1 Integrated OCE (IOCE) CMS Specifications V20.2

Effective 07/01/2019

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2 Summary of Quarterly Release Modifications

The modifications of the IOCE for the **July 2019 V20.2** release is 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 be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

Item #	Type	Effective Date	Edits Affected	Modification
1	Logic	7/1/2019	24	Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. The earliest date included for this release is 10/1/2012.
2	Logic	**10/1/2012**	6	Implement logic to return edit 6 if an invalid procedure code is submitted on a 770-bill type.
3	Logic	**10/1/2012**	48, 9	Update the valid revenue table and apply conditions for revenue code 760 to bypass edit 48 and instead apply edit 9, if a blank HCPCS is submitted using this revenue code.
4	Logic	**1/1/2018**	41	Update the effective date for the following revenue codes: 870, 871, 872, 873, 874, 875, and 891
5	Logic	**1/1/2018**	111	Implement new edit 111: Service cost is duplicative; included in cost of associated biological. (LIR) Edit Criteria: A claim is submitted with a procedure (HCPCS) identified as being bundled into the cost of a biological or a blank HCPCS is submitted with revenue code 870, 871, 872, or 873 (Cell/Gene Therapy). See Special Processing of Drugs and Biologicals logic section.
6	Logic	**1/1/2019**		Implement logic to allow certain wound care services identified as being *"sometimes therapy"* to be excluded from comprehensive APC packaging if the conditions are present for changing the SI to A. See logic sections "Sometimes Therapy Processing for Wound Care Services" and Comprehensive APC Assignment Criteria for more information.
7	Logic	7/1/2019		*Add new Input Payer Value Code:* QA: Offset for combining partial PHP week on interim PHP claim (passed to the IOCE) *Add new Payer Condition Code:* MV: Second portion of combined PHP week is not 20 hours (Calculated by the IOCE) MW: First portion of combined PHP week is not 20 hours (passed as input to the IOCE)
8	Logic	7/1/2019		Update effective date of Value Code and Value Code Amount QW 000000000 to return if an interim Partial Hospitalization Program claim has a partial week present. (July 1, 2019)
9	Logic	7/1/2019		Implement logic to accept Payer Value Code and Value Code Amount QA 000000000 on input to identify that the previous Partial Hospitalization Program (PHP) claim had a partial last week that needs to be combined into the first week of the processing claim to calculate one full week of services (7 days). The Value Code Amount represents the amount of days and hours of PHP services that were on the previous claims partial last week. See Partial Hospitalization Logic section for more information.
10	Logic	7/1/2019	95	Implement logic to return Payer Condition Code MV if the combined partial weeks (first and second portion equal 7 days) is not 20 hours. Note: MV is returned on the second interim claim based on the input of Payer Value Code and Value Code Amount QA 000000000. Additionally, line items submitted on the second portion of the combined PHP week return edit 95 if the combined week is not 20 hours. See Partial Hospitalization Logic section for more information.
11	Logic	7/1/2019	95	Implement logic to accept Condition Code MW on input, indicating that after combining the partial weeks together, 20 hours of services are not provided, and the first portion of the combined week needs editing. All line items associated with the partial last week on the initial claim return edit 95. See Partial Hospitalization Logic section for more information.
12	Logic	7/1/2019		Update logic to return Payer Condition Code MQ if an admission to discharge claim (761 or 131 CC 41) or an interim to discharge claim (764 or 134 CC 41) is submitted and the last 7- day week on the claim is not 20 hours. See Partial Hospitalization Logic section for more information.

Item #	Type	Effective Date	Edits Affected	Modification
13	Documentation	7/1/2019		Update description of Claim Processed Flag value of 4 4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted; exit immediately.
14	Content	7/1/2019		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files). - Add-on Type I (edit 106) - Add-on Type II (edit 107) - Comprehensive APC rank and list update - Device and Device Procedure lists (edit 92) - Terminated Device Procedure for offset APC - Edit 99 Exclusions list - FQHC Flu PPV list - FQHC Non-Covered list - Skin Substitute Hi and Low-Cost lists (edit 87) - Not recognized by OPPS (edit 62) - Valid Revenue Code list (edit 41)
15	Content	7/1/2019	20, 40	Implement version 25.2 of the NCCI (as modified for applicable outpatient institutional providers).
16	Other	7/1/2019		Create 508-compliant versions of the Specifications, Summary of Data Changes and File Layout documents for publication on the CMS web site. Provide MF and PC IOCE software and supporting quarterly data file reports for publication on the CMS web site.
17	Other	7/1/2019		Deliver quarterly software update and all related documentation and files to users via electronic download.

3 Introduction to the IOCE

3.1 IOCE Processing

This 'integrated' OCE (IOCE) 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 Medicare Administrative Contractor (MAC) identify the claim as 'OPPS' or 'Non-OPPS' by passing a flag to the IOCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

This version of the IOCE processes claims consisting of single or multiple days of service. The IOCE performs two major functions:

1. Edit the data to identify errors and return a series of edit flags.
2. 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. For Non-OPPS claims an APC is not assigned, instead a series of Non-OPPS applicable edits are returned.

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

The IOCE 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 IOCE 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 IOCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers and ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for historical claims with From Dates prior to 10/1/2015). Since these coding systems are complex, the centralization of the direct reference to these codes and modifiers in a single program reduces effort and reduces the chance of inconsistent processing.

The span of time that a claim represents is controlled by the **From** and **Through** dates that are part of the input header information. If the claim spans more than one calendar day, the IOCE subdivides 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.

All institutional outpatient claims, regardless of facility type, process through the Integrated Outpatient Code Editor (IOCE); however, not all edits are performed for all sites of service or types of claim. Table 6.3 contains IOCE edits that apply for each bill type under OPPS processing; Table 6.4 contains OCE edits that apply to claims from hospitals not subject to OPPS.

3.2 Contractor (MAC) Actions Impacting IOCE Processing

The Medicare Administrative Contractor may on occasion require an override or bypass of IOCE grouping or editing results, to apply payment adjustment outside of the IOCE process or for reprocessing OPPS/ Non-OPPS adjusted claims. This may be accomplished by the following actions which may only be applied by the MAC; these actions are not meant to be input by an end-user or provider.

1. Line Item Action Flag: A value passed as input to the IOCE to override a line item denial or rejection or to allow the MAC to indicate the line item should be denied or rejected, even if no IOCE edits are present. **Note:** If a Line item action flag is present on any line item that also contains a contractor bypass, the line item action flag logic takes precedence and no contractor bypass is applied to the line.
2. Contractor Bypass: Values passed as input to bypass IOCE edits and any payment value which may need adjusted by the MAC for payment determination. The presence of an IOCE edit in the Contractor Bypass edit field allows the bypass to execute as defined by the contractor. **Note:** A line level edit bypass for an OPPS claim requires all contractor bypass fields to be provided on input while a claim level edit bypass requires only the contractor bypass edit field to be populated. A Non-OPPS claim with either a line level or claim level edit only require the edit to be populated in the contractor bypass edit field. Any line item with a contractor bypass applied returns a payment method flag of Z to indicate that the line(s) payment is set by the Contractor.

