CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 962

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 26, 2006

Change Request 5065

SUBJECT: July 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE)
Specifications Version 7.2

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

NEW/REVISED MATERIAL
EFFECTIVE DATE: July 1, 2006
IMPLEMENTATION DATE: July 3, 2006

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

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

R/N/D	Chapter / Section / SubSection / Title

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

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 962	Date: May 26, 2006	Change Request 5065

SUBJECT: July 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.2

I. GENERAL INFORMATION

A. Background: This notification reflects specifications that were issued for the April revision of the OPPS OCE (Version 7.1). All shaded material in Attachment A reflects changes that were incorporated into the July version of the revised OPPS OCE (Version 7.2).

B. Policy: This notification provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, Community Mental Health Centers (CMHC's) and for limited services provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5065.1	The Shared System Maintainer shall install OPPS OCE Version 7.2 into their systems.	X	X			X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5065.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X				

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: OPPS OCE/ PRICER

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

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

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

ATTACHMENTS:
Attachment A 5065 – July 2006 Outpatient Code Editor (OCE) Specifications Version 7.2
Summary of Data Changes 5065 – Final Summary of Data Changes OCE/APC v7.2

ATTACHMENT A

(Rev. 962, Issued: 05-26-06, Effective: 07-01-06, Implementation: 07-03-06)

July 2006 Outpatient Code Editor (OCE) Specifications Version (V7.2)

This attachment contains specifications issued for the July 2006 OCE (Version 7.2). All shaded material reflects changes incorporated into the April 2006 version of the OPPS OCE (Version 7.1).

Introduction

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

- All outpatient hospital Part B bills (bill types 12X, 13X, or 14X) with the exception of critical access hospitals (CAHs), Indian Health Service Hospitals (IHS)/ Tribal hospitals including IHS/ Tribal CAHs, Maryland hospitals, and hospitals located in American Samoa, Guam, and The Northern Mariana Islands. In addition, claims from Virgin Island hospitals with dates of service January 1, 2002, and later, and claims from hospitals that furnish only inpatient Part B services with dates of service January 1, 2002, and later should not be sent through the OPPS OCE since they are also excluded from OPPS. (See below for more detail regarding these hospitals.);

- CMHC bills (bill type 76X);

- HHA bills containing certain Healthcare Common Procedure Coding System (HCPCS) codes as identified in the chart entitled “HCPCS Codes for Reporting Antigens, Vaccine Administration, Splints and Casts” below (bill types 34X); and

- Any bill containing a condition code 07, “treatment of non-terminal illness – hospice”, with certain HCPCS codes as identified in the chart entitled “HCPCS Codes for Reporting Antigens, Vaccine Administration, Splints and Casts” below.

Send all other outpatient bill types (22X, 23X, 24X, 32X, 33X, 43X, 71X, 72X, 73X, 74X, 75X, 81X or 82X) through the OPPS OCE. Send IHS/Tribal Hospitals including IHS Tribal CAH’s, CAH’s, Maryland hospitals, and hospitals located in American Samoa, Guam, and The Northern Mariana Islands through the non-OPPS OCE (original OCE). Also send claims from Virgin Island hospitals with dates of service on or after January 1, 2002, and claims from hospitals that furnish only inpatient Part B services with dates of service on or after January 1, 2002, through the non-OPPS OCE. Refer to the IOM Chapter 100-04, Chapter 4, Section 150, for information regarding hospitals that provide Part B only services to their inpatients.

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

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

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

General Functions of the OCEs

The OPPS OCE performs the following two major functions:

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

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

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

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

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

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

Information Sent to OPPS OCE

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

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

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

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

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

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

Information Returned From OPPS OCE

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

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

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

Line item input information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Criteria for Applying Standard OPPS Payment Calculations

- APC value is not 00000

Payment 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

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 E). The line item action flag is passed as input to the OPPS OCE as a means of allowing you to override a line item denial or rejection (used by you to override OPPS OCE and have OPPS PRICER compute payment ignoring the line item rejection or denial) or allowing you to indicate that the line item should be denied or rejected even if there are no OPPS OCE edits present. The action flag is also used for handling external line item adjustments. For some sites of service (e.g., HHAs) only some services are paid under OPPS. The line item action flag also impacts the computation of the discounting factor as described in Appendix D "Computation of Discounting Fraction". OPPS payment for the claim is computed as the sum of the payments for each line item with the appropriate conversion factor, wage rate adjustment, outlier adjustment, etc., applied. The OPPS OCE overview below summarizes the process of filling in the APC return buffer.

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

for a single day or multiple days. If a multiple day claim has a subset of the days with a claim denial, RTP, or suspend, the whole claim is denied, RTP, or suspended.

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

Tables

Table 1: OPPS OCE Control Block

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

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

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

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

Table 2: Edit Return Buffers

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

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

Table 3: Description of Edits/Claim Reasons

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

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

	(V3.0-V6.3)	
53	Codes G0378 and G0379 only allowed with bill type 13x	Line item rejection
54	Multiple codes for the same service	RTP
55	Non-reportable for site of service	RTP
56	E/M-condition not met and line item date for obs code G0244 is not 12/31 or 1/1 **(Active V4.0 – V6.3)**	RTP
57	E/M condition not met for separately payable observation and line item date for code G0378 is 1/1	Suspend
58	G0379 only allowed with G0378	RTP
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis	RTP
60	Use of modifier CA with more than one procedure not allowed	RTP
61	Service can only be billed to the DMERC	RTP
62	Code not recognized by **OPPS**; alternate code for same service may be available	RTP
63	This OT code only billed on partial hospitalization claims **(See appendix C)**	RTP
64	AT service not payable outside the partial hospitalization program **(See appendix C)**	Line item rejection
65	Revenue code not recognized by Medicare	Line item rejection
66	Code requires manual pricing	Suspend
67	Service provided prior to FDA approval	Line item rejection
68	Service provided prior to date of National Coverage Determination (NCD) approval	Line item rejection
69	Service provided outside approval period	Line item rejection
70	CA modifier requires patient status code 20	RTP
71	Claim lacks required device code	RTP
72	Service not billable to the Fiscal Intermediary	RTP
73	Incorrect billing of blood and blood products	RTP

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

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

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

[4] Not applicable for admitting diagnosis

Table 4: Claim Return Buffer

	Bytes	Number	Values	Description
Claim processed Flag	1	1	0-3, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, or 46[a]). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 9 - Fatal error; OCE can not run - the environment can not be set up as needed; exit immediately.
Num of line items	3	1	nnn	Input value from Nsgptr, or 450, whichever is less.
National provider identifier (NPI)	13	1	aaaaaaaaaaaaa	Transferred from input, for Pricer.
OSCAR Medicare provider number	6	1	aaaaaa	Transferred from input, for Pricer.
Overall claim	1	1	0-5	0 - No edits present on claim.

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

			50, 53, 64, 65, 67-69	
Line item denied reasons	3	6	9, 18, 49	Three-digit code specifying the edits that caused the line item to be denied (see Table 6). There are currently 3 active edits that cause a line item denial.
APC return buffer flag	1	1	0-1	0 - No services paid under OPPS. APC return buffer filled in with default values (See Appx. F). 1 - One or more services paid under OPPS. APC return buffer filled in.
Version Used	8	1	yy.vv.rr	Version ID of the version used for processing the claim (e.g., 2.1.0).
Patient Status	2	1		Patient status code - transferred from input.
Opps Flag	1	1	1-2	OPPS/Non-OPPS flag - transferred from input.

