
E0441	Oxygen contents, gaseous	Stationary O2 contents, gas
E0442	Oxygen contents, liquid	Stationary O2 contents, liq
E1035	Patient transfer system	Patient transfer system <300
G0379	Direct admit hospital observ	Direct refer hospital observ
G8456	Smokeless tobacco user	Current smkless tobacco user
G8492	Prev Care measures grp	Periop Care measures grp
G8496	PC meas qual act perform	Prev Care MG qual act perfrm
G8502	BP meas qual act perform	Back Pain MG qual act perfrm
J0585	Botulinum toxin a per unit	Injection,onabotulinumtoxinA
J0587	Botulinum toxin type B	Inj, rimabotulinumtoxinB
J7192	Factor viii recombinant	Factor viii recombinant NOS
L8030	Breast prosthesis silicone/e	Breast prosthes w/o adhesive
L8619	Replace cochlear processor	Coch imp ext proc/contr rplc
L8691	Aud osseo dev ext snd proces	Osseointegrated snd proc rpl
Q2009	Fosphenytoin, 50 mg	Fosphenytoin inj PE

HCPCS	Old Description	New Description
S3713	Kras mutation analysis	KRAS mutation analysis
S3861	Genetic test Brugada	Genetic test brugada

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

The following code(s) had an APC and/or SI and/or edit change, **effective 07-01-09** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
75558	Cardiac mri flow/velocity	00000	00336	E	S	9	N/A
75560	Cardiac mri flow/vel/stress	00000	00336	E	S	9	N/A
75562	Card mri flow/vel w/dye	00000	00337	E	S	9	N/A
75564	Ht mri w/flo/vel/strs & dye	00000	00337	E	S	9	N/A

The following code(s) had an APC and/or SI and/or edit change, **effective 10-01-09** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
90663	Flu vacc pandemic					9	28

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-10** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0182T	Hdr elect brachytherapy	01519	00313				
0183T	Wound ultrasound	00015	00013				
0575F	HIV rna plan care docd			E	M	9	72
11044	Debride tissue/muscle/bone	00682	00020				
11600	Exc tr-ext mlg+marg 0.5 < cm	00019	00020				
11719	Trim nail(s)	00013	00012				
11760	Repair of nail bed	00134	00133				
13122	Repair wound/lesion add-on	00134	00133				
13132	Repair of wound or lesion	00134	00135				
15170	Acell graft trunk/arms/legs	00134	00135				
20103	Explore wound, extremity	00136	00007				
21015	Resect face tum < 2 cm	00253	00021				
21256	Reconstruction of orbit	00000	00256	C	T		
21555	Exc neck les sc < 3 cm	00022	00021				
21557	Resect neck tum < 5 cm	00022	00021				
21930	Exc back les sc < 3 cm	00022	00021				
21935	Resect back tum < 5 cm	00022	00021				
23076	Exc shoulder tum deep < 5 cm	00022	00021				
23077	Resect shoulder tum < 5 cm	00022	00021				
24076	Ex arm/elbow tum deep < 5 cm	00022	00021				
24077	Resect arm/elbow tum < 5 cm	00022	00021				
24400	Revision of humerus	00050	00051				
24410	Revision of humerus	00050	00051				
25020	Decompress forearm 1 space	00049	00050				
25076	Exc forearm tum deep < 3 cm	00022	00021				
25077	Resect forearm/wrist tum<3cm	00022	00021				
25350	Revision of radius	00052	00051				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
25360	Revision of ulna	00050	00051				
25365	Revise radius & ulna	00050	00051				
25390	Shorten radius or ulna	00050	00051				
26115	Exc hand les sc < 1.5 cm	00022	00021				
26116	Exc hand tum deep < 1.5 cm	00022	00021				
26117	Exc hand tum ra < 3 cm	00022	00021				
27047	Exc hip/pelvis les sc < 3 cm	00022	00021				
27048	Exc hip/pelv tum deep < 5 cm	00022	00021				
27049	Resect hip/pelv tum < 5 cm	00022	00021				
27179	Revise head/neck of femur	00000	00052	C	T		
27328	Exc thigh/knee tum deep <5cm	00022	00021				
27329	Resect thigh/knee tum < 5 cm	00022	00021				
27446	Revision of knee joint	00681	00425				
27496	Decompression of thigh/knee	00049	00050				
27498	Decompression of thigh/knee	00049	00050				
27499	Decompression of thigh/knee	00049	00050				
27615	Resect leg/ankle tum < 5 cm	00050	00021				
27619	Exc leg/ankle tum deep <5 cm	00022	00021				
27664	Repair of leg tendon, each	00049	00050				
27726	Repair fibula nonunion	00062	00063				
27892	Decompression of leg	00049	00050				
27893	Decompression of leg	00049	00050				
27894	Decompression of leg	00049	00050				
28043	Exc foot/toe tum sc < 1.5 cm	00022	00021				
28045	Exc foot/toe tum deep <1.5cm	00055	00021				
28046	Resect foot/toe tumor < 3 cm	00055	00021				
28805	Amputation thru metatarsal	00000	00055	C	T		
29888	Knee arthroscopy/surgery	00042	00052				
29889	Knee arthroscopy/surgery	00042	00052				
29892	Ankle arthroscopy/surgery	00042	00052				
30120	Revision of nose	00253	00254				
30802	Ablate inf turbinate submuc	00252	00253				
31526	Dx laryngoscopy w/oper scope	00075	00074				
31530	Laryngoscopy w/fb removal	00075	00074				
31531	Laryngoscopy w/fb & op scope	00075	00074				
31535	Laryngoscopy w/biopsy	00075	00074				
31536	Laryngoscopy w/bx & op scope	00075	00074				
31540	Laryngoscopy w/exc of tumor	00075	00074				
31541	Larynscop w/tumr exc + scope	00075	00074				
31576	Laryngoscopy with biopsy	00075	00074				
31820	Closure of windpipe lesion	00253	00254				
3511F	Chlmyd/gonrh tsts docd done			E	M	28	72
3512F	Syph scrng docd as done			E	M	28	72
35226	Repair blood vessel lesion	00093	00020				
37799	Vascular surgery procedure	00103	00624	T	X		
38205	Harvest allogenic stem cells	00111	00000	S	B	N/A	62
41108	Biopsy of floor of mouth	00252	00019				
41530	Tongue base vol reduction	00253	00254				
41826	Excision of gum lesion	00253	00254				
42405	Biopsy of salivary gland	00253	00254				
4270F	Pt rcvng anti r-viral thxpy			E	M	9	72