3.3 Record Input

Information is passed to the IOCE by means of a control block of pointers which is described in the IOCE Control Block Table. Multiple items are assumed to be in contiguous locations. The input for each line item contains the information described in the Line Item Input Information Table

3.3.1 Line Item Input Information Table

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	May be blank; up to 5, 2-character modifiers allowed per single line item; validated in the order received
Service date	45	1	8	Required for all lines
Revenue code	42	1	4	Required for all lines
Service units	46	1	9	A blank or zero value is defaulted to 1
Charge	47	1	10	Used by PRICER to determine outlier payments
Contractor bypass edit(s)	n/a	4	12	4 occurrences of 3-byte alphanumeric characters allowed per single line item (12 bytes total); right-justified, zero-filled, default value per occurrences is ‘000’
CB payment APC	n/a	1	5	Numeric; right-justified, zero-filled, default: ‘00000’
CB Status Indicator	n/a	1	2	Alphanumeric; right-justified, zero-filled, default: ‘00’ **NOTE:** if the SI reported has only one character it must be provided with a leading blank value ex. " bA" "_A"
CB Payment Indicator	n/a	1	2	Numeric; right-justified, zero-filled, default: ‘00’
CB Discounting Formula Number	n/a	1	1	Numeric; zero-filled, default: ‘0’
CB Line Item Denial or Rejection Flag	n/a	1	1	Numeric; zero-filled, default: ‘0’
CB Packaging Flag	n/a	1	1	Numeric; zero-filled, default: ‘0’
CB Payment Adjustment Flag	n/a	1	2	Numeric; right-justified, zero-filled, default: ‘00’
CB Payment Method Flag	n/a	1	1	Alphanumeric; zero-filled, default: ‘0’

3.3.2 IOCE Control Block Table

Pointer Name	Pointer Description	UB-04 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for historical claims with from dates prior to 10/1/2015)	70 a-c (Pt's rvdx) 67 (pdx) 67A-Q (sdx)	Up to 28	8 (7 for code, 1 for POA flag)	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First three listed diagnoses are considered 'patient's reasons for visit dx', fourth diagnosis is considered 'principal dx'
Sgptr	Line item entries	42, 44-47	Up to 450	**73**	Table 3.1.1
Flagptr	Line item action flag Flag set by MAC and passed by OCE to Pricer	n/a	Up to 450	1	Used to bypass editing
Ageptr	Numeric age in years	n/a	1	3	0-124
Sexptr	Numeric sex code	11	1	1	0, 1, 2 (unknown, male, female)
Dateptr	From and Through dates (yyyymmdd)	6	2	8	Used to determine multi-day claim
CCptr	Condition codes	18-28	Up to 30	2	Used to identify special circumstances impacting grouping results.
Billptr	Type of bill	4 (Pos 2-4)	1	3	Used to identify claims with bill types for special processing. It is presumed that bill type has been edited for validity by the Standard System before the claim is sent to IOCE.
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	n/a	1	1	1=OPPS, 2=Non-OPPS (A blank, zero or any other value is defaulted to 1)
OccPtr	Occurrence codes	31-34	Up to 30	2	For MAC use
VCAMTptr	Value codes and value code amounts	39-41	Up to 36	11	2-character Value Code followed by amount (nnnnnnn.nn*) zero-filled right justified **Note:** Value Code QA is provided on input and the value code amount provided should zero-fill the first 4 values, the next 5 values represent an IOCE calculated amount for total days and hours of PHP services. One byte for days and 4 bytes to record full and partial hours. For example, 2 days and 8 and ½ hours converts to the following value code amount 000020850. QA: Offset for combining partial PHP week on interim PHP claim
Dxeditptr	Diagnosis edit return buffer	n/a	Up to 28	Table 6.1.2	Diagnosis edits returned
Proceditptr	Procedure edit return buffer	n/a	Up to 450	Table 6.1.2	Procedure edits returned
Mdeditptr	Modifier edit return buffer	n/a	Up to 450	Table 6.1.2	Modifier edits returned
Dteditptr	Date edit return buffer	n/a	Up to 450	Table 6.1.2	Date edits returned
Rceditptr	Revenue code edit return buffer	n/a	Up to 450	Table 6.1.2	Revenue code edits returned
APCptr	APC return buffer	n/a	Up to 450	Table 7.1.2	APC detail returned
Claimptr	Claim return buffer	n/a	1	Table 7.1.1	Claim detail returned
Wkptr	Work area pointer	n/a	1	1.25 MB	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by Wkptr	n/a	1	4	Binary full word

3.4 Component Initialization

The following example references the required values needed to initialize the component. On the following page is a flowchart of the execution and processing of the IOCE component.

Note: If the 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.

1. 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:

APC Return Buffer, Default Values

APC Return Buffer Item	Default Value
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, 25 and 26
Composite adjustment flag	00

2. 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.

Revenue Code with No HCPCS Code Example 1.

APC Return Buffer Item	Default list value	Default list value	Default list value	Default list value
Line item	N-list	E/E1-list	B-list	F-list
HCPCS APC	00000	00000	00000	00000
Payment APC:	00000	00000	00000	00000
Status Indicator:	N	E or E1	B	F
Payment Indicator	9	3	3	4
Packaging flag:	1	0	0	0

3. 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:

Revenue Code with No HCPCS Code Example 2.

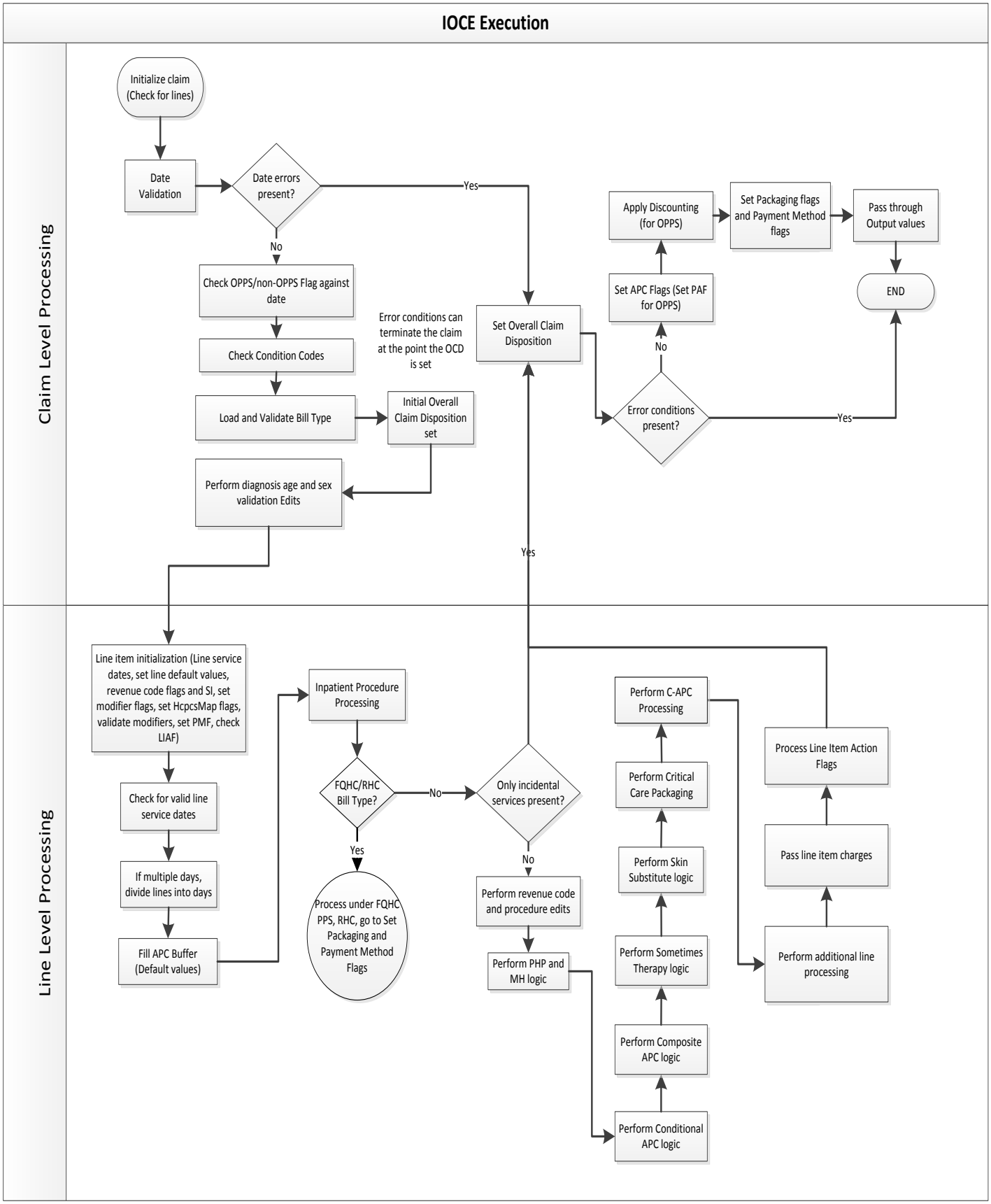
APC Return Buffer Item	Default Value
HCPCS APC	00000
Payment APC:	00000
Status Indicator:	Z
Payment Indicator	3
Packaging flag:	0