Table 5: APC Return Buffer

Name	Size (bytes)	Values	Description
HCPCS procedure code	5	Alpha	For potential future use by Pricer. Transfer from input
Payment APC	5	00001-nnnnn	APC used to determine payment. If no APC assigned to line item, the value 00000 is assigned. For partial hospitalization and some inpatient-only procedure claims the payment APC may be different than the APC assigned to the HCPCS code.
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status indicator	2	Alpha [Right justified, blank filled]	A - Services not paid under OPPS B - Non-allowed item or service for OPPS C - Inpatient procedure E - Non-allowed item or service F - Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines G - Drug/Biological Pass-through H – Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents J - New drug or new biological pass-through [1] K - Non pass-through drugs and biologicals L – Flu/PPV vaccines M – Service not billable to the FI N - Packaged incidental service P - Partial hospitalization service Q - Packaged services subject to separate payment based on criteria S - Significant procedure not subject to multiple procedure discounting T - Significant procedure subject to multiple procedure discounting V - Medical visit to clinic or emergency department W – Invalid HCPCS or Invalid revenue code with blank HCPCS X - Ancillary service Y – Non-implantable DME, Therapeutic Shoes Z – Valid revenue with blank HCPCS and no other SI assigned
Payment indicator	2	Numeric (1- 00) [Right justified,	1 - Paid standard hospital OPPS amount (status indicators K, S, T, V, X) 2 - Services not paid under OPPS (status indicator A) 3 - Not paid (Q, M, W, Y, E), or not paid under OPPS (B, C, Z) 4 - Paid at reasonable cost (status indicator F, L) 5 - Paid standard amount for pass-through drug or biological (status indicator G) 6 - Payment based on charge adjusted to cost 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

		blank filled].	indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy), or G0177 (patient education and training service))
Discounting formula number	1	1-8	See Appendix D for values
Line item denial or rejection flag	1	0-2	0 - Line item not denied or rejected 1 - Line item denied or rejected (edit return buffer for line item contains a 9, 13, 18, 19, 20, 21, 28, 39, 40, 45, 47 ,49, 50, 53, 64, 65, 67, 68, 69) 2- The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/1/02 - v3.0).
Packaging flag	1	0-4	0 - Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of partial hospital per diem or daily mental health service per diem 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01) 4 – Packaged as part of drug administration APC payment
Payment adjustment flag	2	0-6 [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
Payment Method Flag	1	0-4	0 - OPPS pricer determines payment for service 1 - Based on OPPS coverage or billing rules, the service is not paid 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
Service units	7	1-x	Transferred from input, for Pricer. For the line items assigned APCs 33 or 34, the service units are always assigned a value of one by the OCE even if the input service units were greater than one [Input service units also may be reduced for some Drug administration APCs, based on Appendix I]
Charge	10	nnnnnnnnnn	Transferred from input, for Pricer; CO
Line item action flag	1	0-4	Transferred from input to Pricer, and can impact selection of discounting formula (Appx. D). 0 - OCE line item denial or rejection is not ignored 1 - OCE line item denial or rejection is ignored 2 - External line item denial. Line item is denied even if no OCE edits 3 - External line item rejection. Line item is rejected even if no OCE edits 4 - External line item adjustment. Technical charge rules apply.

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

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

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

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

Correct Coding Initiative (CCI) Edits

The OPPS OCE will generate CCI edits. All CCI edits will be incorporated in the OPPS OCE with the exception of anesthesiology, E&M, mental health, and certain drug administration code pairs. 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 will apply to ALL services billed, under bill types 22X, 23X, 34X, 74X, and 75X, by the following providers: Skilled Nursing Facilities (SNF's), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPT's), CORF's, and Home Health Agencies (HHA's).

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

Version 12.1 of CCI edits is included in the July OPPS OCE.

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

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

Units of Service Edit

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

Appendix A
Bilateral Procedure Logic

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

Condition	Action	Edit
The same code which can be performed bilaterally occurs two or more times on the same date of service, all codes *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

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

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

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

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

** 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.

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

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

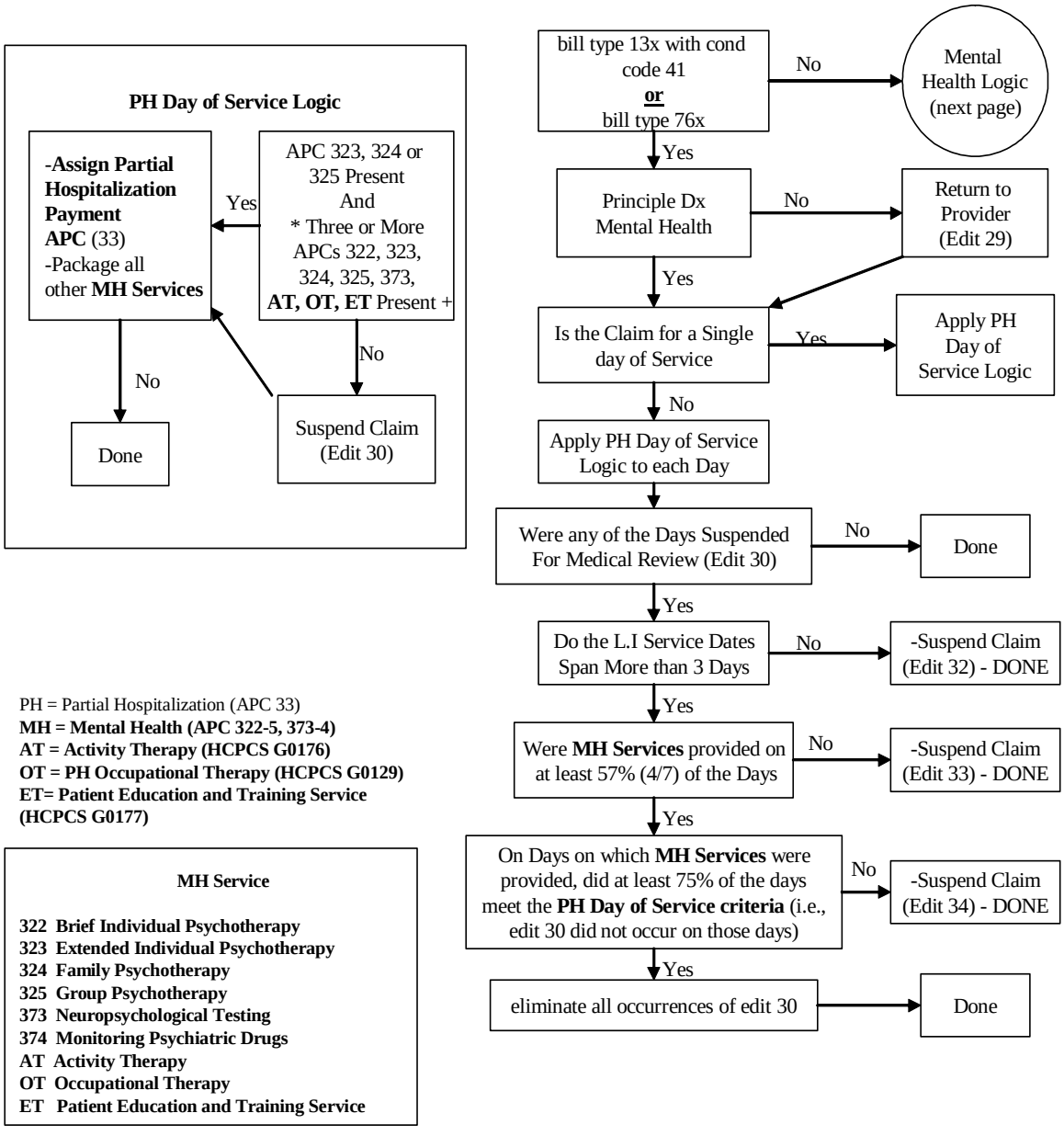
If there are multiple E&M codes on the same day, on the same claim the rules associated with multiple medical visits are shown in the following table.