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
4271F	Pt rcvng anti r-viral thxpy			E	M	9	72
42808	Excise pharynx lesion	00253	00254				
4280F	PCP prophylax Rxd 3mon low %			E	M	9	72
4290F	Pt scrned for inj drug use			E	M	28	72
4293F	Pt scrnd - hgh-rsk sex behav			E	M	28	72
43760	Change gastrostomy tube	00121	00676				
44950	Appendectomy	00000	00153	C	T		
44955	Appendectomy add-on	00000	00153	C	T		
46220	Excise anal ext tag/papilla	00149	00155				
46505	Chemodenervation anal musc	00155	00149				
47371	Laparo ablate liver cryosurg	00131	00174				
49652	Lap vent/abd hernia repair	00130	00132				
49653	Lap vent/abd hern proc comp	00130	00132				
49654	Lap inc hernia repair	00130	00132				
49655	Lap inc hern repair comp	00130	00132				
49656	Lap inc hernia repair recur	00130	00132				
49657	Lap inc hern recur comp	00130	00132				
50385	Change stent via transureth	00161	00162				
50395	Create passage to kidney	00161	00162				
51060	Removal of ureter stone	00000	00163	C	T		
51710	Change of bladder tube	00427	00121				
52005	Cystoscopy & ureter catheter	00161	00162				
52204	Cystoscopy w/biopsy(s)	00161	00162				
52290	Cystoscopy and treatment	00161	00162				
56405	I & D of vulva/perineum	00189	00188				
57285	Repair paravag defect, vag	00195	00202				
57452	Exam of cervix w/scope	00189	00188				
59070	Transabdom amnioinfus w/us	00189	00188				
59200	Insert cervical dilator	00189	00188				
62367	Analyze spine infusion pump	00692	00691				
63076	Neck spine disk surgery	00000	00208	C	T		
63685	Insrt/redo spine n generator	00222	00039				
64408	N block inj, vagus	00206	00207				
64445	N block inj, sciatic, sng	00206	00207				
64446	N blk inj, sciatic, cont inf	00203	00207				
64448	N block inj fem, cont inf	00206	00207				
64605	Injection treatment of nerve	00203	00220				
64610	Injection treatment of nerve	00203	00220				
64626	Destr paravertebrl nerve c/t	00203	00207				
64680	Injection treatment of nerve	00203	00207				
66185	Revise eye shunt	00673	00234				
67010	Partial removal of eye fluid	00237	00672				
67101	Repair detached retina	00235	00237				
68810	Probe nasolacrimal duct	00231	00238	S	T		
69801	Incise inner ear	00256	00254				
69802	Incise inner ear	00256	00254				
74475	X-ray control, cath insert	00317	00161				
74480	X-ray control, cath insert	00317	00161				
74485	X-ray guide, GU dilation	00317	00161				
75898	Follow-up angiography	00263	00261				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
75978	Repair venous blockage	00083	00093				
76098	X-ray exam, breast specimen			X	Q2		
76820	Umbilical artery echo	00096	00265				
76821	Middle cerebral artery echo	00096	00265				
76825	Echo exam of fetal heart	00269	00270				
76826	Echo exam of fetal heart	00697	00269				
78003	Thyroid suppress/stimul	00392	00389				
78601	Brain image w/flow < 4 views	00403	00402				
78610	Brain flow imaging only	00402	00403				
78803	Tumor imaging (3D)	00408	00414				
78807	Nuclear localization/abscess	00414	00406				
88162	Cytopath smear, other source	00433	00343				
88361	Tumor immunohistochem/comput	00343	00344				
88368	Insitu hybridization, manual	00343	00344				
90296	Diphtheria antitoxin	01212	00000	K	E	N/A	9
90393	Vaccina ig, im			N	E	N/A	9
90476	Adenovirus vaccine, type 4	00000	01254	N	K		
90477	Adenovirus vaccine, type 7			N	E	N/A	9
90581	Anthrax vaccine, sc			N	E	N/A	9
90650	Hpv vaccine 2 valent, im			E	M	9	72
90680	Rotovirus vacc 3 dose, oral	00000	01255	N	K		
90696	Dtap-ipv vacc 4-6 yr im	01219	00000	K	N		
90725	Cholera vaccine, injectable	00000	01271	N	K		
90727	Plague vaccine, im			N	E	N/A	9
90735	Encephalitis vaccine, sc	00000	09144	E	K	50	N/A
90945	Dialysis, one evaluation	00607	00608				
92002	Eye exam, new patient	00605	00606				
92588	Evoked auditory test	00660	00363				
93225	ECG monitor/record, 24 hrs			X	S		
93226	ECG monitor/report, 24 hrs			X	S		
93231	Ecg monitor/record, 24 hrs			X	S		
93232	ECG monitor/report, 24 hrs			X	S		
93236	ECG monitor/report, 24 hrs			X	S		
93270	ECG recording			X	S		
93278	ECG/signal-averaged	00340	00035				
93299	Icm/ilr remote tech serv	00209	00689				
93303	Echo transthoracic	00269	00270				
93304	Echo transthoracic	00697	00269				
93313	Echo transesophageal	00270	00269				
93351	Stress tte complete	00269	00270				
93786	Ambulatory BP recording			X	S		
93788	Ambulatory BP analysis			X	S		
93799	Cardiovascular procedure			X	S		
93922	Extremity study	00096	00097				
93982	Aneurysm pressure sens study			X	S		
94370	Breath airway closing volume	00367	00035				
94680	Exhaled air analysis, o2	00368	00369				
94775	Ped home apnea rec, hk-up			X	S		
94776	Ped home apnea rec, downld			X	S		
95145	Antigen therapy services	00436	00437				

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
95149	Antigen therapy services	00439	00437				
95170	Antigen therapy services	00436	00437				
95921	Autonomic nerv function test	00215	00218				
95990	Spin/brain pump refil & main	00440	00439				
95991	Spin/brain pump refil & main	00440	00439				
95992	Canalith repositioning proc			A	E	N/A	9
96111	Developmental test, extend	00382	00373				
96120	Neuropsych tst admin w/comp	00373	00382				
96369	Sc ther infusion, up to 1 hr	00438	00439				
96406	Chemo intralesional over 7	00438	00439				
96420	Chemo, ia, push tecnique	00439	00438				
96440	Chemotherapy, intracavitary	00440	00439				
96521	Refill/maint, portable pump	00440	00439				
96542	Chemotherapy injection	00439	00438				
96567	Photodynamic tx, skin	00013	00016				
97606	Neg press wound tx, > 50 cm	00013	00015				
99241	Office consultation			B	E	62	9
99242	Office consultation			B	E	62	9
99243	Office consultation			B	E	62	9
99244	Office consultation			B	E	62	9
99245	Office consultation			B	E	62	9
99251	Inpatient consultation			C	E	N/A	9
99252	Inpatient consultation			C	E	N/A	9
99253	Inpatient consultation			C	E	N/A	9
99254	Inpatient consultation			C	E	N/A	9
99255	Inpatient consultation			C	E	N/A	9
A9517	I131 iodide cap, rx			H	K		
A9530	I131 iodide sol, rx			H	K		
A9543	Y90 ibritumomab, rx			H	K		
A9545	I131 tositumomab, rx			H	K		
A9563	P32 Na phosphate			H	K		
A9564	P32 chromic phosphate			H	K		
A9600	Sr89 strontium			H	K		
C9354	Veritas collagen matrix, cm2	09354	00000	G	N		
C9355	Neuromatrix nerve cuff, cm	09355	00000	G	N		
E0315	Bed accessory brd/tbl/supprt			Y	E	61	9
G0127	Trim nail(s)	00013	00012				
G0175	OPPS Service,sched team conf	00606	00607				
G0384	Lev 5 hosp type B ED visit	00616	00630				
G0402	Initial preventive exam	00605	00607				
G0406	Telhealth inpt consult 15min			M	C	72	N/A
G0407	Telheath inpt consult 25min			M	C	72	N/A
G0408	Telhealth inpt consult 35min			M	C	72	N/A
J0128	Abarelix injection	09216	00000	K	E	N/A	9
J0132	Acetylcysteine injection	01186	01272				
J0350	Injection anistreplase 30 u			N	E	N/A	9
J0395	Arbutamine hcl injection			N	E	N/A	9
J0470	Dimecaprol injection	01206	01273				
J0600	Edetate calcium disodium inj	00999	01274				
J0945	Brompheniramine maleate inj	00000	01256	N	K		
J1260	Dolasetron mesylate	00750	00000	K	N		

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
J1300	Eculizumab injection			G	K		
J1324	Enfuvirtide injection	00000	01257	N	K		
J1452	Intraocular Fomivirsen na			N	E	N/A	9
J1455	Foscarnet sodium injection	01189	00000	K	N		
J1470	Gamma globulin 2 CC inj	00898	01282				
J1480	Gamma globulin 3 CC inj	00899	01283				
J1500	Gamma globulin 5 CC inj	00919	01284				
J1562	Vivaglobin, inj	00804	01275				
J1626	Granisetron hcl injection	00764	00000	K	N		
J1652	Fondaparinux sodium	00883	01276				
J1817	Insulin for insulin pump use	00000	01277	N	K		
J1835	Itraconazole injection	09047	00000	K	N		
J2320	Nandrolone decanoate 50 MG	00000	01285	N	K		
J2321	Nandrolone decanoate 100 MG	00000	01260	N	K		
J2322	Nandrolone decanoate 200 MG	00000	01286	N	K		
J2405	Ondansetron hcl injection	00768	00000	K	N		
J2460	Oxytetracycline injection	01211	00000	K	E	N/A	9
J2515	Pentobarbital sodium inj	01223	00000	K	N		
J2805	Sincalide injection	01224	00000	K	N		
J3350	Urea injection	01227	00000	K	N		
J3400	Triflupromazine hcl inj	01218	00000	K	N		
J3472	Ovine, 1000 USP units	01703	00000	K	N		
J3473	Hyaluronidase recombinant	01228	00000	K	N		
J3488	Reclast injection			G	K		
J7191	Factor VIII (porcine)	01208	01279				
J7197	Antithrombin iii injection	00000	01263	N	K		
J7502	Cyclosporine oral 100 mg	00888	01292				
J7515	Cyclosporine oral 25 mg	00000	01294	N	K		
J7518	Mycophenolic acid	09219	00000	K	N		
J8510	Oral busulfan	07015	00000	K	N		
J8650	Nabilone oral	01230	00000	K	N		
J9212	Interferon alfacon-1 inj	00000	01266	N	K		
J9261	Nelarabine injection			G	K		
J9265	Paclitaxel injection	00863	00000	K	N		
J9270	Plicamycin (mithramycin) inj	01231	00000	K	N		
J9330	Temsirolimus injection			G	K		
J9390	Vinorelbine tartrate inj	00855	00000	K	N		
L8680	Implt neurostim elctr each			B	N	62	N/A
M0064	Visit for drug monitoring	00606	00607				
Q0166	Granisetron hcl 1 mg oral	00765	00000	K	N		
Q0179	Ondansetron hcl 8 mg oral	00769	00000	K	N		
Q0180	Dolasetron mesylate oral	00763	00000	K	N		
Q2004	Bladder calculi irrig sol	00000	01293	N	K		