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

Invalid HCPCS or Invalid Revenue Code

APC Return Buffer Item	Default Value
HCPCS APC	00000
Payment APC:	00000
Status Indicator:	W
Payment Indicator	3
Packaging flag:	0

3.4.1 IOCE Execution and Processing Flowchart



4 Processing that Applies to Both OPPS and Non OPPS Claims

4.1 National Correct Coding Initiative (NCCI) Edits

The IOCE generates NCCI edits for OPPS and Non OPPS Facilities. All applicable NCCI edits are incorporated into the IOCE. Modifiers and coding pairs in the IOCE may differ from those in the NCCI because of differences between facility and professional services.

Effective January 1, 2006, NCCI edits apply to ALL services billed under bill types 12x, 13x, 14x, 22x, 23x, 34x, 72x, 74x, 75x,76x, and 85x by the following providers: Skilled Nursing Facilities (SNFs), ESRD facilities (ESRDs), Community Mental Health Clinics (CMHCs), Outpatient Physical Therapy and Speech-Language Pathology Providers (ORFs), CORFs, Home Health Agencies (HHAs), and Critical Access Hospitals (CAHs).

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

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

All institutional outpatient claims, regardless of facility type, process through the Integrated Outpatient Code Editor (IOCE); however, not all edits are performed for all sites of service or types of claim. Please see the Edits by Bill Type (OPPS=1) table, which contains IOCE edits that apply for each bill type under OPPS processing; please see the Edits by Bill Type (Non-OPPS=2) table, which contains OCE edits that apply to claims from hospitals not subject to OPPS.

Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have NCCI editing applied across facility and professional services appearing on the same day; NCCI editing is applied for the professional services separately from facility services

4.2 Add-On Code Editing

Effective April 1, 2018 (v19.1), claims with certain bill-types are subject to add-on code edits if the primary procedure for the add-on code is not present on the same day or day before. Add-on codes describe procedures or services that are always provided "in addition to" other, related services or procedures. These add-on procedure codes cannot be reported stand alone as separately reportable services. One add-on code may have multiple primary procedures with which it can be reported. In addition, there may be circumstances where reporting multiple add-on procedure codes are necessary, and in this instance the primary procedure for both add-ons must be present on the day of or day before. There are three different types of add-on codes defined by CMS for which the IOCE returns an edit(s) if the conditions to satisfy the edit(s) are not met.

1. Type I add-on codes have a defined list of primary procedure codes. If one or multiple Type I add-on codes are reported without their primary procedure edit 106 is returned on the add-on procedure line(s) and line item denied (LID).
2. Type II add-on codes do not have a defined list of primary procedures; individual contractors must define the list of primary procedure codes for Type II add-on codes. Type II add-on code editing in the IOCE is applied only to Critical Access Hospitals (bill type 85x) reporting professional services revenue codes (96x, 97x or 98x). Edit 107 is returned on all Type II add-on procedure line(s) for contractor review (LID).
3. Type III add-on codes have defined primary procedures but there may be additional contractor defined primary procedures. Type III add-on codes act the same as Type I in how the edit is applied, with edit 108 (LID).

Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have add-on code editing applied across facility and professional services; add on code editing is applied for the professional services separately from facility services.

See Edit Description and Reason for Edit Generation Table for edit information as well as Edits by Bill Type Table [Non-OPPS] to view what bill types are applicable to Add on Editing.

5 Processing Conditions Applied to OPPS Claims Only

5.1 Medical Visit Processing

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 result in additional payments. Modifier 25 reported 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 applies and the claim is returned to the provider.

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

5.1.1 Multiple Medical Visit Conditions

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, one in the morning and one in the afternoon, and/or two visits to the ER, one in the morning for a fractured arm and one later in the day for chest pain).

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

5.2 Computation of Discounting Fraction

There are nine different discount formulas that can be applied to a line item:

D = Discounting Fraction (Currently 0.5)
U = Number of Units
T = Terminated Procedure Discount (Currently 0.5)

1. 1.0
2. (1.0 + D(U-1))/U
3. T/U
4. (1 + D)/U
5. D
6. TD/U *[Discontinued 1/1/2008, v9.0]*
7. D(1 + D)/U *[Discontinued 1/1/2008, v9.0]*
8. 2.0
9. 2D

Note: Formula six and seven are discontinued and replaced with formula 3 and 9.

5.2.1 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 is not multiple procedure discounted, and all other "T" line items are multiple procedure discounted. All line items that do not have a status indicator of "T" are 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 is also 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 are 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 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, are ignored in determining the discount; packaged line items, (the packaging flag is not zero or 3), is also ignored in determining the discount. The discounting process utilizes an APC payment amount file. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

Note: There may be some procedure codes that have a SI value assigned that differs from the APC SI (for example, HCPCS SI = T, but APC SI =S). In these circumstances, the discounting formula is assigned based on the HCPCS SI; the APC with the highest payment rate (if multiple 'T' procedures are present) although having a different SI, is used to determine the discounted amount for the multiple procedures that may be present.

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

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, or a comprehensive APC, the modifier is ignored in assigning the discount formula.

5.2.1.1 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

5.2.2 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.

5.2.2.1 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 Discount Formulas applied to non-type T procedures: If not terminated, non-type T Conditional bilateral procedures with modifier 50 are assigned discount formula eight; non-type T Independent bilateral procedures with modifier 50 are also assigned to formula eight (*8).

5.3 Inpatient Procedure Processing (Through v16.3)

Through IOCE version 16.3, for outpatients who undergo inpatient-only procedures on an emergency basis 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 (procedure payable inpatient) 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 (edit 60). 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 (edit 70). See also Inpatient Procedure Processing under Comprehensive APCs for processing logic (v17.0-Current).

5.4 Conditional APC Processing

5.4.1 Processing Procedures with Status Indicators of Q1 and Q2

Effective January 1, 2017 (v18.0), conditional APC assignment and packaging discussed in this section for procedures with SI = Q1 or Q2 are executed across the claim if multiple service dates are present, and not by individual date of service. References noted as processed by day are to be considered for claims with From Dates prior to January 1, 2017. Procedure codes with SI of Q1 or Q2 are packaged when they appear with other specified services on the same day or claim; however, they may be assigned to a payable SI and APC and paid separately if there are no other specified services on the same day or claim. Procedures with SI = Q1 are packaged in the presence of any payable procedure code with SI of S, T, or V (and through version 15.3, SI = X). Procedures with SI = Q2 are packaged only in the presence of payable codes with SI = T or effective with version 16.0, J1. The SI is changed from Q1 or Q2 to N for packaging if present with other payable services, or to the standard SI and APC specified for the code when separately payable. If there are multiple Q1 or Q2 procedures on a specific date or claim and no service with which the codes would be packaged on the same date or claim, the Q1/Q2 code assigned to the APC with the highest payment rate is paid and all other codes are packaged. If a procedure with SI = Q1 or Q2 has been previously packaged (SI = N) prior to the execution of the conditional APC processing logic, the packaged Q1 or Q2 is ignored from the selection as the service with the highest paying APC payment rate. Additionally, procedures with SI = Q1 or Q2 that are packaged with SI = N under conditional APC processing logic are not evaluated in any subsequent processing (e.g. composite or comprehensive APC processing).