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

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

* 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
Partial Hospitalization Logic



PH = Partial Hospitalization (APC 33)
MH = Mental Health (APC 322-5, 373-4)
AT = Activity Therapy (HCPCS G0176)
OT = PH Occupational Therapy (HCPCS G0129)
ET= Patient Education and Training Service (HCPCS G0177)

MH Service

322 Brief Individual Psychotherapy
323 Extended Individual Psychotherapy
324 Family Psychotherapy
325 Group Psychotherapy
373 Neuropsychological Testing
374 Monitoring Psychiatric Drugs
AT Activity Therapy
OT Occupational Therapy
ET Patient Education and Training Service

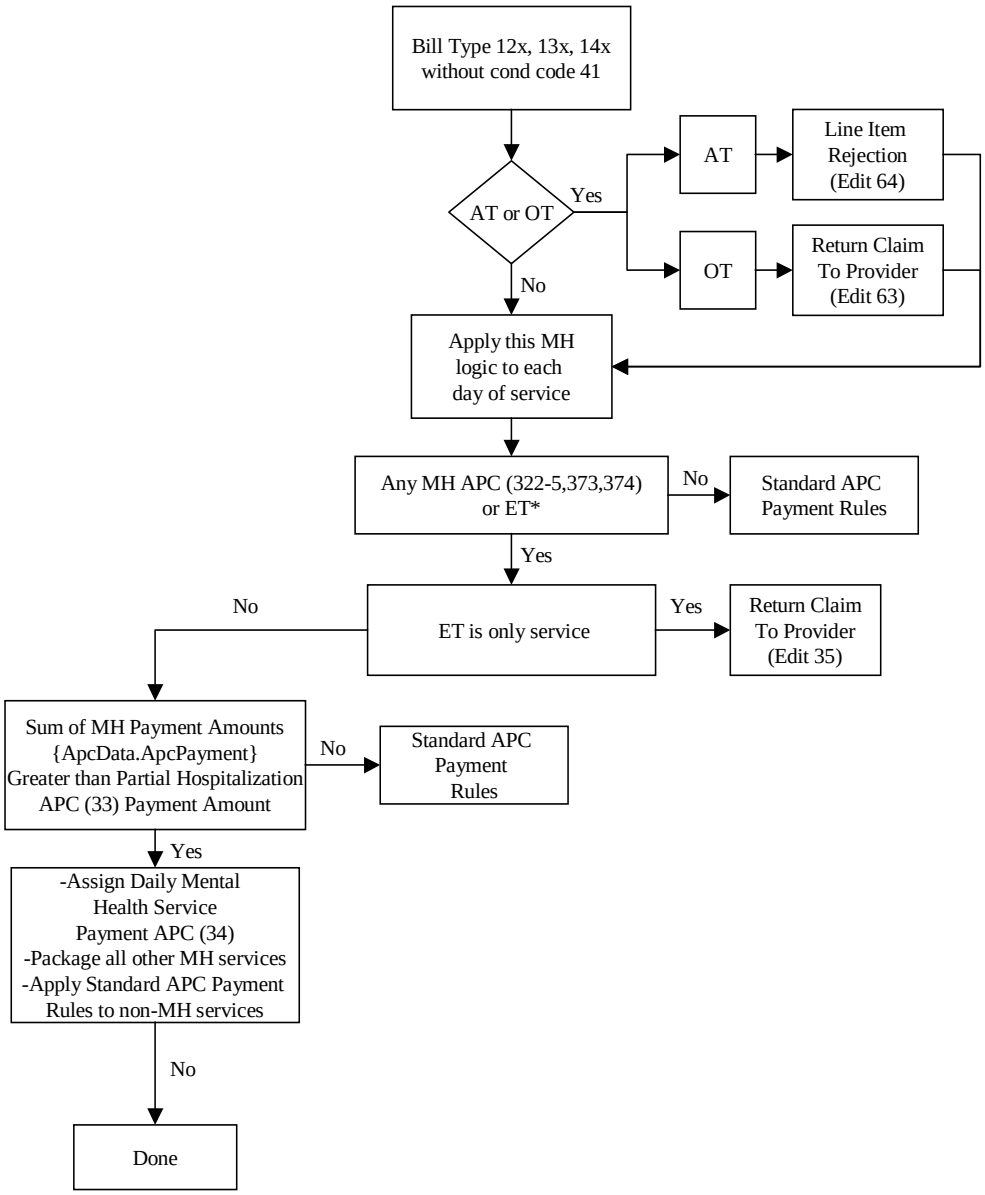
+ Multiple occurrences of APC 322, 323, 324, 325, and 373; AT and ET are treated as separate units in determining whether 3 or more MH services are present. However, multiple occurrences of OT are treated as a single service.

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

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

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

Appendix C (cont'd)
Mental Health Logic



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

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

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

Appendix D
Computation of Discounting Fraction

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

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

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

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

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

Where

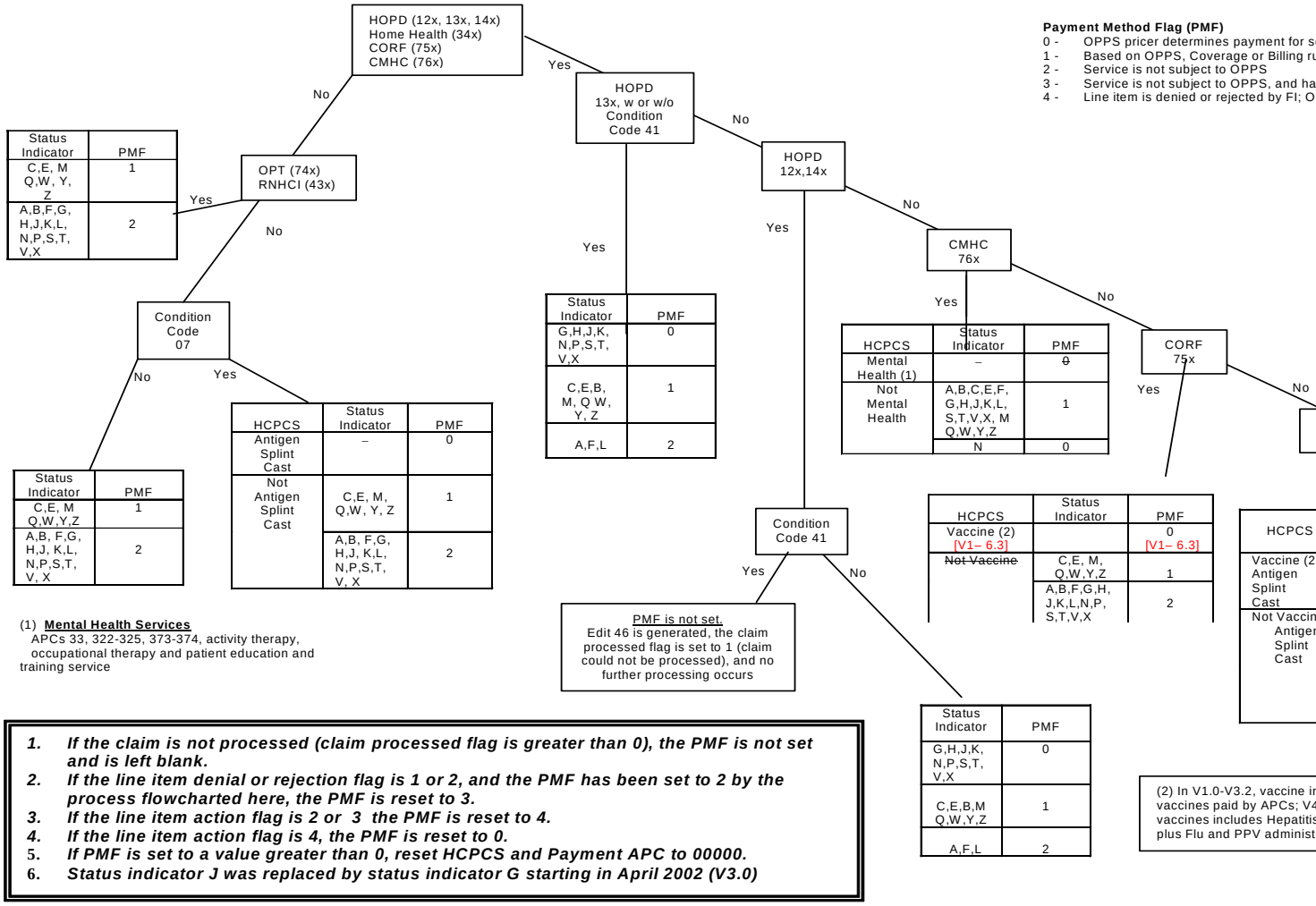
D = discounting fraction (currently 0.5)
U = number of units
T = terminated procedure discount (currently 0.5)