Hcpcs Edit Changes

The following code(s) were added to the list of male procedures, **effective 01-01-10**

Hcpcs
53855

The following code(s) were added to the list of female procedures, **effective 01-01-10**

Hcpcs
3015F
57426
A4264

HCPCS Approval and/or Termination Date Changes

The following code(s) had approval and /or termination date changes

HCPCS	Old ApprovalDt	New ApprovalDt	Old TerminationDt	New TerminationDt
75558	0	20090928		
75560	0	20090928		
75562	0	20090928		
75564	0	20090928		
G9141	0	20090901		
G9142	0	20090901		

Edit Assignments

The following code(s) were added to edit 67, 68, 69 or 83 **effective 07-01-09**

HCPCS	Edit#	ActivDate	TermDate
75558	68	20090928	
75560	68	20090928	
75562	68	20090928	
75564	68	20090928	
90470	69	20090928	20190101
G9141	69	20090901	20190101
G9142	69	20090901	20190101
G9143	68	20090803	

The following code(s) were added to Deductible n/a, **effective 07-01-09**

HCPCS
G9141

The following code(s) were added to the conditional bilateral list, **effective 01-01-10**

HCPCS
0213T
0214T
0215T
0216T
0217T
0218T

HCPCS
23071
23073
23078
23700
24071
24073
24079
25071
25073
25078
27043
27045
27059
27337
27339
27364
27616
27632
27634
28039
28041
28047
29581
37760
37761
58661
64490
64491
64492
64493
64494
64495
69200

The following code(s) were removed from the conditional bilateral list, **effective 01-01-10**

HCPCS
36589

The following code(s) were added to the inherently bilateral list, **effective 01-01-10**

HCPCS
92550
92570

Radiolabeled product Changes

The following code(s) were added to the radiolabeled product list, **effective 01-01-10**

HCPCS
A9582
A9604
A9699

Procedure/ Device Pair Changes

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

Proc	Device1
37208	C2617
37215	C1874
37215	C1875
37215	C1876
37215	C1877
37215	C2617
37215	C2625
43647	L8680
61886	L8687
63650	L8680
63655	L8680
64553	L8680
64555	L8680
64560	L8680
64561	L8680
64565	L8680
64573	L8680
64575	L8680
64577	L8680
64580	L8680
64581	L8680

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

Proc	Device1
G0392	C1725
G0392	C1874
G0392	C1876
G0392	C1885
G0392	C2625
G0393	C1725
G0393	C1874
G0393	C1876
G0393	C1885
G0393	C2625

Device/Procedure Pair Changes

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

Device	Proc
C1778	63663
C1778	63664
C1897	63663
C1897	63664
L8680	43647
L8680	63650
L8680	63655
L8680	64553
L8680	64555
L8680	64560
L8680	64561
L8680	64565
L8680	64573
L8680	64575
L8680	64577
L8680	64580
L8680	64581
L8687	61886

MODIFIERS

Added Modifiers

The following modifier(s) were added to the list of valid modifiers, **effective 01-01-10**

modif	ACTIVATIONDATE
AI	0
J4	0
V5	0
V6	0
V7	0
V8	0
V9	0

REVENUE CODES

Revenue Code Status Indicator Changes

The following revenue code(s) had Status Indicator changes, **effective 01-01-10**

RevenueCode	Old SI	New SI
0261	E	N

RevenueCode	Old SI	New SI
0392	E	N
0560	N	Z
0569	N	Z
0623	E	N
0943	B	N
0948	Z	N

V11. 0 - Effective 01/01/10
Integrated OCE (IOCE)
CMS Specifications

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		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 16	6	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First listed diagnosis is considered 'patient's reason for visit dx', second 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 7	2	Used to identify partial hospitalization and hospice claims
NCCptr	Count of the number of condition codes entered		1	4	Binary fullword count
Billptr	Type of bill	4 (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
Dxeditptr	Diagnosis edit return buffer		Up to 16	Table 3	Count specified in Ndxptr
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
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 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	
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 83 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 can not 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.

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 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 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 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 are submitted on a 12x, 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 procedure~~s~~ 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 ~~admission~~ referral from a physician ~~'s office to~~ 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 ~~admission~~ referral is processed as a medical visit (see Appendix ~~H-b~~ K-b). Code G0379 that has been denied or rejected will not be included in any subsequent special direct ~~admission~~ 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 ~~admission~~ 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 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 or V), 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.

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 L), 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.

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.

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 N for the specific list of HCPCS codes for reporting antigens, vaccine administration, splints and casts).

Correct Coding Initiative (CCI) Edits

The Integrated OCE generates CCI 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 CCI 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 CCI edits are applied to services submitted on a single claim, and on lines with the same date of service. CCI edits address two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. The edit is set to pay the lesser-priced service.

In some instances, both codes in a CCI 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: 25, 27, 58, 59, 78, 79, 91, E1-E4, F1-F9, FA, LC, LD, LT, RC, RT, T1-T9, and TA).

Version 15.3 of CCI edits is included in the January, 2010 IOCE.

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

See Appendix Fa and Fb "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 L 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 (CCI 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	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 16 diagnoses.
Procedure edit return buffer	3	30	0,6,8-9,11-21, 28,30,35,37-40, 42-45,47, 49-50,52-64, 66 -74, 76-83	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	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 83 different edits in the OCE, ten 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 Hospitals	Disposition
1	Invalid diagnosis code	Y	RTP
2	Diagnosis and age conflict	Y	RTP
3	Diagnosis and sex conflict	Y	RTP
4[4]	Medicare secondary payor 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	Procedure and sex conflict	Y	RTP
9	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 rejection
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		Line item rejection
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present		Line item rejection
21	Medical visit on same day as a type "T" or "S" procedure without modifier 25 (see Appendix B)		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 rejection
	(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		Line item rejection
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present		Line item rejection

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 exceeds the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS is on a list of codes that are exempt, the unit edits are not applied.

[2] Edit 18 causes all other line items on the same day to be line item denied with Edit 49 (see APC/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

Edit	Description	Non-OPPS Hospitals	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 rejection
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 rejection
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		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)		RTP
64	AT service not payable outside the partial hospitalization program (See appendix C)		Line item rejection
65	Revenue code not recognized by Medicare	Y	Line item rejection
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 rejection
77	Claim lacks allowed procedure code		RTP
78	Claim lacks required radiolabeled product		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

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 can not run - the environment can not be set up as needed; exit immediately.
Num of line items	3	1	nnn	Input value from Nsgptr, or 450, whichever is less.
National provider identifier (NPI)	13	1	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 6) that caused the claim to be rejected. There is currently one edit that causes a claim to be rejected.
Claim denial reasons	3	8	10,	Three-digit code specifying edits (see Table 6) that caused the claim to be denied. There is currently one active edit that causes a claim to be denied.
Claim returned to provider reasons	3	30	1-3, 5-6, 8, 14 - 17, 21-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 50, 52, 54, 55,56, 58-63, 70-75, 77-82	Three-digit code specifying edits (see Table 6) that caused the claim to be returned to provider. There are 48 edits that could cause a 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 6). There are 12 edits that could cause a claim to be suspended.
Line item rejection reasons	3	12	13, 19, 20, 28, 39, 40, 45, 47, 53, 64, 65, 76	Three-digit code specifying the edits that caused the line item to be rejected (See Table 6). There are 12 edits that could cause a line item to be rejected.
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 6). There are currently 8 edits that cause a line item denial.
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 , ~~therapeutic radiopharmaceuticals~~ 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 Q1 – STVX-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC R – Blood and blood products S - Significant procedure not subject to multiple procedure discounting T - Significant procedure subject to multiple procedure discounting 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 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, ~~U~~) 7 – Additional payment for new drug or new biological (status indicator J) 8 - Paid partial hospitalization per diem (status indicator P) 9 - No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy), or G0177 (patient education and training service))
Discounting formula number**	1	1-9	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 (edit return buffer for line item contains a 9, 13, 18, 19, 20, 28, 30, 39, 40, 45, 47 ,49, 53, 64, 65, 67, 68, 69, 76, 83) 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	0-4	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)
Payment adjustment flag**	2	0-8, 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 8 – Item provided with partial credit to provider 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	0-4	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
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	0-4	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.
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.

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)
***** 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** (v11.0): 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 there will be a line item rejection.