There are several codes with SI = Q2 that may resolve to a final SI of J1 (comprehensive APC procedure) if they are present with no other payable procedures. In the event this occurs, the Q2 procedure is not subject to comprehensive APC procedure ranking or complexity adjustment, but all other comprehensive APC packaging and exclusion processing is applied.

In the execution of conditional APC processing logic, which occurs prior to the composite APC logic, procedure codes with SI of Q3 (composite candidates) that may be present with Q1 or Q2 procedures are evaluated as payable procedures using the standard SI associated with the Q3 procedure's standard APC.

If a Q1 or Q2 procedure is an independent or conditional bilateral code with modifier 50 and resolves to a standard SI and APC assignment (i.e. not packaged), the modifier is ignored in assigning the discount formula.

Procedures with SI = Q1 or Q2 that are denied or rejected are not included in any subsequent conditional packaging logic, and the default SI (Q1, Q2) is retained as the final SI. If codes with SI of Q1 or Q2 that are denied or rejected are present with other non-denied/rejected Q1 or Q2 codes, if no other payable procedure is present, the non-denied/rejected Q1 or Q2 codes are evaluated and processed for separate payment. There is an exception if Line Item Action Flag = 1 is assigned to the line; the denial or rejection is ignored, and the line is included in subsequent conditional packaging logic, from which the final SI is determined.

Service units are reduced to 1 for any line where an SI of Q1 or Q2 is changed to a separately payable SI and APC and Payment Adjustment Flag 11 is assigned. The reduction of units for procedures designated as sometimes therapy that may have default SI assignment of Q1 or Q2 does not occur if the reporting of the sometimes therapy service under a therapy plan of care results in final assignment of SI = A.

5.4.2 Sometimes Therapy Processing for Wound Care Services

Certain wound care services considered "sometimes therapy" may be paid an APC rate or from the Physician Fee Schedule, depending on the circumstances under which the service was provided. The IOCE changes the status indicator to A and removes the APC assignment when sometimes therapy codes are appended with therapy modifiers (GP for physical therapy, GO for occupational therapy, or GN for speech language pathology) or therapy revenue codes (042x, 043x, 044x). If the SI is changed to A these services are excluded from being packaged in the presence of a comprehensive APC (See Comprehensive APC Processing logic section).

5.4.3 Critical Care Processing

Processing of certain ancillary services with SI of Q1 or Q3 that are reported with critical care code 99291 are packaged when reported on the same service date, or effective with version 18.0, on the same claim, as the critical care code. If procedure code 99291 is present with any of the specified ancillary procedure codes, the IOCE changes the SI of the ancillary procedure code from Q1 or Q3 to N for packaging. An exception applies if code 99291 is present and modifier 59, XE, XP, XS or XU are present on any line with the same date of service or on the same claim, the specified critical care ancillary codes are not packaged; the SI is changed to the standard SI and APC specified for the code. If 99291 is not present on the same date of service or the same claim, the SI for the ancillary procedures is changed to the standard SI and APC specified for the code when separately payable, or packaged under previous conditional APC processing logic for specified ancillary services with SI = Q1, if there are other payable procedures present.

If critical care code 99291 is present and the claim meets the criteria for assignment under the Comprehensive Observation APC (version 17.0), the exception for the presence of modifier 59, XE, XP, XS or XU does not occur; all ancillary, adjunctive services are packaged under the Comprehensive Observation APC.

Critical care-packaged ancillary service code 94762 is not subject to the modifier 59, XE, XP, XS, XU exception, and always packages when present with critical care code 99291. If reported in the absence of 99291, 94762 (SI = Q3) is subject to conditional APC processing and may package with other payable procedures, or assign the standard APC and SI for separate payment. Note: effective with version 18.3, critical care ancillary service code 36600 is no longer subject to the modifier exception.

5.4.4 Advance Care Planning

Effective January 1, 2016 (v17.0), Advance Care Planning services reported with procedure codes 99497 and 99498, that are also reported on the same date of service with the Medicare annual wellness visit (initial or subsequent), are paid under the Medicare Physician Fee Schedule (SI changed to A); otherwise, advance care planning is subject to conditional packaging. If advance care planning procedure 99497 is reported with no other payable OPPS service, it is assigned its standard SI and APC values; if reported with other OPPS payable services (SI = S, T, V, J1, J2, Q1, Q2, Q3), on the same claim, it is packaged (SI = N).

Note that procedure code 99498 is an add-on procedure code with standard SI = N. If 99498 is reported with the annual wellness visit but the primary code 99497 is not present, it continues to be packaged with SI = N. If 99498 is not reported with the annual wellness visit, it retains packaging status with SI = N.

5.4.5 Conditional Processing for Laboratory Procedures

Effective 1/1/2014 (v15.0 – v16.3), packaged laboratory codes (with status indicator of N) that are submitted on a claim with bill type 12x or 14x, or 13x when the L1 modifier is appended to a packaged laboratory code, have the SI changed to A and set the packaging flag to 0 (not applicable to edit 27) . If packaged laboratory codes are submitted on a claim with bill type 12x and condition code W2 is present, the laboratory codes remain packaged (status indicator N).

Effective January 1, 2016 (v17.0), laboratory codes with SI = Q4 are subject to conditional packaging criteria in determining the final SI assignment, i.e., paid under the clinical lab fee schedule (SI = A), or packaged (SI = N): If a laboratory code with an SI= Q4 results in a final SI assignment of A, it returns a PMF value of 2.

- For claims with bill type 13x: if the laboratory code(s) with SI Q4 is reported with modifier L1 and is present with other payable OPPS services that have SI = J1, J2, S, T, V, Q1, Q2, or Q3 on the same claim, the SI is changed to A; otherwise the laboratory code(s) is packaged with SI=N. If there are only laboratory codes present, all laboratory codes with SI=Q4 are changed to SI=A.

  Note: Modifier L1 is deactivated as of January 1, 2017 (v18.0), and the provision to change the SI to A if modifier L1 is present is discontinued. If laboratory codes with SI = Q4 are present with other payable OPPS procedures, the laboratory codes are packaged with SI = N.

- Effective January 1, 2017 (v18.0), special conditions apply to OPPS services that have a final SI of Q1, Q3, S, T, or V and a line item action flag of 2 or 3 present. If the payable OPPS service(s) has the line item action flag of 2or 3 present, the laboratory codes with SI = Q4 are processed for payment by having the SI changed from SI=Q4 to SI=A.

- For claims with bill type 12x without condition code W2, and for claims with bill type 14x: if a laboratory code(s) is present with SI Q4, the SI is changed to A. Laboratory services on claims with bill type 12x that do contain condition code W2 remain packaged (SI = N).

Note: Some laboratory codes (e.g. molecular pathology codes) are always assigned SI = A, and are not subject to the conditional packaging logic. There are also laboratory codes that are assigned SI = N and are not subject to conditional packaging logic; laboratory codes with SI = N are always packaged.

5.5 Composite APC Processing

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. Composite adjustment flags are not assigned for composite-packaged lines that are included on a claim containing a comprehensive APC. 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. Some composites may have additional or different assignment criteria. Lines that are denied or rejected are ignored in the composite criteria.

5.5.1 Partial Hospitalization and Community Mental Health Center Processing

Effective January 1, 2017 (v18.0), partial hospitalizations are paid a single level per diem PH APC dependent on the provider type (hospital-based PHP program or a CMHC program), condition codes, bill types and HCPCS codes. To obtain the PH APC a minimum of three or more PH services must be reported per day, one of which must be from the PHP Primary List. (Please reference the HCPCS Map within the data files for the PHP Primary list as well as the list for All PHP services.) The first line item containing the HCPCS code from the PHP Primary list is assigned the PH APC and the final SI = P. All other partial hospitalization services on the same day are packaged, SI is changed to N. A composite adjustment flag identifies the PH APC and all the packaged PH services on the day; a different composite adjustment flag is assigned for each PHP day on the claim. Effective 4/1/2015 through the current version, the payment adjustment flag value of 11 is assigned to the PHP payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

If there is an inpatient only procedure (SI = C) on the same claim as PHP or Daily Mental Health services, no Partial Hospitalization or Daily Mental Health processing logic is performed.