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

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

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

Appendix E
Logic for Assigning Payment Method Flag Values



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

a/apc/pmf

Appendix F - OCE Edits Applied by Bill Type

Appendix F - OCE Edits Applied by Bill Type

FLOW CHART CELL (*)	Provider/Bill Types	Dx & Proc [1-5,7-9 [11-12,50,53[e],54,59, 69]	HCPC [6,13]	OPPS site of svc [14]	Non Mcare [28] Non OPPS [62]	Proc & Modifier [18,38,43,45,47,49,71,73]	HCPC Req'd [48[d]]	Modifier [16,17,[b],22,37]	CCI [19,20,39,40]	Units [15]	[a] Line Item Date [23]	Rev Code [41,44, 65]	Age, Sex [25,26]	Partial Hosp [29-34]	APC [21,27,42]	MH [35,36, 63, 64]	Bill Type [46]	APC buffer completed	Obs Logic [52,56,57], DirAdm [50], Spec Inpt [60] Manual Price [66, 70], FDA/NCD [67, 68]	Opps Proc [35]	DME (61); Not F1 (72)
1	12X or 14X w condition code 41	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No
2	12X or 14X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	No	Yes
3	13X w condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
4	13X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes
5	76X (CMHC)	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	Yes
6	34X[h] (HHA) w Vaccine[e], Antigen, Splint or Cast	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No	No	No	No	Yes	No	Yes	No
7	34X[h] (HHA) w.o Vaccine[e], Antigen, Splint or Cast	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No
8	75X (CORF) w Vac[e] (PPS) [v1-6.3]	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes
9	43X (RNHCI)	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	No	No	Yes	No
10	Any bill type except 12x, 13x, 14x, 76x, 34x, or ~~[75x with Vaccine[e]]~~, w condition code 07, w Antigen, Splint or Cast	Yes[f]	Yes	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	No
11	75X[h] (CORFs) ~~w.o Vaccine[e]~~	Yes	Yes	No	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
12	22X[h,j], 23X[h,i] (SNF), 24X[g]	Yes	Yes	No	Yes[j]	No	No	No	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
13	32X, 33X (HHA)	Yes[f]	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No
14	71X (RHC), 73X (FQHC)	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
15	72X (ESRD)	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
16	74X[h] (OPTs)	Yes	Yes	No	No	No	Yes	No	Yes	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
17	81x (Hospice), 82x	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes

(*) FLOW CHART CELLS ARE IN HIERARCHICAL ORDER

Yes = edits apply, No = edits do not apply

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

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

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

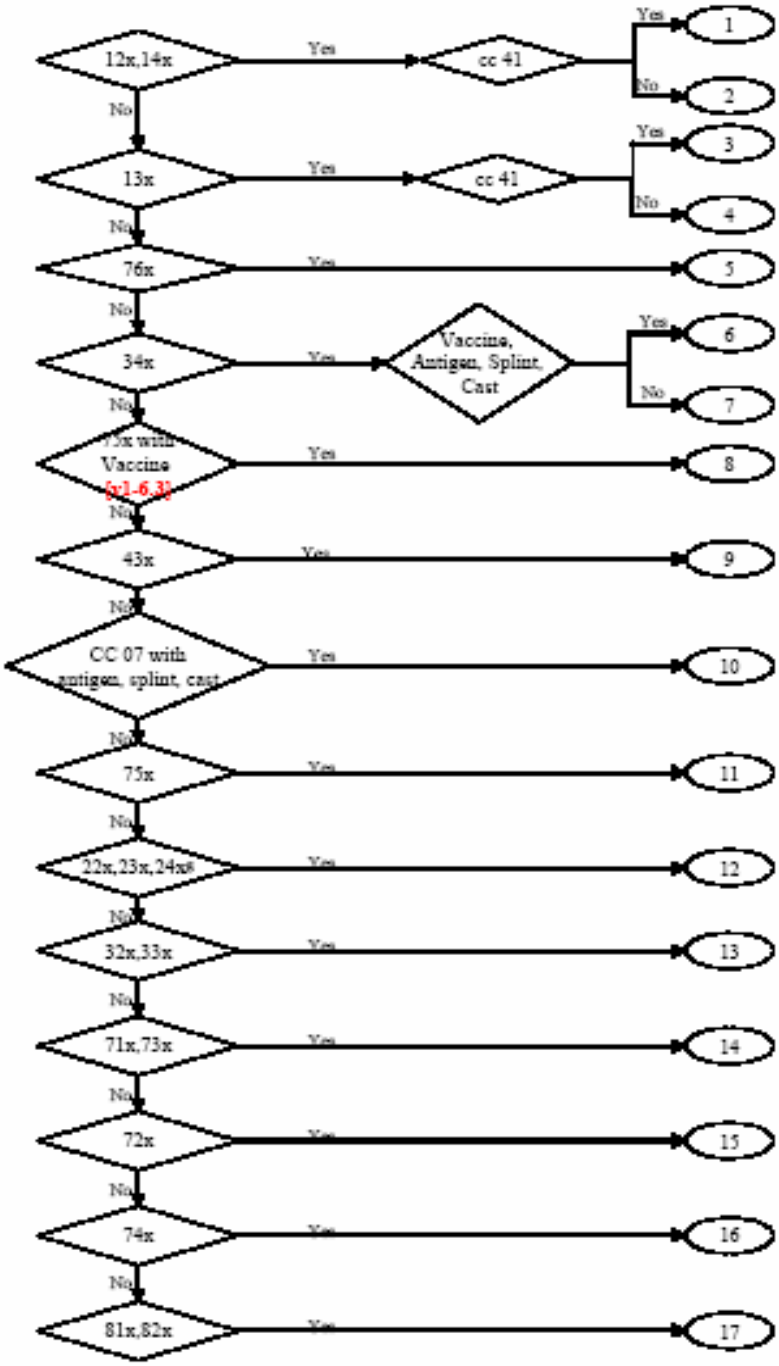
[d] Bypass edit 48 if Revenue code is 100x, 210x, 310x, 0905, 0906, 0907; 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932; 0521-2, 0524-5, 0527-8

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

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

[g] Delete TOB 24X effective 10/1/05 [h] Apply CCI edits to TOB 22x, 23x, 34x 74x and 75x, effective 1/1/06 [i] Apply edit 28, effective 10/1/05

Appendix F Flow Chart



Appendix G

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

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

[1] Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)
[2] See Appendix J for assignment logic (v6.2)

Appendix H
OCE Observation Criteria

Rules:

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

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

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

4. Code G0379 has default Status Indicator "Q" and default APC 0
a. If associated with a payable observation (payable G0378 present on the same day), the SI for G0379 is changed to "N".
b. If ~~no payable~~ the observation on the same day is not payable, the SI is changed to "V" and APC 600 is assigned.

5. Observation logic is performed only for claims with bill type 13x, with or without condition code 41. Lines with G0378 and G0379 are rejected if the bill type is not 13x.

6. If any of the criteria for separately payable observation is not met, the observation is packaged, or the claim or line is suspended or rejected according to the disposition of the observation edits.

7. In order to qualify for separate payment, each observation must be paired with a unique E/M or critical care (C/C) visit, or with code G0379 (Direct admission from physician's office).
E/M or C/C visit is required the day before or day of observation; Direct admission is required on the day of observation.

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

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

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

11. Both the associated E/M or C/C visit (APCs 600-602, 610-612, 620) and observation are paid separately if the criteria are met for separately payable observation.