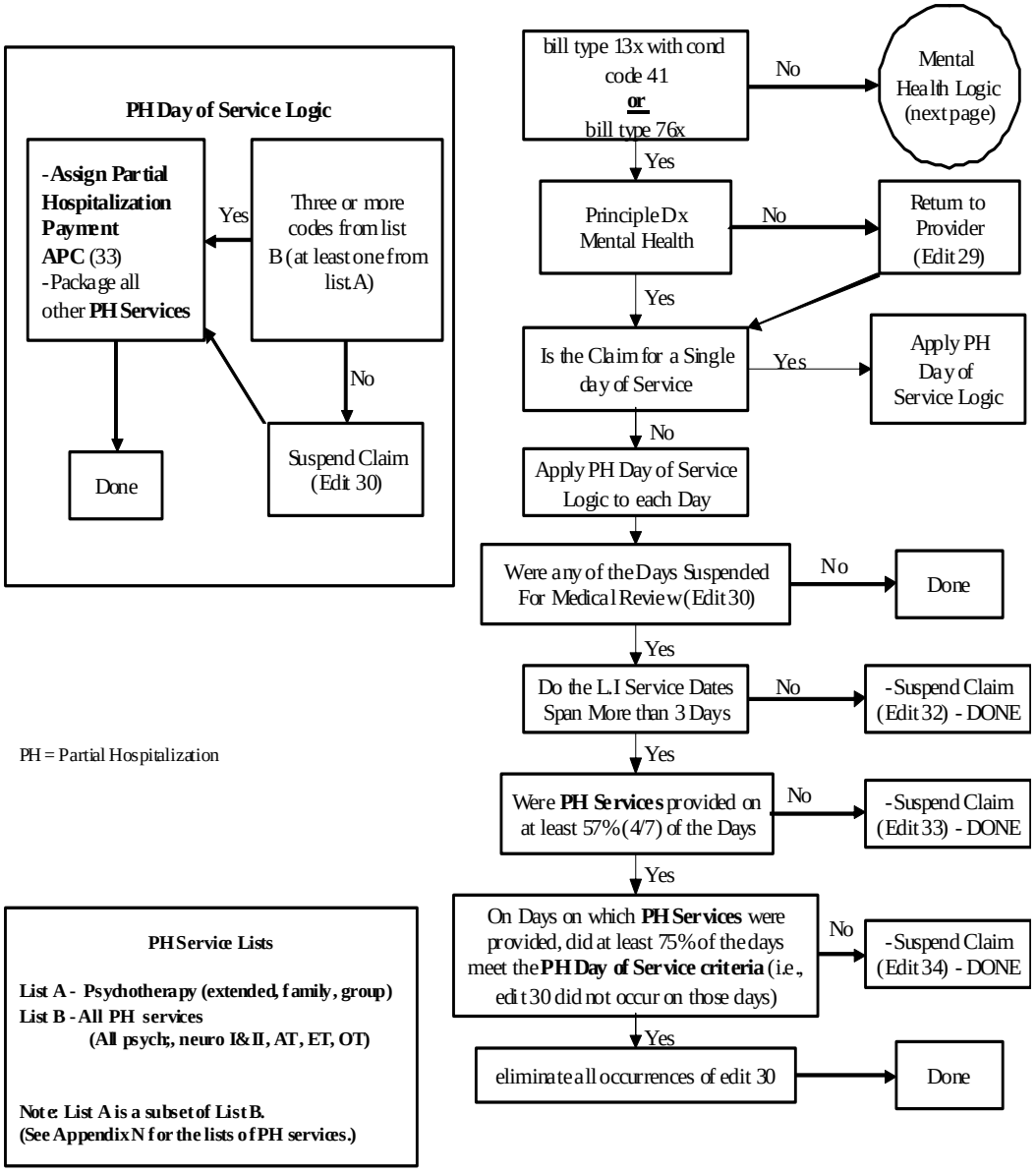
If there are multiple E&M codes on the same day, on the same claim the rules associated with multiple medical visits are shown in the following table.

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

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

* 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)



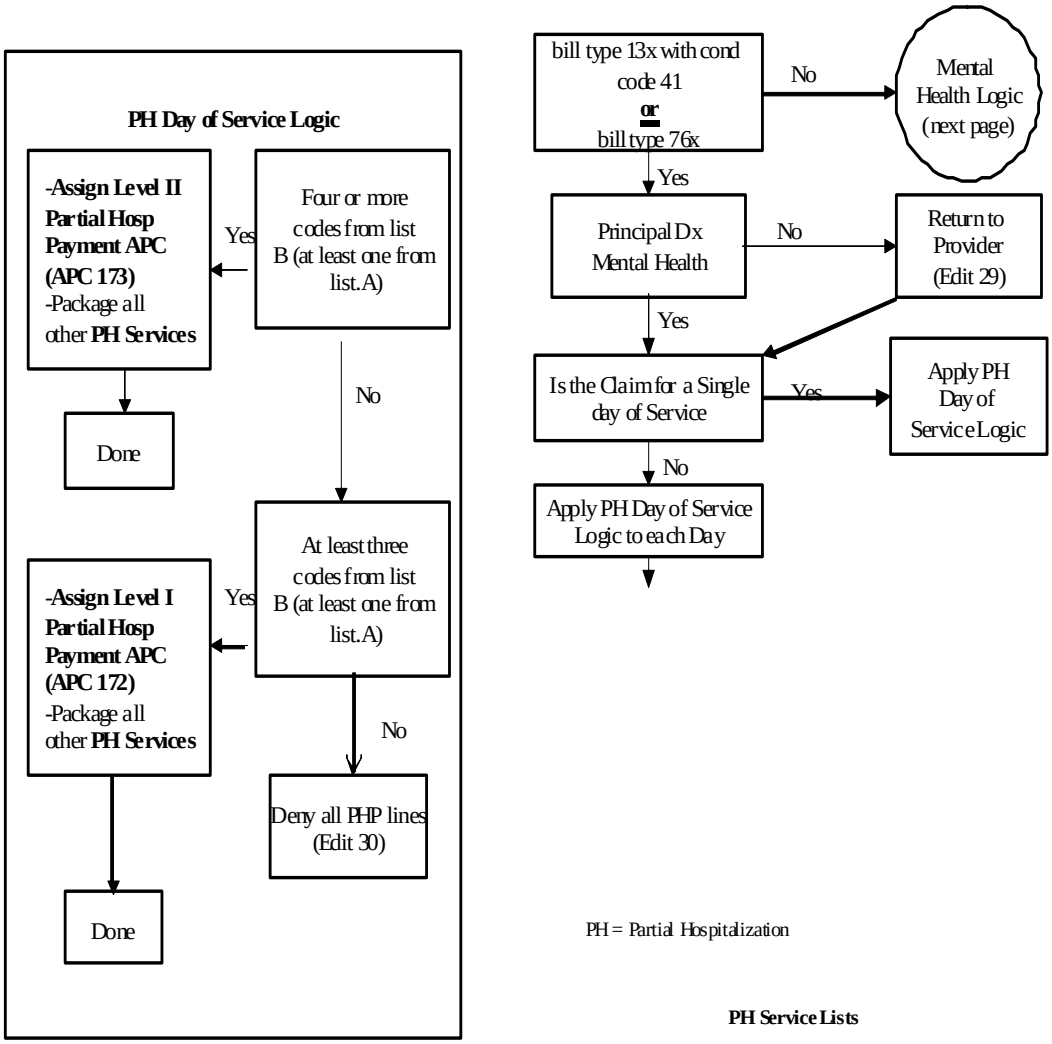
+ Multiple occurrences of services from list A or B are treated as separate units in determining whether 3 or more PH services are present..

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)

Note: List A is a subset of List B.
(See Appendix N for the lists of PH services.)