If less than the minimum amount (number and type) of services required for PHP are reported for any day, the PHP day is denied, i.e., all PHP services on the day are denied and no PHP APC is assigned (edit30). Note that certain PHP services that are add-on codes are not included in the count of number of services for the day (Please reference the HCPCS Map within the data files for list of PHP services flagged as add-on codes). Any non-PHP services on the same day are processed per 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 (edit 80).

Effective October 1, 2017 (v18.3), edit 95 is reactivated for informational purposes only, with no impact on payment. Edit 95 is returned if a PHP claim contains weekly services with less than 20 hours of PHP services per week. Hours of service for PHP services that result in packaging (SI = N) due to PHP APC processing are included in the total count of hours per week; however, certain PHP services that are add-on codes are not included towards the weekly count of hours. If the PHP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week. If conditions are present for edit 95, an informational only line item denial or rejection flag value of 3 is returned, indicating that although the conditions for edit 95 exist, payment is not impacted, and the line item rejection disposition flag in the claim return buffer is not set. The IOCE continues to process lines with edit 95 for payment by the OPPS Pricer.

The IOCE does not apply edit 95 on the admission week submitted on an admission PHP claim (761, 762, 131 w CC 41, or 132 w CC41); instead, if the admission week has less than 20 hours of PHP services, Payer Condition Code MP is provided. The IOCE also does not apply edit 95 on the discharge week when submitted on a PHP discharge claim (761, 764, 131 w CC 41, or 134 w CC41); instead, Payer Condition Code MQ is provided if the discharge week contains less than 20 hours of PHP services. Effective July 1, 2019 (v20.2), the discharge week is identified as the last full (7 day) week on the claim and is never edited with 95 nor any partial days that follow; instead, MQ is returned if the last full week contains less than 20 hours of PHP services.

Effective July 1, 2019 (v20.2), the IOCE returns Payer Value Code and Value Code Amount QW 0.0000 on Interim PHP claims that have a partial last week present. The last 5 values of the Value Code Amount provided with QW represents the count of days and hours in which PHP services are provided for the partial week (first portion of week). For example, if the last week on an interim PHP claim is not 7 days but instead only 3 days, and in those 3 days 15 ½ hours of PHP services are provided, the last 5 values in the Value Code Amount is 3.1550. Note that the partial week is not edited with 95. The IOCE processes the next claim and can combine the partial week (first portion) from the previous claim to the next claim by input Value Code and Value Code Amount QA 0.0000 which is submitted by the Shared System Maintainer (SSM). The IOCE combines the two partial weeks into one full week (7 days) and if the full week does not contain up to 20 hours of PHP services, the lines on the second portion of the full week are editing with 95 and Payer Value Code MV is output. The output of MV requires the SSM to adjust the claim containing the first portion of the partial week. The SSM submits Condition Code MW on input to a PHP adjustment claim indicating that the IOCE needs to edit the partial last week present on the claim.

Effective January 1, 2017 (v18.0), CMHC providers may be subject to outlier payment limitations. If condition code 66 (Provider does not wish outlier payment) is present for a CMHC claim with bill type 76x, payment method flag value of 6 is provided on each OPPS payable line (OPPS paid lines are those that would have previously had payment method flag 0). If condition code MY (Outlier cap bypass) is passed to the IOCE by the MAC, with or without condition code 66, payment method flag value of 9 is returned and the outlier payment limitation is bypassed.

Effective October 1, 2018 (v19.3), PHP claims submitting a claim with a code first diagnosis in the principal diagnosis position without a mental health diagnosis in the first secondary diagnosis position, return edit 109. Please reference the Dx10Map within the data files for diagnoses flagged as code first as well as diagnoses flagged as mental health diagnoses.

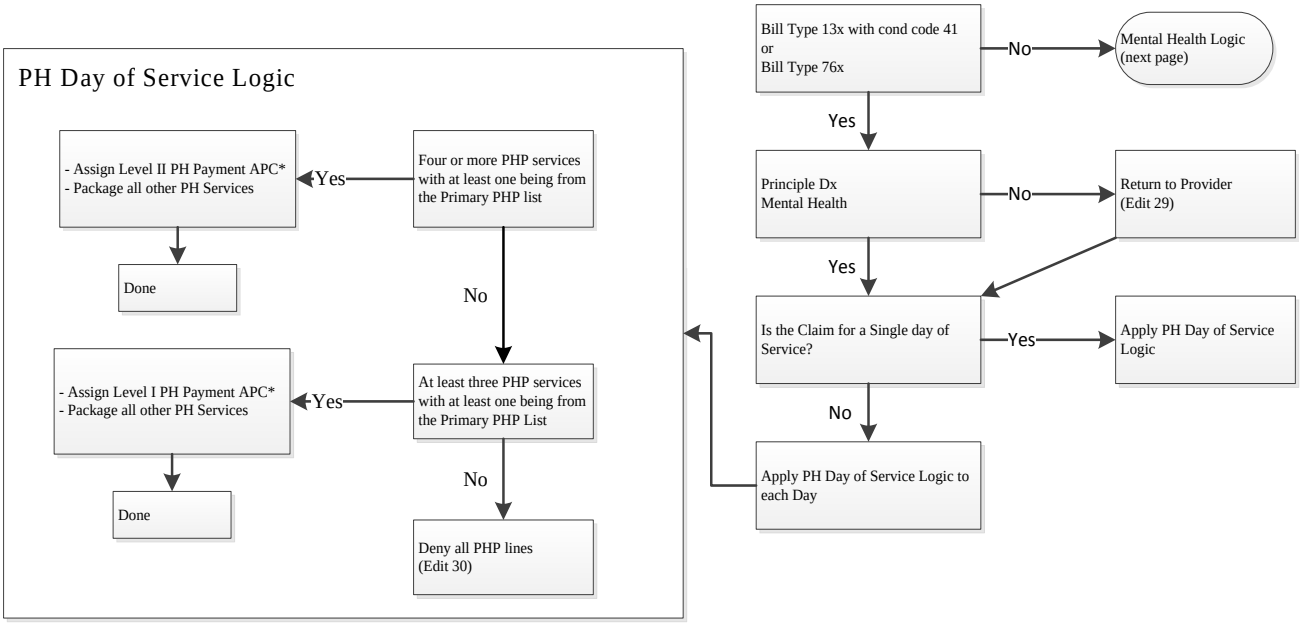
5.5.1.1 Partial Hospitalization and CMHC Processing Continued

The program logic determining level I or level II APCs is no longer required effective January 1, 2017. Effective 1/1/2011 (v12.0-v17.3), different PHP APCs, Level I and Level II, are assigned for hospital-based and Community Mental Health Center (CMHC) partial hospitalization programs according to the number of services provided. In obtaining the level II PH APC a minimum of 4 or more services is provided, with at least one of those services being from the PHP Primary List. To obtain the level I PH APC a minimum of 3 or more services is provided, with at least one of those services also being from the PHP Primary list. As mentioned above the line item that obtains the PH APC is the first reported Primary PHP HCPCS reported (SI=P), and all other services on the claim are packaged with an SI of N.

Effective 7/1/2016 (v17.2), additional editing is implemented for PHP claims to monitor weekly claim submission of at least 20 hours of PHP services. PHP claims with a From and Through date greater than 7 days are returned to the provider (edit 97). Interim PHP claims, identified by bill type 133 with condition code 41 or bill type 763 for CMHC, that have a From and Through date span of less than 5 days are returned to the provider (edit 96). PHP claims with less than 20 hours of PHP services per week are returned to the provider (edit 95). Hours of service for PHP services that result in packaging (SI = N) due to PHP APC processing are included in the total count of hours per week. If the PHP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week.