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

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

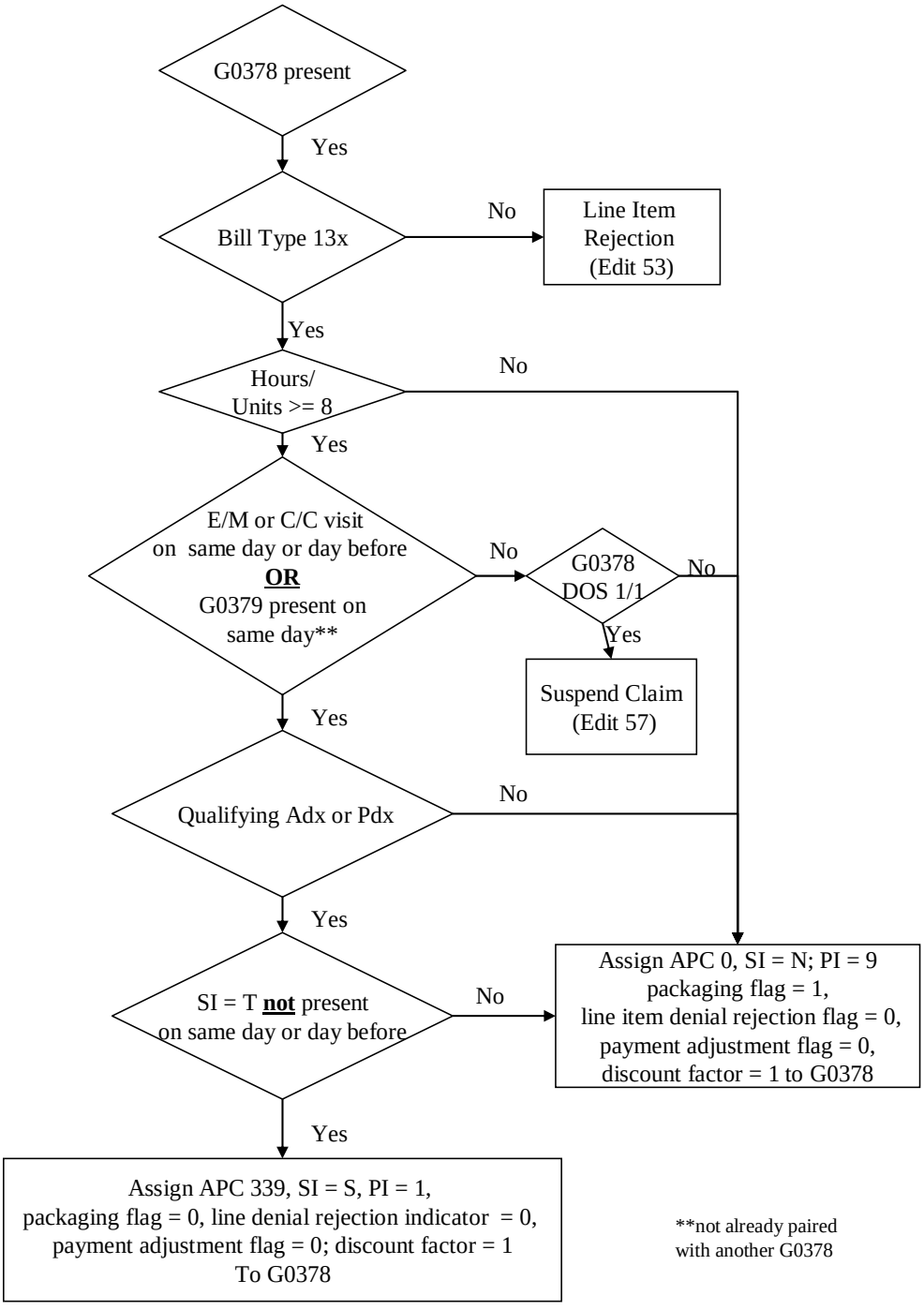
14. If there are multiple observations within the same time period and only one meets the criteria for separate APC payment, the observation with the most hours is considered to have met the criteria, and the other observations will be packaged.
15. Observation date is assumed to be the date admitted for observation.

16. The diagnoses (admitting or principal) required for the separately payable observation criteria are:

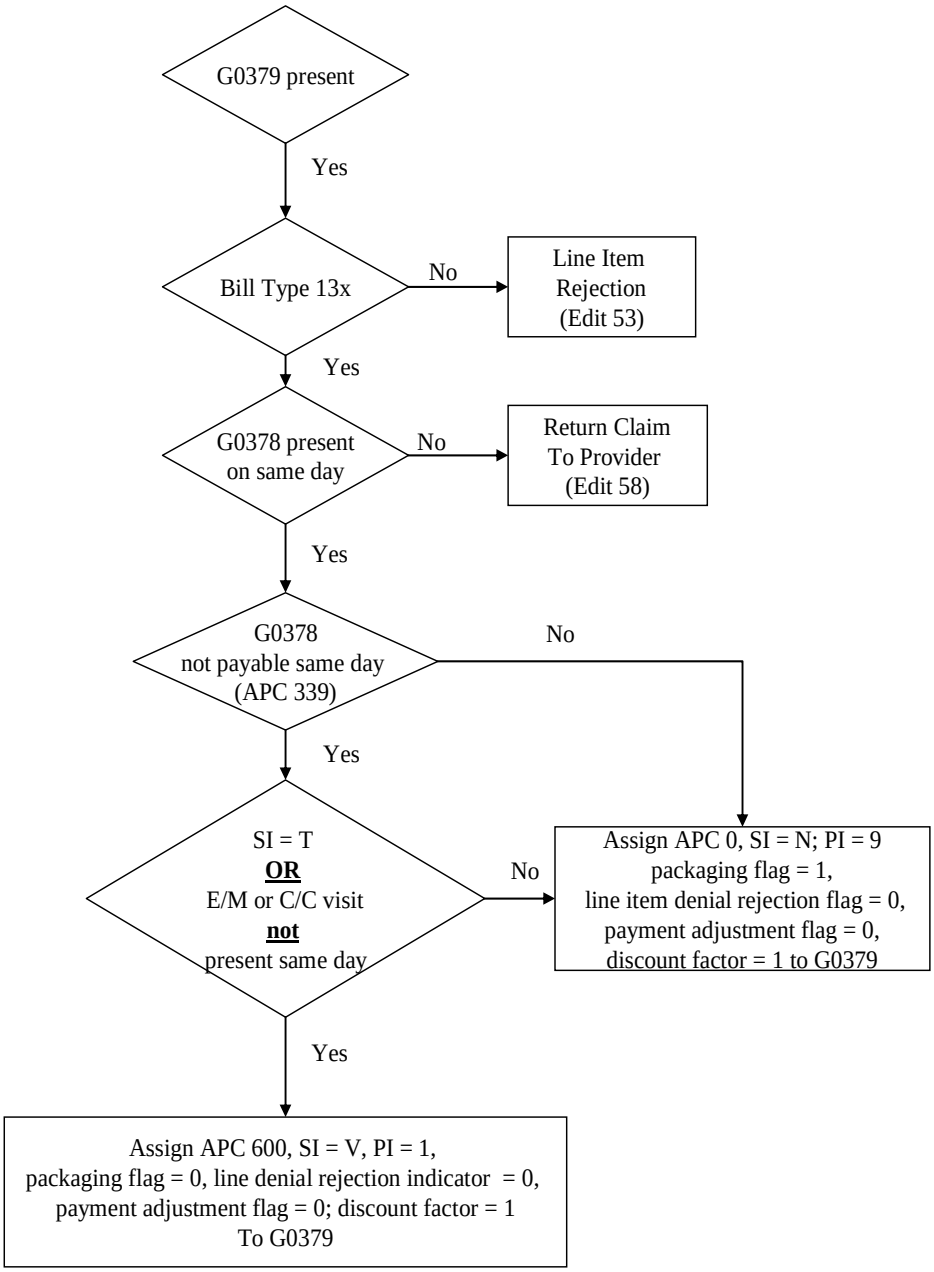
Chest Pain	Asthma	CHF
4110, 1, 81, 89	49301, 02, 11, 12, 21, 22, 91, 92	3918
4130, 1, 9		39891
78605, 50, 51, 52, 59		40201, 11, 91
		40401, 03, 11, 13, 91, 93
		4280, 1, 9, 20-23, 30-33, 40-43

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

Appendix H
OCE Observation Criteria (cont'd)