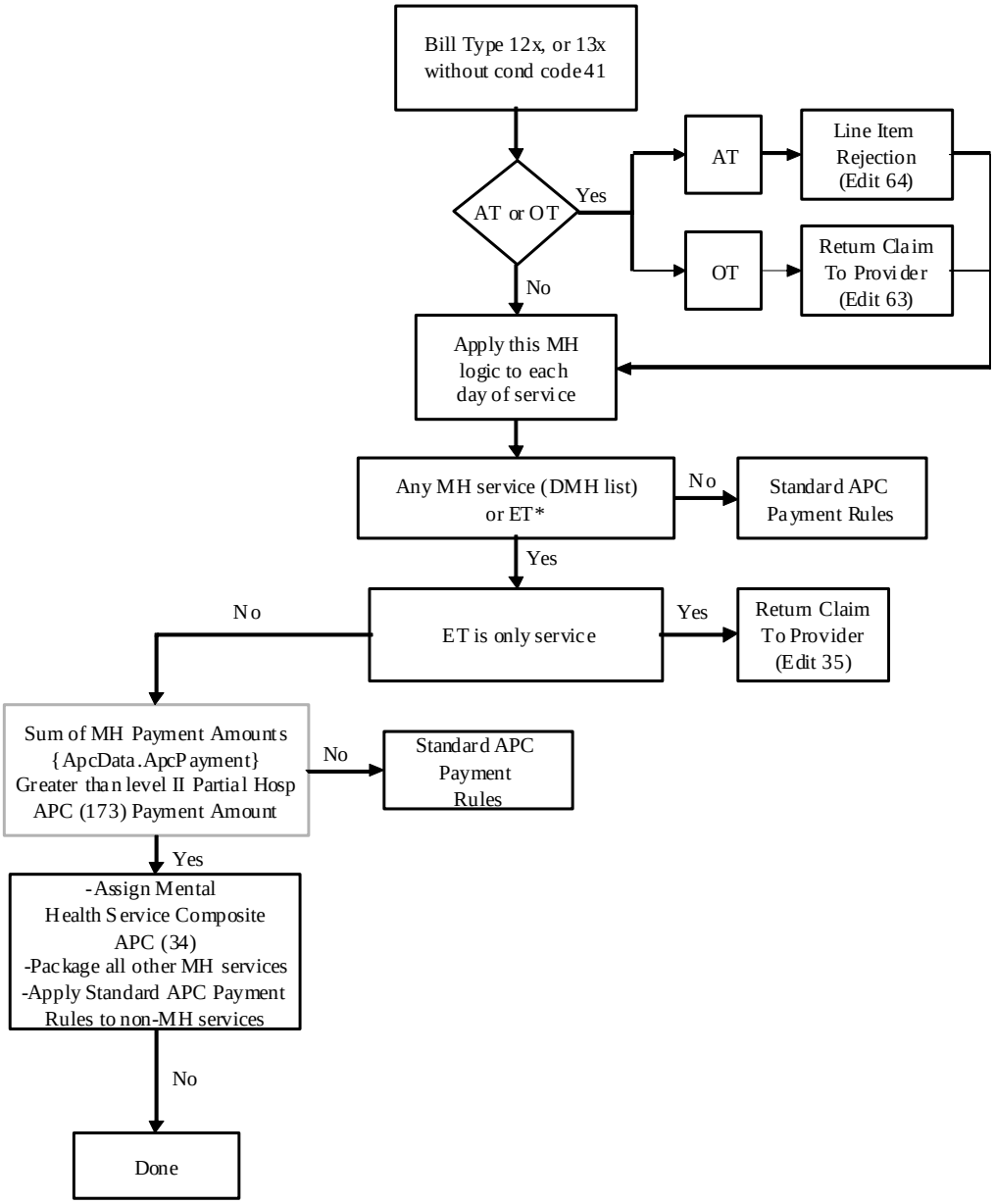
+ Multiple occurrences of services from list A or B are treated as separate units in determining whether 3 or more PH services are present..

Assign Partial Hospitalization Payment APC
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) is assigned the PHP payment APC (173 or 172), 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 CC 41, 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 CC 41; 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 #7 discontinued; new formula #9 created.

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), Use of 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

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

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)		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 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 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)**

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, 11-23, 25-28, 35-45, 47-50, 52-54, 56-79 81, 82, 83.	Buffer completed
3	13X with condition code 41	1-9, 11-23, 25-28, 29-34, 37-45, 47-50, 52, 54, 56-62, 65 - 80, 82, 83.	Buffer completed
4	13X without condition code 41	1-9, 11-23, 25-28, 35- 45, 47- 50, 52, 54, 56-79, 81, 82, 83.	Buffer completed
5	76X (CMHC)	1-9, 11-13, 15, 18, 23, 25, 26, 29-34, 38, 41, 43-45, 47-50, 53-55, 59, 61, 65, 69, 71-73, 75, 77- 80, 82.	Buffer completed
6	34X (HHA) with Vaccine, Antigens, Splints or Casts	1- 9, 11-13, 15, 18-20, 25-26, 28, 38-41, 43-45, 47, 49-50, 53-55, 59, 62, 65, 69, 71, 73, 75, 77-79, 82.	Buffer completed
7	34X (HHA) without Vaccine, Antigens, Splints or Casts	1-9, 11-13, 19, 20, 25, 26, 39-41, 44, 50, 53-55, 59, 65, 69.	Buffer not completed
8	75X (CORF) with Vaccine (PPS) [v1-6.3]	1-9, 11-13, 15, 18-20, 25, 26, 38-41, 43-45, 47-50, 53-55, 59, 61, 62, 65, 69, 71-73, 75, 77 -79, 82.	Buffer completed
9	43X (RNHCI)	25, 26, 41, 44, 46, 55, 65.	Buffer not completed
10	71X (RHC), 73X (FQHC)	1-5, 25, 26, 41, 61, 65, 72.	Buffer not completed
11	Any bill type except 12x, 13x, 14x, 34x, 43x, 71, 73x, 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, 59, 62, 65, 69, 71, 73, 75, 77 -79, 82.	Buffer completed
12	75X (CORF)	1-9, 11-13, 15, 19, 20, 23, 25, 26, 39, 40, 41, 44, 48, 50, 53-55, 59, 61, 65, 69, 72.	Buffer not completed
13	22X, 23X (SNF), 24X	1-9, 11-13, 19, 20, 23, 25, 26, 28, 39-41, 44, 50, 53, 54, 55, 59, 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, 59, 65, 69.	Buffer not completed
15	72X (ESRD)	1-5, 7-9, 11, 12, 25, 26, 41, 44, 50, 53, 54, 55, 59, 61, 65, 69, 72.	Buffer not completed
16	74X (OPT)	1-9, 11-13, 19, 20, 25, 26, 39-41, 44, 48, 50, 53, 54, 55, 59, 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, 59, 61, 65, 69, 72.	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.
8) Bill type 24x deleted, effective 10/1/05.
9) CCI edits (19, 20, 39 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 10/1/05.
11) Effective 4/1/06, 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).

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, ~~U~~	2
Status indicator J [1]	3
Code is flagged 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	7
Item provided with partial credit to provider	8
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).

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]:

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

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

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

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

5. Observation logic is performed only for claims with bill type 13x, with or without condition code 41.

6. Lines with G0378 and G0379 are rejected if the bill type is not 13x (or 85x).

7. 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.

8. In order to qualify for separate payment, each observation must be paired with a unique E/M or critical care
    a. (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.

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

10. 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.

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

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

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

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

15. 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.

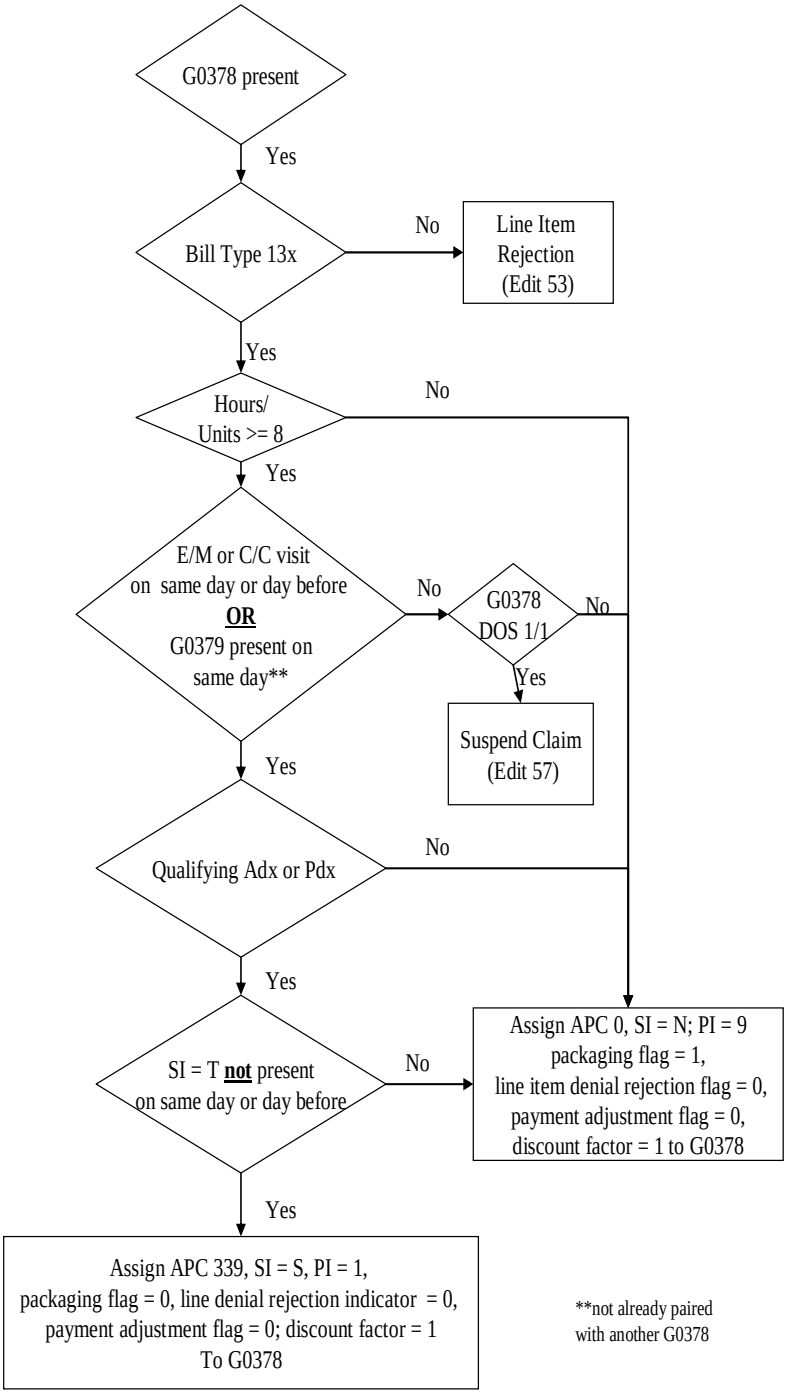
16. Observation date is assumed to be the date admitted for observation
17. The diagnoses (patient's reason for visit or principal) required for the separately payable observation criteria are:

Chest Pain	Asthma	CHF
4110, 1, 81, 89	49301, 02, 11, 12, 21, 22, 91, 92	3918, 39891
4130, 1, 9		40201, 11, 91

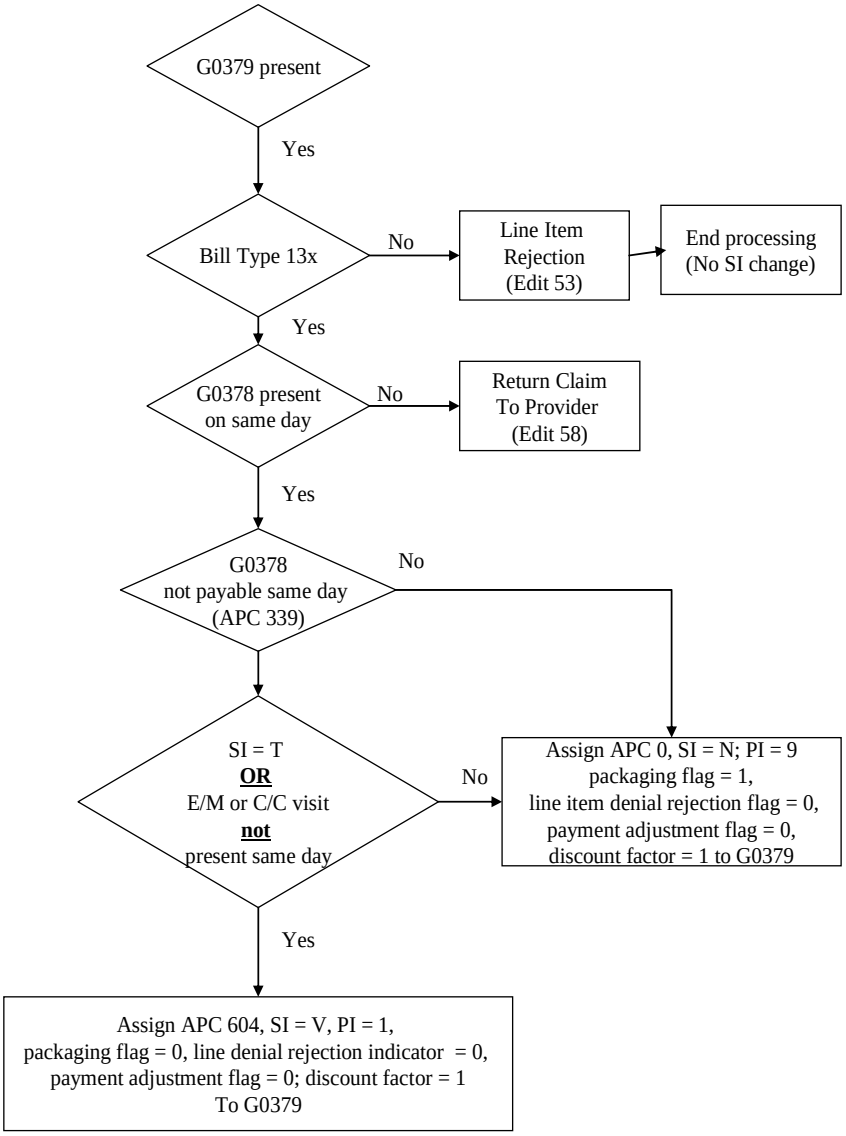
Chest Pain	Asthma	CHF
7860<u>5</u>, 50, 51, 52, 59		404<u>0</u>1, 03, 11, 13, 91, 93
		428<u>0</u>, 1, 9, 20-23, 30-33, 40-43

18. 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)

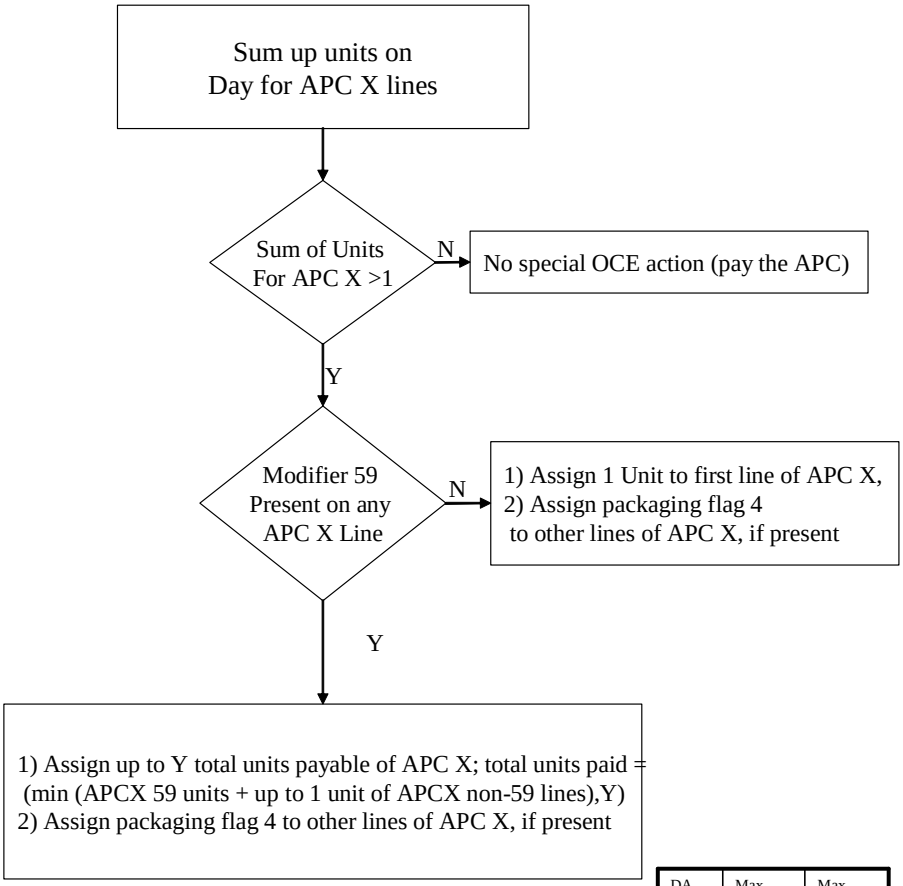


Appendix H-b (cont'd)
Direct Referral Logic (v3.0 – v8.3)