Note: Edits 95, 96 and 97 are deactivated with the October 2016 (v17.3) release, retroactively to 7/1/2016. Edit 95 is reactivated effective October 1, 2017 as an information only edit with no impact to payment.

5.5.2 Partial Hospitalization Logic Flowchart (Effective v10.0-v17.3)



Notes:

Assign Partial Hospitalization Payment APC according to Bill Type

For bill type 13xw/cc41: Level I (3 services) or Level II (4 or more services) Partial Hospitalization for Hospital-Based PHPs
For bill type 76x: Level I (3 services) or Level II (4 or more services) Partial Hospitalization for CMHCs

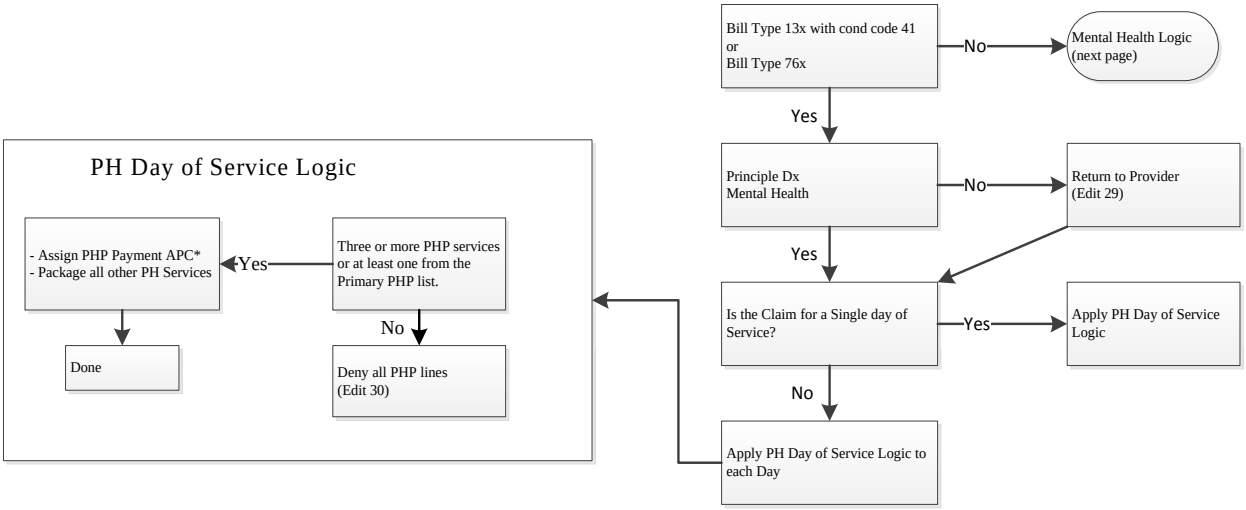
For any day that meets the criteria for Level I PHP APC, the first listed line item with a Primary PHP service is assigned the PHP payment APC, a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the PHP APC, assign units of service = 1 and payment adjustment flag = 11.

For all other PHP services reported for 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 the HCPCS APC is set to 0 (effective 1/1/08).
Note: If mental health services, that 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).

5.5.2.1 Partial Hospitalization Logic Flowchart (effective v18.0)



Notes:

Assign Partial Hospitalization Payment APC according to Bill Type

For bill type 13xw/cc41: Partial Hospitalization for Hospital-Based PHPs
For bill type 76x: Partial Hospitalization for CMHCs

For any day that meets the criteria for PHP APC, the first listed line item containing a Primary PHP service is assigned the PHP payment APC, a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the PHP APC, assign units of service = 1 and payment adjustment flag = 11.

For all other line items with a partial hospital service 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, the HCPCS APC is set to 0 (effective 1/1/08).

If mental health services that 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).

Effective 10/1/2017 (v18.3), PHP claims containing weeks with less than 20 hours of PH services are line item rejected with edit 95, however line item denial rejection flag 3 is returned indicating no impact to payment.

5.5.3 Daily Mental Health Processing

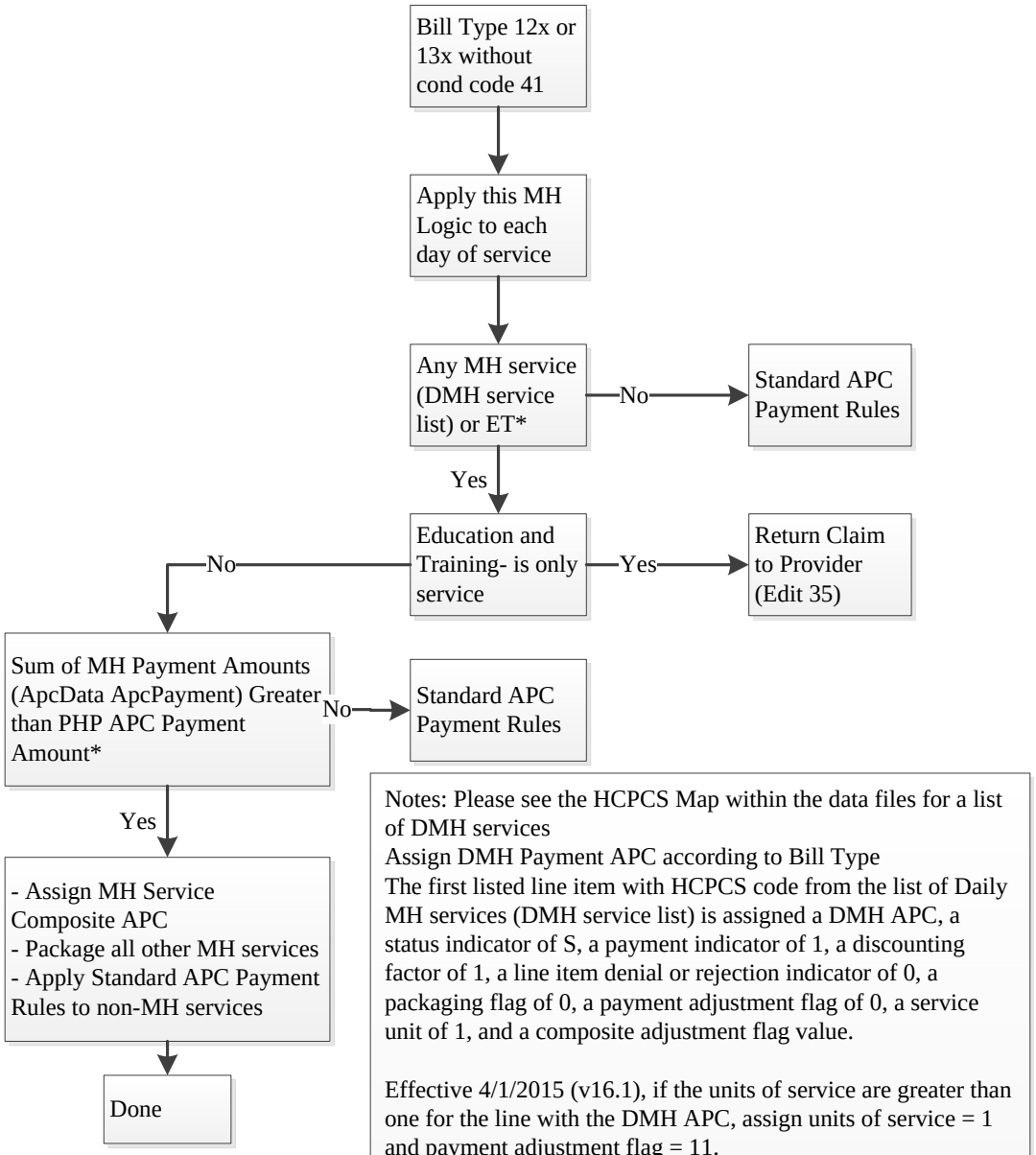
Effective January 1, 2017 (v18.0), the comparison for summing the payment of the individual MH services to the level II partial hospital-based per diem APC payment rate is changed to compare the sum to the single level PH hospital-based per diem APC payment rate. All other processing logic listed below occurs as indicated in the flowchart that follows.