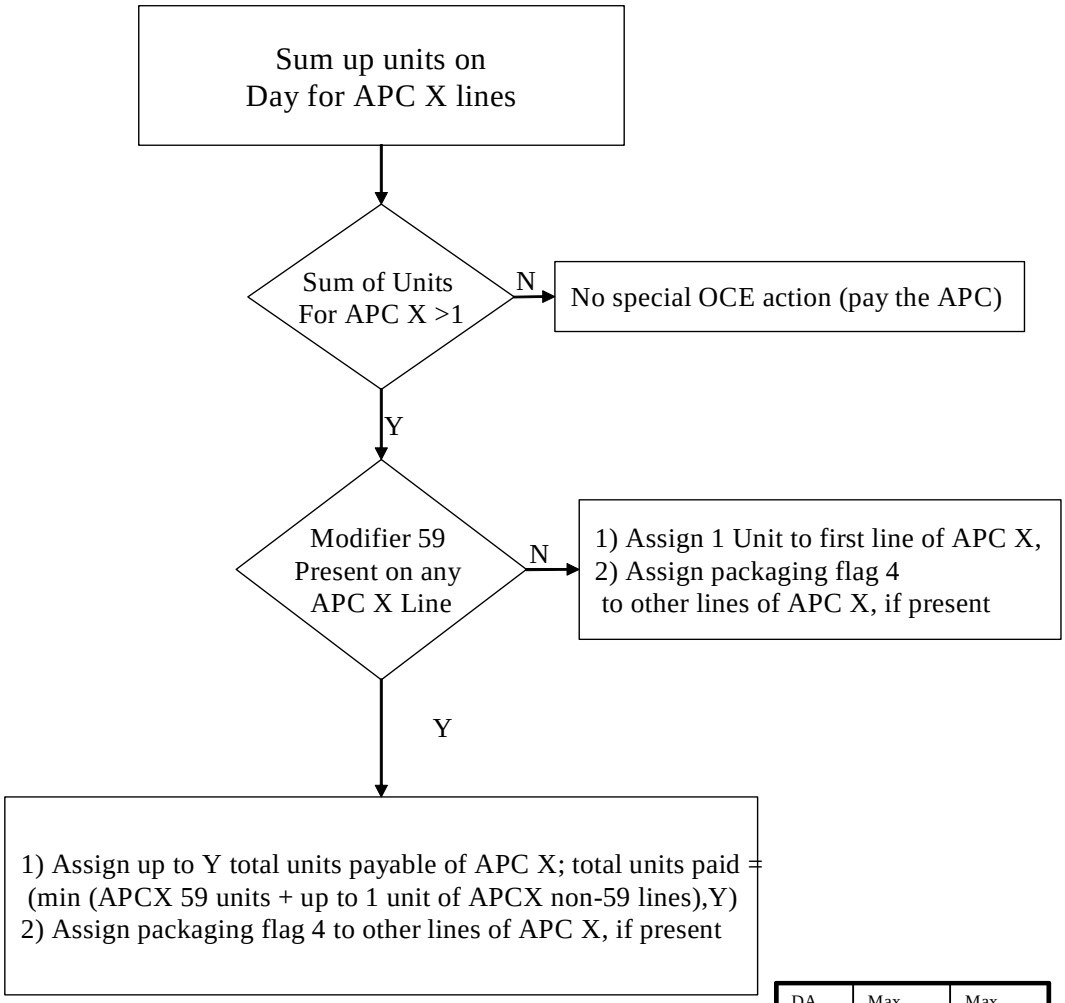


Appendix H (cont'd)
Direct Admission Logic



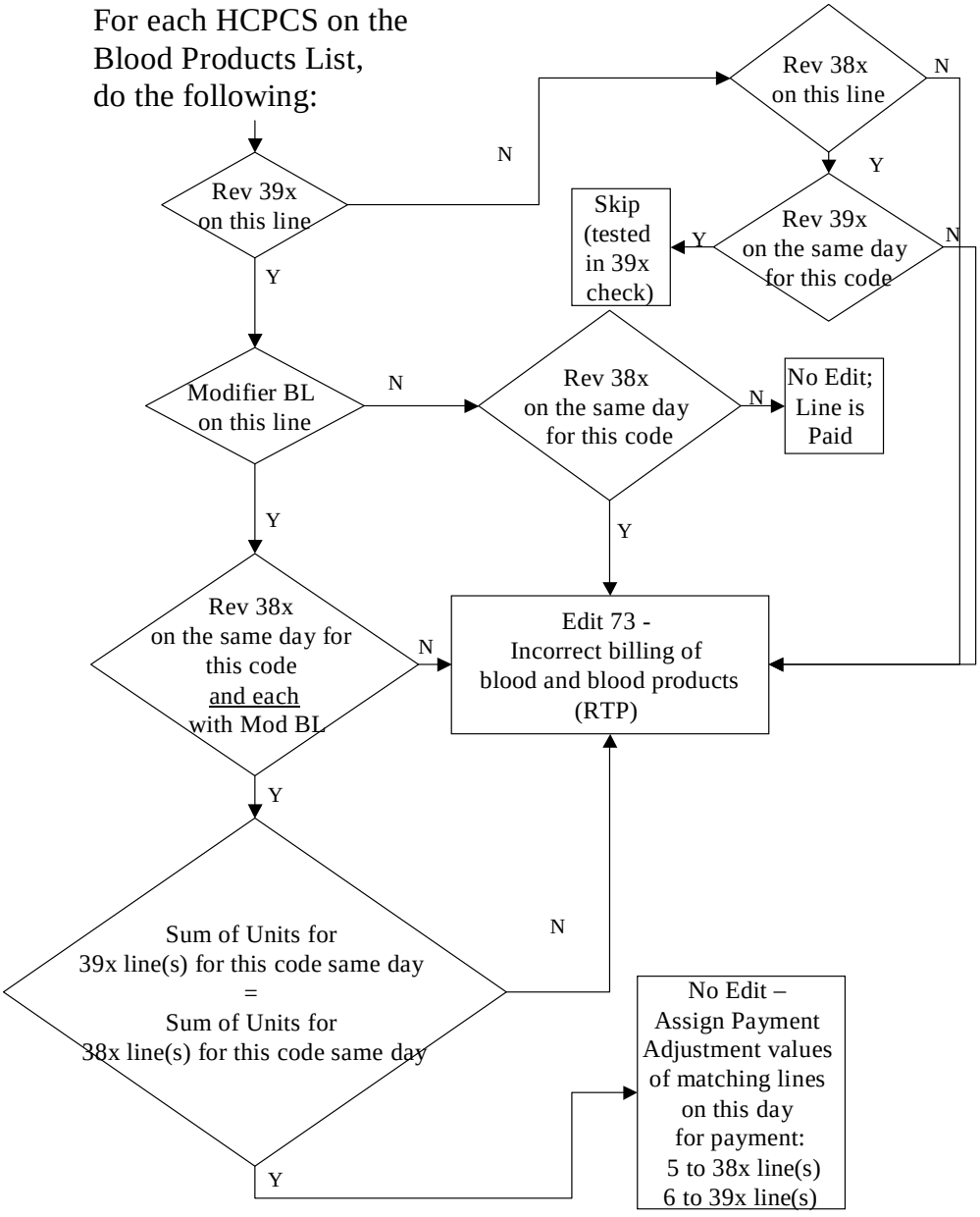
Appendix I
Drug Administration

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



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
Billing for blood/blood products



Appendix K
OCE overview

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

Payment APC	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, 20 and 21

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

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

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

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

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

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

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

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

Appendix L
Summary of Modifications

The modifications of the OCE/APC for the July 2006 release (V7.2) are summarized in the attached table. *Readers should also read through the specifications and note the highlighted sections, which also indicate change from the prior release of the software.*