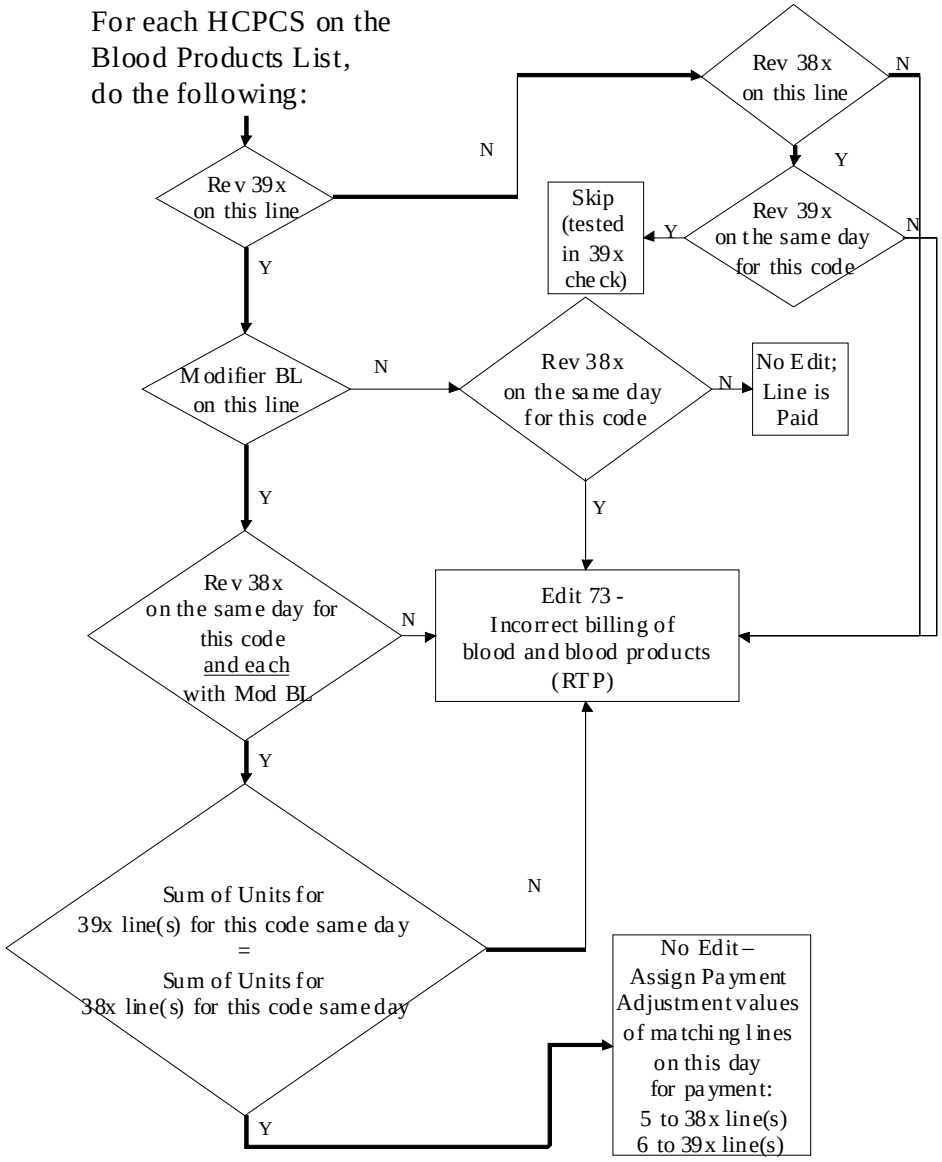
Appendix I [OPPS Only]
Drug Administration (v6.0 – v7.3 only)

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 and Electrophysiology/ablation 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

Prime/Group A codes	Non-prime/Group B codes	Composite APC
93619 93620	93650 93651 93652	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.

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) Level I and II 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:

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

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

Level I Extended Assessment and Management criteria:

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

Separate Direct Referral (G0379) Processing Logic

(See appendix K-b for flowchart):

a) Code G0378 must be present on the same day

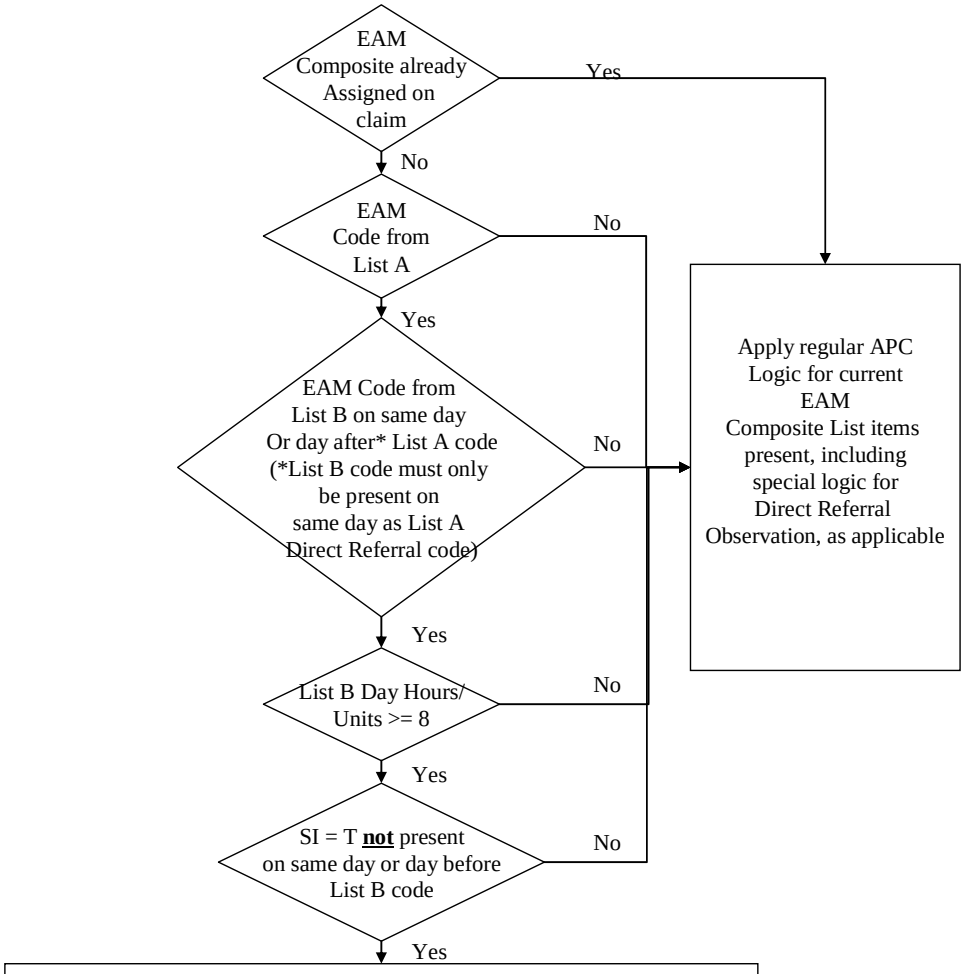
b) No SI = T, E/M, or C/C visit on the same day

c) Code G0379 may be paid under the composite 8002, paid under APC 604, or packaged with SI = N.

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) do the following:



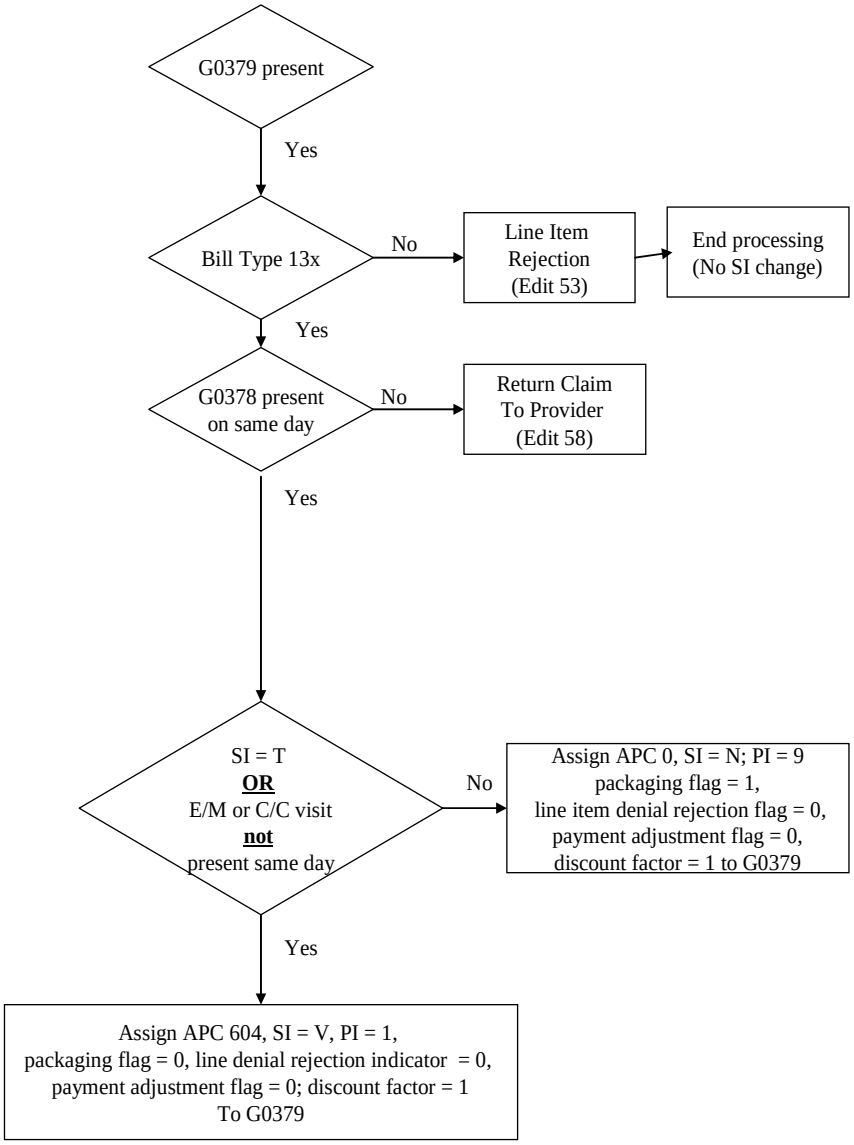
Assign EAM Composite:

Assign the composite APC, SI , PI, packaging flag = 0,
payment adjustment flag = 9[1-9]**; composite adjustment flag = (01-xx)***,
discount factor = 1, units output= 1 to the highest weighted list A code present.