Reimbursement for a day of outpatient mental health services in a non-PHP program is capped at the amount of the level II hospital-based partial hospital per diem. On a non-PHP claim, the IOCE totals the payments for all the designated MH services with the same date of service; if the sum of the payments for the individual MH services exceeds the level II hospital-based partial hospital per-diem, the IOCE 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. The payment rate for the Mental Health Services composite APC is the same as that for the level II hospital-based partial hospitalization APC. Lines that are denied or rejected are ignored in the Daily Mental Health logic. Some mental health services are specific to partial hospitalization and are not payable outside of a PH program; if any of these codes is submitted on a 12x, or 13x TOB without condition code 41, the claim is returned to the provider (edit 81).

Effective 4/1/2015 (v16.1), payment adjustment flag value 11 is assigned to the Mental Health payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

The Flowchart for Daily Mental Health Processing is located on the next page.

5.5.3.1 Daily Mental Health Logic Flowchart



PH = Partial Hospitalization
MH = Mental Health

Notes: Please see the HCPCS Map within the data files for a list of DMH services
Assign DMH Payment APC according to Bill Type
The first listed line item with HCPCS code from the list of Daily MH services (DMH service list) is assigned a DMH APC, 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.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the DMH APC, assign units of service = 1 and payment adjustment flag = 11.

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 DMH APC line is assigned.

The use of code G0177 (Education and Training) is allowed on MH claims that are not billed as Partial Hospitalization

If mental health services, that are not payable outside the PH program, are submitted on a 12x or 13x TOB without CC41, the claim is returned to the provider (Edit 81).
*Effective 1/1/2017 (v18.0), the sum of MH payment amounts are compared to the single Partial Hospital-Based APC payment rate (no longer Level I/Level II PHP APCs).

5.5.4 LDR Prostate Brachytherapy Composite APC Processing and Assignment Criteria: [v9.0-v18.3]

(**Note:** The LDR composite APC is effective only for versions 9.0 – 18.3; LDR claims with From Dates on or after 1/1/2018 {v19.0} are included in the comprehensive APC processing logic.)

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

A. 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.
B. Assign units of service = 1 to the line with the composite APC.
C. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
D. 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.
E. Assign the indicated composite adjustment flag to the composite and all component codes present.
F. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.
G. Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.
H. Procedures that are packaged (SI changed to 'N' in an earlier processing step) are not included in the composite assignment logic.
I. Effective 1/1/2017 (v18.0), prime code 55875 may be subject to comprehensive APC processing when reported without non-prime code 77778.

5.5.5 Electrophysiology/Ablation Composite APC Processing and Assignment Criteria: [v9.0 – v15.3]

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

(Note: *The electrophysiology/ablation composite APC is effective only for versions 9.0 – v15.3; electrophysiology/ablation claims with From Dates on or after 1/1/2015 {v16.0} are included in the comprehensive APC processing logic.)*

A. If there is a single code present from group C, or one 'prime' code (group A) and at least one non-prime code (group B) on the same date of service, assign status indicator N to the non-primary code(s) present.
B. Assign units of service = 1 to the line with the composite APC.
C. If multiple codes from group C are present, assign the composite APC to the code with the lowest numerical value and assign status indicator N to additional group C codes on the same day.
D. 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.
E. If the criteria for APC assignment are met with a code from group C as well as from groups A&B, assign the composite APC to the group C code and assign SI of N to the codes from groups A&B.
F. If there is one or more codes from group C present with one or more codes from either group A or group B; assign the composite APC to the group C code and assign the standard APC and related SI to any separate group A or group B codes present.
G. Assign the indicated composite adjustment flag to the composite and all component codes present.
H. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component group A and group B codes present.
I. Terminated codes (modifier 52 or 73 present) in group C are assigned to the composite APC; terminated codes in groups A and B are ignored in composite APC assignment
J. Procedures that are packaged (SI changed to 'N' in an earlier processing step) are not included in the composite assignment logic.

5.5.6 EAM Composite APC Level I and Level II Assignment Criteria:

Level I APC Prime List A codes	Level I APC Non-Prime List B codes	Level I Composite APC
99205, 99215, G0379	G0378	8002
Level II APC Prime List A codes	**Level II APC Non-Prime List B codes**	**Level II Composite APC**
99284, 99285, 99291, G0384	G0378	8003

(**Note:** *Level I and II EAM APCs deleted effective 1/1/2014 [v9.0-v14.3])*

A. 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 composite APCs are met.
B. 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).
C. If there is at least one Level I APC Prime List A 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 Level I composite APC and related status indicator to the clinic visit or direct referral code.
D. If there is at least one Level II APC Prime List A critical care or emergency room visit code on the day of or day before observation (G0378), assign the composite APC and related SI to the critical care or emergency visit code.
E. Hours/Units of service for observation (G0378) must be at least 8 or the composite APC is not assigned. A composite adjustment flag will be applied to the visit line that gains the C-APC and the line for G0378. Note: The SI for G0378 is always N.
F. If the criteria is met for a level I and a level II EAM composite APC, assignment of the Level II takes precedence.
G. Extended assessment and management composite APCs have SI = V if paid and are assigned units of service =1.
H. If multiple qualifying Prime Codes (visit or CC) 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.
I. Additional clinic, critical care, or emergency room visit codes (whether or not on the prime lists) are assigned to their standard APCs as separately paid items. Exception: Additional reporting of G0379 is always packaged (SI = N) if there is an extended assessment and management APC on the claim. Note: Only one EAM composite APC is assigned per claim.
J. If a "T" or "J1" procedure occurs on the day of or day before observation, the composite APC is not assigned.
K. Lines with G0378 and G0379 are rejected if the bill type is not 13x (or 85x).
L. EAM logic is performed only for claims with bill type 13x, with or without condition code 41.