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

	Mod. Type	**Effective Date**	**Edit**	
1.	Logic	**8/1/00**	17, 42	Modify the OCE program such that 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 A, B).
2.	Logic	**1/1/06**		Modify appendices E & F to remove CORFs (bill type 75x) from OPPS vaccine payment.
3.	Logic	7/1/06	48	Modify appendix F to bypass edit 48 for rev codes 0524, 0525, 0527, 0528
	Logic	**8/1/00**	48	Modify appendix F to bypass edit 48 for rev codes 0521, 0522
4	Logic	**1/1/06**	9	Modify the OCE program to change the SI from 'C' to 'E' for code 43842 when submitted from 2/21/06 – 3/31/06 … The SI will be changed in the OCE tables, effective 4/1/06)
5	Logic	**1/1/06**		Update appendix D to use the 'terminated procedure' discount formula (#3) for terminated non-type T procedures. [**Note**: The discount fraction (50%) is the same as formula #5, reimbursement calculation will yield the same outcome as terminated procedures always have units = 1]
6	Content			Make HCPCS/APC/SI changes, as specified by CMS.
7	Content	7/1/06	19,20, 39,40	Implement version **12.1** of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911); and the following Drug Admin code pairs: C8950-C8952, C8953-C8950,C8953-C8952,C8954-C8950, C8954-C8952,C8954-C8953.
8	Content	**8/1/00**	17	Reinstate Inherent Bilateral indicator **in the OCE** for codes 92002, 92004, 92012 and 92014.
9	Content	7/1/06	41	Add rev codes 0524, 0525, 0527, 0528 to the list of valid revenue codes (recognized by Medicare)
10	Documentation		38	Modify the description for edit 38 to include the administered substances (in addition to implanted devices) that have SI of 'H' and require an associated S, T or X procedure.
11	Documentation			Clarify description for Payment Indicators 5 and 6 to more accurately reflect how the associated payment is made (User request - p12): [**Note:** There is no change in the way reimbursement is made or calculated for the associated SIs] PI #5 – Paid standard amount for pass-through drug or biological (status indicator G). PI #6 – Payment based on charge adjusted to cost (status indicator H)
12	Documentation			Correct the criteria for applying standard OPPS payment calculations (p5) - include Payment indicator value '5' and Payment adjustment flag '1' in the qualifying criteria for standard APC payment. (User request)
13	Documentation			Modify the description of Payment adjustment flags '1' and '2' to be consistent with the descriptions of the associated Payment Indicators 5 and 6. (User request)
14	Documentation			Document the "Right justified, blank filled" format of the expanded Status Indicator, Payment Indicator and Payment adjustment flag fields in the APC Return Buffer. (User request – p12)
15	Documentation			Update the Overview in Appendix K to reflect the correct default values assigned for SI and PI. Status indicator "W" and payment indicator "3" replaced SI-A/PI-2 in v5.0 (1/1/04).

Final

Summary of Data Changes

OCE/APC v7.2

Effective July 1, 2006

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CPT codes, descriptions, and material only are Copyright 2005 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

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DEFINITIONS

- A blank in a field indicates ‘no change’

- The “old” column describes the attribute prior to the change being made in the current update, which is indicated in the “new” column. If the effective date of the change is the same as the effective date of the new update, ‘old’ describes the attribute up to the last day of the previous quarter. If the effective date is retroactive, then ‘old’ describes the attribute for the same date in the previous release of the software.

- “Unassigned”, “Pre-defined” or “Placeholder” in APC or HCPCS descriptions indicates that the APC or HCPCS code is inactive. When the APC or HCPCS code is activated, it becomes valid for use in the OCE, and a new description appears in the “new description” column, with the appropriate effective date.

- Activation Date (ActivDate) indicates the mid-quarter date of FDA approval for a drug, or the mid-quarter date of a new or changed code resulting from a National Coverage Determination (NCD). The Activation Date is the date the code becomes valid for use in the OCE. If the Activation Date is blank, then the effective date takes precedence.

- Termination Date (TermDate) indicates the mid-quarter date when a code or change becomes inactive. A code is not valid for use in the OCE after its termination date.

APC CHANGES

Added APCs

The following Apc(s) were added to the OCE/APC, **effective 07-01-06**

APC	APCDesc	StatusIndicator
09229	Injection ibandronate sodium	G
09230	Injection, abatacept	G

APC Description Changes

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

APC	Old Description	New Description
09119	Pentastarch 10% solution	Injection, pegfilgrastim 6mg
09164	Inj Gad-base MR contrast, ml	Inj Gad-base MR contrast,1ml
09165	Oral MR contrast, 100 ml	Oral MR contrast

HCPCS/CPT PROCEDURE CODE CHANGES

Added HCPCS/CPT Procedure Codes

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

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
3046F	Hemoglobin A1c level > 9.0%	M	00000	72		
3047F	Hemoglobin A1c level <= 9.0%	M	00000	72		
3048F	LDL-C <100 mg/dL	M	00000	72		
3049F	LDL-C 100-129 mg/dL	M	00000	72		
3050F	LDL-C >= 130 mg/dL	M	00000	72		
3076F	Syst bp < 140 mm hg	M	00000	72		
3077F	Syst bp > = 140 mm hg	M	00000	72		
3078F	Diast bp < 80 mm hg	M	00000	72		
3079F	Diast bp 80-89 mm hg	M	00000	72		
3080F	Diast bp >= 90 mm hg	M	00000	72		

The following new HCPCS/CPT code(s) were added to the OCE/APC, **effective 07-01-06**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
0012F	Cap bacterial assess	M	00000	72		
0155T	Lap ins gastr eltrd for mo	T	00130			
0156T	Lap redo gastr eltrd for mo	T	00130			
0157T	Opn ins gastr eltrd for mo	C	00000			
0158T	Opn redo gastr eltrd for mo	C	00000			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
0159T	Computer breast MRI add-on	N	00000			
0160T	Transcran mag stim planning	X	00340			
0161T	Transcran mag stim delivery	X	00340			
1015F	Copd symptoms assess	M	00000	72		
1018F	Assess dyspnea not present	M	00000	72		
1019F	Assess dyspnea present	M	00000	72		
1022F	Pneumo imm status assess	M	00000	72		
1026F	Co-morbid condition assess	M	00000	72		
1030F	Influenza imm status assess	M	00000	72		
1034F	Current tobacco smoker	M	00000	72		
1035F	Smokeless tobacco user	M	00000	72		
1036F	Tobacco non-user	M	00000	72		
1038F	Persistent asthma	M	00000	72		
1039F	Intermittent asthma	M	00000	72		
2010F	Vital signs recorded	M	00000	72		
2014F	Mental status assess	M	00000	72		
2018F	Hydration status assess	M	00000	72		
2022F	Dil retina exam interp rev	M	00000	72		
2024F	7 field photo interp doc rev	M	00000	72		
2026F	Eye image valid to dx rev	M	00000	72		
2028F	Foot exam performed	M	00000	72		
3006F	Cxr doc rev	M	00000	72		
3011F	Lipid panel doc rev	M	00000	72		
3014F	Screen mammo doc rev	M	00000	72		
3017F	Colorectal ca screen doc rev	M	00000	72		
3020F	Lvf assess	M	00000	72		
3021F	Lvef mod/sever deprs syst	M	00000	72		
3022F	Lvef >= 40% systolic	M	00000	72		
3023F	Spirom doc rev	M	00000	72		
3025F	Spirom fev/fvc<70% w copd	M	00000	72		
3027F	Spirom fev/fvc >=70% w/o copd	M	00000	72		
3028F	O2 saturation doc rev	M	00000	72		
3035F	O2 saturation <=88% /pa0 <=55	M	00000	72		
3037F	O2 saturation> 88% /pa0>55	M	00000	72		
3040F	Fev<40% predicted value	M	00000	72		
3042F	Fev>= 40% predicted value	M	00000	72		
3060F	Pos microalbuminuria rev	M	00000	72		
3061F	Neg microalbuminuria rev	M	00000	72		
3062F	Pos macroalbuminuria rev	M	00000	72		
3066F	Nephropathy doc tx	M	00000	72		
3072F	Low risk for retinopathy	M	00000	72		
4025F	Inhaled broncholidator rx	M	00000	72		
4030F	Oxygen therapy rx	M	00000	72		
4033F	Pulmonary rehab rec	M	00000	72		
4035F	Influenza imm rec	M	00000	72		
4037F	Influenza imm order/admin	M	00000	72		
4040F	pneumoc imm order/admin	M	00000	72		
4045F	Empiric antibiotic rx	M	00000	72		
4050F	Ht care plan doc	M	00000	72		
6005F	Care level rationale doc	M	00000	72		
C9229	Injection ibandronate sodium	G	09229	55		

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
C9230	Injection, abatacept	G	09230	55		
K0733	12-24hr sealed lead acid	Y	00000	61		
K0734	Adj skin pro w/c cus wd<22in	Y	00000	61		
K0735	Adj skin pro wc cus wd>=22in	Y	00000	61		
K0736	Adj skin pro/pos wc cus<22in	Y	00000	61		
K0737	Adj skin pro/pos wc cus>=22"	Y	00000	61		
K0738	Matt, hospital bed	Y	00000	61		
K0739	Matt, hvy duty hospital bed	Y	00000	61		
K0740	Side rails, hospital bed	Y	00000	61		