Assign standard APC, SI, PI to other List A* codes and List B code.
*Package special Direct Referral List A code on same claim as EAM composite assignment
** Claims prior to 1/1/09. *** effective 1/1/09.

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)

76604	76776
76700	76831
76705	76856
76770	76857
76775	76870

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

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

70450	72131
70480	72192
70486	73200
70490	73700
71250	74150
72125	74261
72128	

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

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

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

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

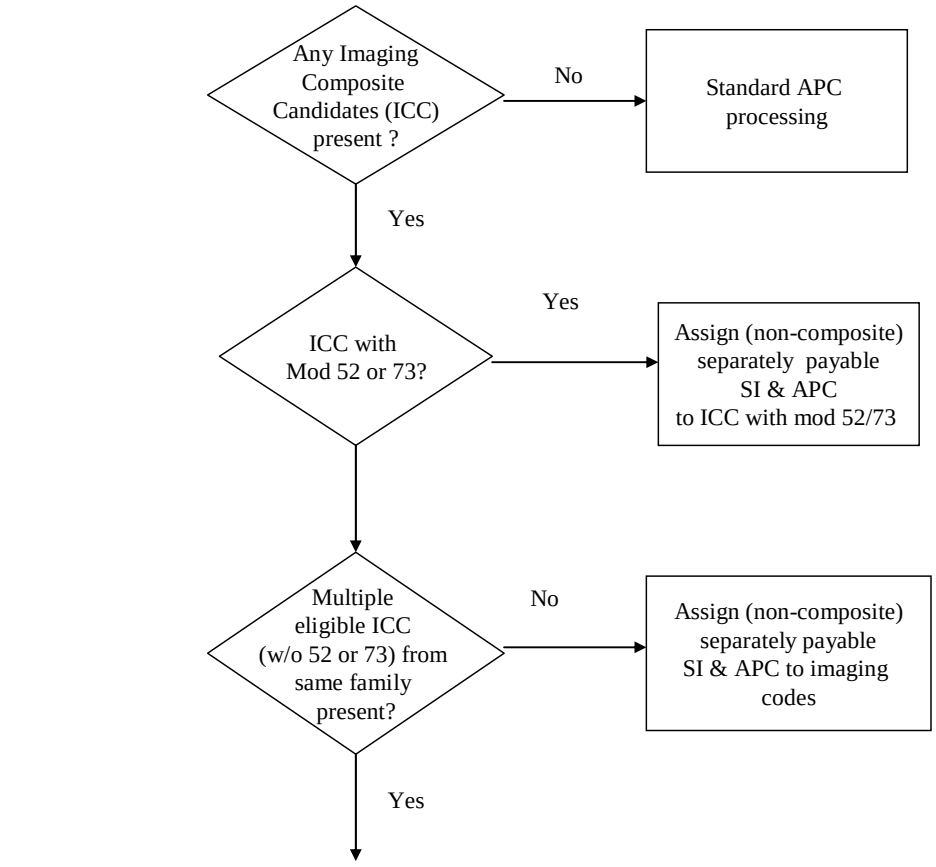
70336	72146	75557
70540	72148	75559
70544	72195	C8901
70547	73218	C8904
70551	73221	C8907
70554	73718	C8910
71550	73721	C8913
72141	74181	C8919

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

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

*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
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. 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.

Appendix L
OCE Overview (cont'd)

6. If edit 18 is present on a claim, generate edit 49 for all other line items occurring on the same day as the line item with edit 18, and set the line item denial or rejection flag to 1 for each of them. Go to step 19.

7. If all of the lines on the claim are incidental, and all of the line item action flags are zero, generate edit 27. Go to step 19.

8. If the line item action flag for a line item has a value of 2 or 3 then reset the values of the Payment APC and HCPCS APC to 00000, and set the payment method flag to 4. If the line item action flag for a line item has a value of 4, set the payment method flag to 0. Ignore line items with a line item action flag of 2, 3 or 4 in all subsequent steps.

9. Perform edits that are not based on the status indicator.

10. If bill type is 13x and condition code = 41, or type of bill = 76x, apply partial hospitalization logic from Appendix C. Go to step 11.

11. If bill type is 12x or 13x without condition code 41, apply mental health logic from Appendix C-b.

12. Apply special packaging logic (T-packaged (SI of Q2); followed by STVX-packaged (SI of Q1)).

13. 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).

14. 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).

15. 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).

16. 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.

17. Perform all remaining edits that are driven by the status indicator.

18. If the payment APC for a line item has not been assigned a value in step 9 thru 17, set payment APC in the APC return buffer for the line item equal to the HCPCS APC for the line item.

19. If edits 9, 13, 19, 20, 28, 30, 39, 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.

20. 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

21. 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.

22. 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.

23. For all bill types where APCs are assigned, apply drug administration APC consolidation logic from appendix I. (v6.0 – v7.3 only).

24. Set the payment adjustment flag for a line item based on the criteria in Appendix G and Appendix J.

25. 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'.

26. 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”:

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

Appendix M
Summary of Modifications

The modifications of the IOCE for the January 2010 release (V11.0) 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	1/1/10	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 January 2010 release will be 4/1/03.
2.	Logic	1/1/10	74	Modify edit 74 for TOB 85x – Apply edit 74 to conditional or independently bilateral codes (indicator 1 or 3) with modifier 50 and more than one unit of service on the same **or multiple** lines on the same day, with the same revenue code. Exclude any bilateral lines with any other modifier present. Apply to bill type 85x with revenue code 96x, 97x or 98x.
3.	Logic	1/1/10	1-5	Bypass diagnosis edits (1-5) for bill types 322 and 332 if FROM date is on/after 9/26 and on/before 9/30
4.	Logic	8/3/09	68	Apply mid-quarter NCD approval date for code G9143.
5.	Logic	9/1/09	69	Apply mid-quarter approval date for codes G9141 and G9142.
6.	Logic	9/28/09	69	Add new code 90470 retro-active to mid-quarter date of 9/28/09.
7.	Logic	9/28/09	68	Apply mid-quarter NCD approval date for codes 75558, 75560, 75562, and 75564.
8.	Logic	1/1/10	-	Add code 92520 to the 'Sometimes Therapy' list and logic.
9.	Logic	1/1/10	-	Update composite APC requirements (add/delete codes as specified)
10.	Logic	1/1/10	-	Modify the program to change the SI from 'M' to 'A' for any HCPCS code with SI = M that is billed with rev code 657 on bill types 81x and 82x.
11.	Logic	1/1/10	-	Modify the program to change the Payment Indicator associated with SI = U, from PI 6 to PI 1. And to remove SI = U from assignment criteria for PAF 2 (appendix G).
12.	Logic	1/1/10	-	Increase the MF working storage area from 768K to 1MB.
13.	Content	1/1/10	-	Make HCPCS/APC/SI changes as specified by CMS (data change files).
14.	Content	1/1/10	19, 20, 39, 40	Implement version 15.3 of the NCCI (as modified for applicable institutional providers).
15.	Content	1/1/10	22	Add new modifiers as specified.
16.	Content	1/1/10	-	Update composite APC requirements (add/delete codes as specified).
17.	Content	1/1/10	71, 77	Update procedure/device and device/procedure edit requirements.
18.	Content	1/1/10	-	Update FB/FC device reduction amounts and crosswalk.
19.	Content	1/1/10	78	Update radiolabeled products edit requirements.
20.	Content	1/1/10	-	Make SI assignment changes for blank revenue codes as specified by CMS.
21.	Doc	1/1/10	-	Revise the description for Payment Method Flag #1 as follows - From: "Based on OPPS coverage or billing rules, the service is not paid" To: "Service not paid based on coverage or billing rules".
22.	Doc	1/1/10	-	Change descriptive references for code G0379 from 'Direct admission…' to 'Direct referral…'
23.	Doc	1/1/10	-	Revise the descriptions for SI = H and K as follows: H: Pass-through device categories. K: Non pass-through drugs and nonimplantable biologicals, including therapeutic radiopharmaceuticals.
24.	Doc	1/1/10	-	Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS web site.

Appendix N

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, G0008, G0009, G9141
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	90818, 90819, 90821, 90822, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90865, 90880, G0410, G0411.
PHP List B	90801, 90802, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90865, 90880, 96101, 96102, 96103, 96116, 96118, 96119, 96120, G0129, G0176, G0177, G0410, G0411.