Deleted HCPCS/CPT Procedure Codes

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

HCPCS	CodeDesc
C8892	Predefined New Device Tech
C8893	Predefined New Device Tech
C8894	Predefined New Device Tech
C8895	Predefined New Device Tech
C8896	Predefined New Device Tech
C8897	Predefined New Device Tech
C8898	Predefined New Device Tech
C8899	Predefined New Device Tech

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

HCPCS	CodeDesc
Q3019	ALS emer trans no ALS serv
Q3020	ALS nonemer trans no ALS ser

HCPCS Description Changes

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

HCPCS	Old Description	New Description
4009F	Ace inhibitor therapy rx	ACE/ARB inhibitor therapy Rx

The following code descriptions were changed, **effective 07-01-06**

HCPCS	Old Description	New Description
1000F	Tobacco use, smoking, assess	Tobacco use assessed
J1945	Lepirudin	Lepiridin

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

The following code(s) had an APC and/or SI and/or edit change, **effective 08-01-00** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
81099	Urinalysis test procedure	00000	00342	A	X		
84999	Clinical chemistry test	00000	00342	A	X		
85999	Hematology procedure	00000	00342	A	X		
86849	Immunology procedure	00000	00342	A	X		
87999	Microbiology procedure	00000	00342	A	X		
99000	Specimen handling			B	E	13	28
99001	Specimen handling			B	E	13	28
L3260	Ambulatory surgical boot eac			B	E	14	28

The following code(s) had an APC and/or SI and/or edit change, **effective 10-01-00** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
81099	Urinalysis test procedure	00349	00342				
84999	Clinical chemistry test	00349	00342				
85999	Hematology procedure	00349	00342				
86849	Immunology procedure	00349	00342				
87999	Microbiology procedure	00349	00342				
88199	Cytopathology procedure	00349	00342				
88399	Surgical pathology procedure	00349	00342				

The following code(s) had an APC and/or SI and/or edit change, **effective 04-01-02** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
88199	Cytopathology procedure	00000	00342	A	X		
88399	Surgical pathology procedure	00000	00342	A	X		

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

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
61793	Focus radiation beam			E	B	28	62
76093	Magnetic image, breast			E	B	28	62
76094	Magnetic image, both breasts			E	B	28	62
89240	Pathology lab procedure	00000	00342	A	X		
G0124	Screen c/v thin layer by MD			A	B	N/A	62
G0141	Scr c/v cyto,autosys and md			E	B	13	62

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-05** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
37216	Transcath stent, cca w/o eps			C	E	N/A	9

The following code(s) had an APC and/or SI and/or edit change, **effective 07-01-05** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
Q4080	Iloprost inhalation solution			B	Y	62	61

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

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0001F	Heart failure composite			E	M	28	72

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0005F	Osteoarthritis composite			E	M	28	72
0500F	Initial prenatal care visit			E	M	28	72
0501F	Prenatal flow sheet			E	M	28	72
0502F	Subsequent prenatal care			E	M	28	72
0503F	Postpartum care visit			E	M	28	72
1000F	Tobacco use, smoking, assess			E	M	28	72
1001F	Tobacco use, non-smoking			E	M	28	72
1002F	Assess anginal symptom/level			E	M	28	72
1003F	Level of activity assess			E	M	28	72
1004F	Clin symp vol ovrld assess			E	M	28	72
1005F	Asthma symptoms evaluate			E	M	28	72
1006F	Osteoarthritis assess			E	M	28	72
1007F	Anti-inflm/anlgsc otc assess			E	M	28	72
1008F	Gi/renal risk assess			E	M	28	72
2000F	Blood pressure measure			E	M	28	72
2001F	Weight record			E	M	28	72
2002F	Clin sign vol ovrld assess			E	M	28	72
2003F	Auscultation heart perform			E	M	28	72
2004F	Initial exam involved joints			E	M	28	72
3000F	Blood press </= 140/90 mmhg			E	M	28	72
3002F	Blood pressure > 140/90 mmhg			E	M	28	72
4000F	Tobacco use txmnt counseling			E	M	28	72
4001F	Tobacco use txmnt, pharmacol			E	M	28	72
4002F	Statin therapy, rx			E	M	28	72
4003F	Pt ed write/oral, pts w/ hf			E	M	28	72
4006F	Beta-blocker therapy rx			E	M	28	72
4009F	Ace inhibitor therapy rx			E	M	28	72
4011F	Oral antiplatelet therapy rx			E	M	28	72
4012F	Warfarin therapy rx			E	M	28	72
4014F	Written discharge instr prvd			E	M	28	72
4015F	Persist asthma medicine ctrl			E	M	28	72
4016F	Anti-inflm/anlgsc agent rx			E	M	28	72
4017F	Gi prophylaxis for nsaid rx			E	M	28	72
4018F	Therapy exercise joint rx			E	M	28	72
61630	Intracranial angioplasty			B	E	62	28
61635	Intracran angioplsty w/stent			B	E	62	28
61640	Dilate ic vasospasm, init			B	E	62	28
61641	Dilate ic vasospasm add-on			B	E	62	28
61642	Dilate ic vasospasm add-on			B	E	62	28
99000	Specimen handling			B	E	62	28
99001	Specimen handling			B	E	62	28
G0141	Scr c/v cyto,autosys and md			E	B	28	62

The following code(s) had an APC and/or SI and/or edit change, **effective 04-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
43842	V-band gastroplasty			C	*E	N/A	9
G9041	Low vision rehab occupationa			B	A	62	N/A
G9042	Low vision rehab orient/mobi			B	A	62	N/A

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
G9043	Low vision lowvision therapi			B	A	62	N/A
G9044	Low vision rehabilate teache			B	A	62	N/A

*For HCPC code 43842, the change of SI = E is effective 2/21/06

The following code(s) had an APC and/or SI and/or edit change, **effective 07-01-06** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
20979	Us bone stimulation	00000	00340	B	X	62	N/A
E0250	Hosp bed fixed ht w/ mattres			Y	E	61	28
E0251	Hosp bed fixd ht w/o mattres			Y	E	61	28
E0255	Hospital bed var ht w/ mattr			Y	E	61	28
E0256	Hospital bed var ht w/o matt			Y	E	61	28
E0260	Hosp bed semi-electr w/ matt			Y	E	61	28
E0261	Hosp bed semi-electr w/o mat			Y	E	61	28
E0265	Hosp bed total electr w/ mat			Y	E	61	28
E0266	Hosp bed total elec w/o matt			Y	E	61	28
E0271	Mattress innerspring			Y	E	61	28
E0272	Mattress foam rubber			Y	E	61	28
E0290	Hosp bed fx ht w/o rails w/m			Y	E	61	28
E0292	Hosp bed var ht w/o rail w/o			Y	E	61	28
E0294	Hosp bed semi-elect w/ mattr			Y	E	61	28
E0296	Hosp bed total elect w/ matt			Y	E	61	28
E0303	Hosp bed hvy dty xtra wide			Y	E	61	28
E0304	Hosp bed xtra hvy dty x wide			Y	E	61	28
E0305	Rails bed side half length			Y	E	61	28
E0310	Rails bed side full length			Y	E	61	28
E2291	Planar back for ped size wc			E	Y	28	61
E2292	Planar seat for ped size wc			E	Y	28	61
E2293	Contour back for ped size wc			E	Y	28	61
E2294	Contour seat for ped size wc			E	Y	28	61

Units of Service Changes

The following code(s) were assigned to the following "units of service", **effective 01-01-06**

HCPCS	Old Max Units	New Max Units
G0379	0	2

Edit Assignments

The following code(s) were added to the conditional bilateral list, **effective 01-01-06**

HCPCS
27165

HCPCS
50387
50592

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

HCPCS
92002
92004
92012
92014

Procedure/ Device Pair Changes

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

Proc	Device1
33206	C1785
33206	C2619
33207	C1785
33207	C2619

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

Proc	Device1
50387	C2625

REVENUE CODES

Added Revenue Codes

The following revenue code(s) were added to the list of valid revenue codes, **effective 07-01-06**

RevenueCode	SI
0524	B
0525	B
0527	B
0528	B

Revenue Code Status Indicator Changes

The following revenue code(s) had Status Indicator changes, **effective 08-01-00**

RevenueCode	Old SI	New SI
0521	E	B
0522	E	B