5.5.7 Extended Assessment and Management Composite APC Criteria v15.0-v16.3

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

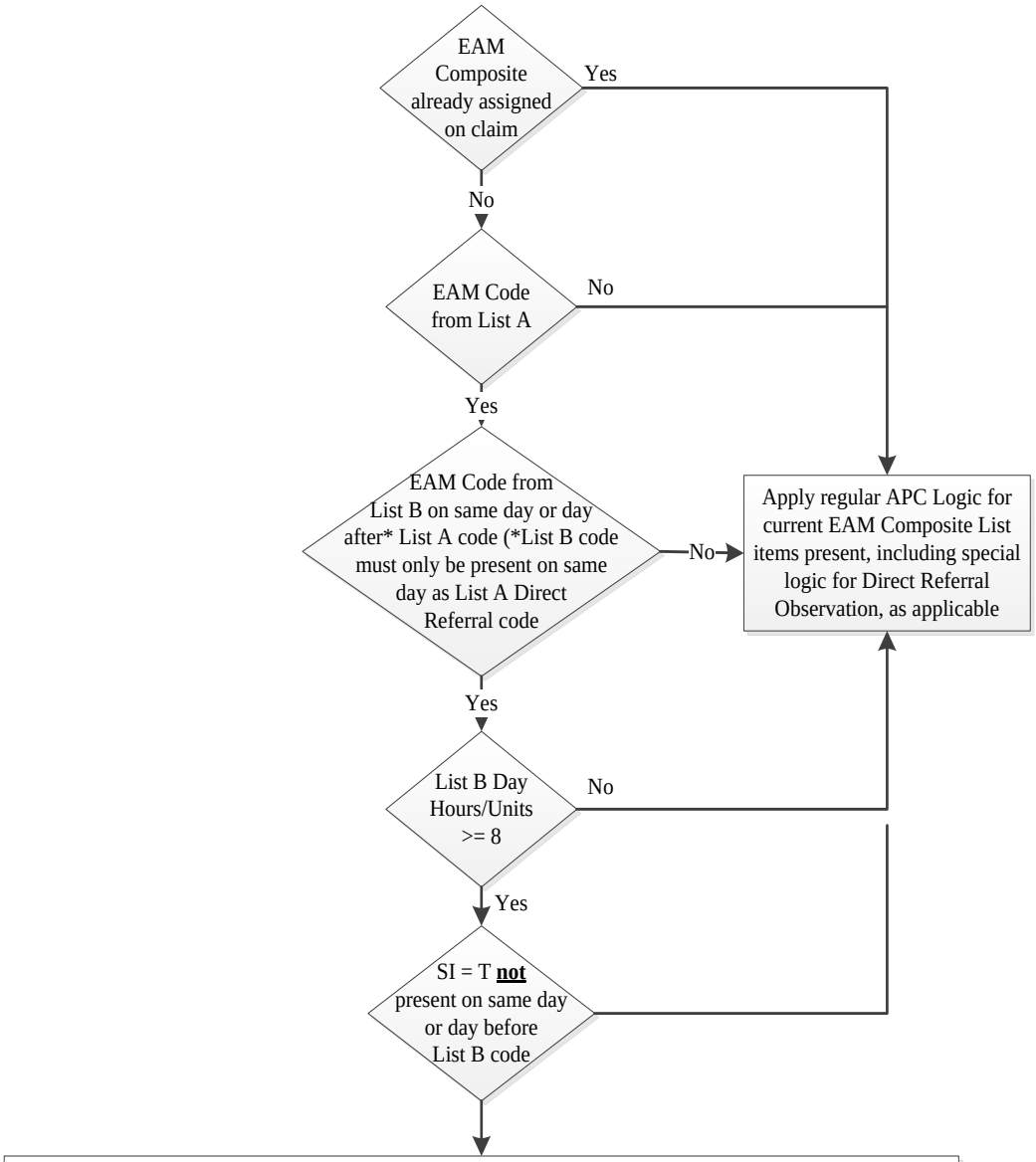
(Note: Effective 1/1/14, [v15.0-v16.3] a new EAM composite APC was created, replacing Level I and Level II EAM composite APCs. Any logic point referenced above is still relevant to how the EAM composite is assigned or not assigned unless stated otherwise below.)

A. If there is at least one of the critical care, emergency room, or clinic visit codes on the day of or day before observation (G0378), or code G0379 is present on the same day as G0378, assign the composite APC and related status indicator to the critical care, emergency department, clinic visit, or direct referral code.
B. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, the units will be reduced to 1 and a payment adjustment flag value of 11 will be returned.
C. Sometimes therapy codes subject to conditional APC processing due to default SI= Q1 with standard SI=T that meet therapy requirements and have final SI= A, are not considered for "T" procedure criteria that would prevent EAM composite APC assignment (v15.0-v16.3 only).

NOTE: Effective 1/1/2016 [v17.0], all EAM Composite APC logic is deactivated; observation claims meeting specified criteria are assigned under a comprehensive observation APC. See Comprehensive Observation Logic for more information.

5.5.7.1 Extended Assessment & Management Composite APC (v9.0-v16.3)

This flowchart encompasses the general process of obtaining either a Level II, Level I, or the non-Level EAM composite APC.



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.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.

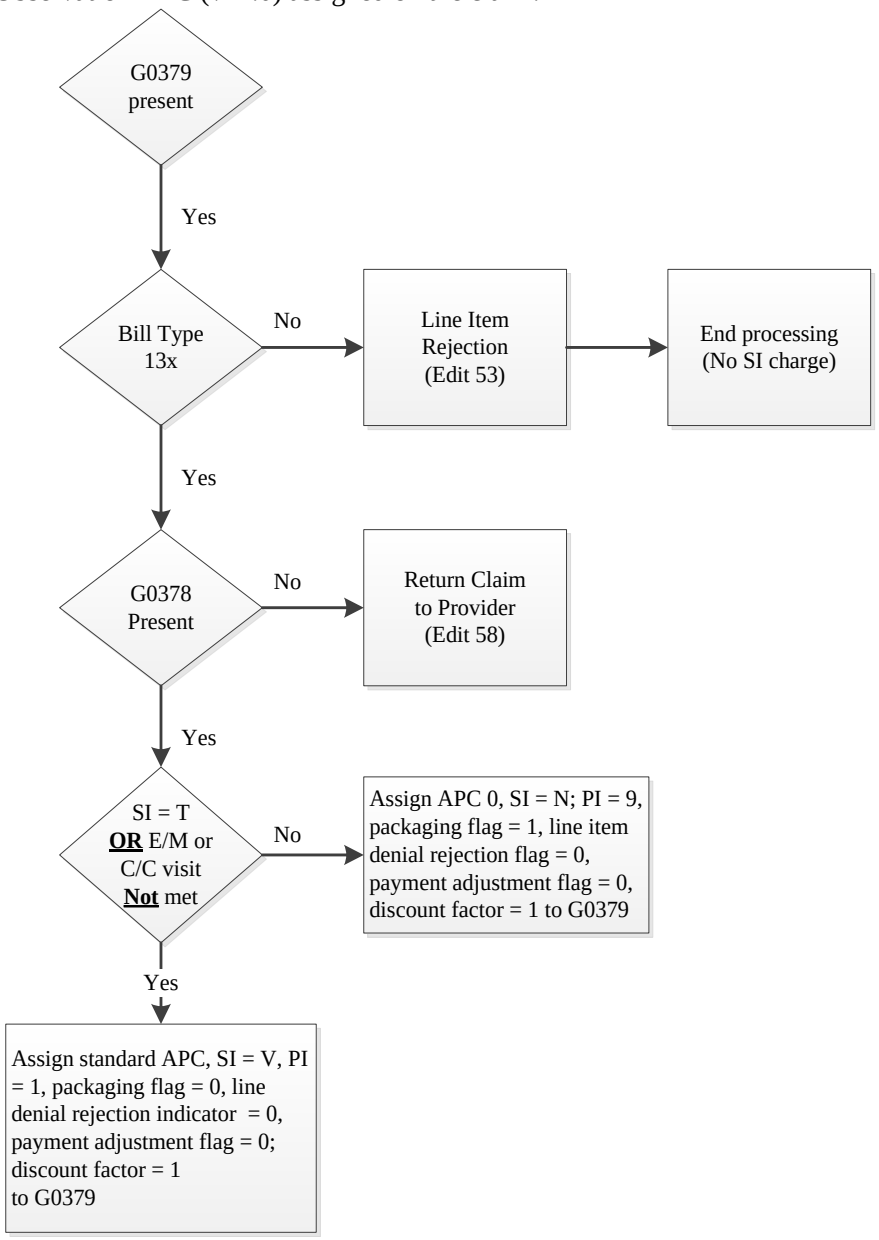
Assign standard APC, SI, PI to other List A* codes and List B code
*Package special Direct Referral List A code on same claim as EAM composite assignment. Edit 57 is returned if G0378 (List B) is reported with service date of 1/1 and the E/M condition is not met.
**Claims prior to 1/1/09. ***effective 1/1/09

5.5.8 Direct Referral Logic

Prior to version 17.0, direct referral from a physician in the community to a hospital for observation care may be used in the assignment of an extended assessment and management composite APC or packaged into T, V or critical care service procedure if present; otherwise, the direct referral is processed as a medical visit. Direct referral for observation that is denied or rejected is not included in any subsequent special direct referral logic, and the default SI is retained as the final SI. Exception: If line item action flag = 1 has been assigned to the line with G0379, the denial/rejection is ignored, the line is included in subsequent direct referral logic, and that logic determines the final SI. (See flowchart next page).

5.5.8.1 Direct Referral Logic Flowchart

If there is no Extended Assessment & Management APC (v9.0-v16.3) or no Comprehensive Observation APC (v17.0) assigned on the claim:

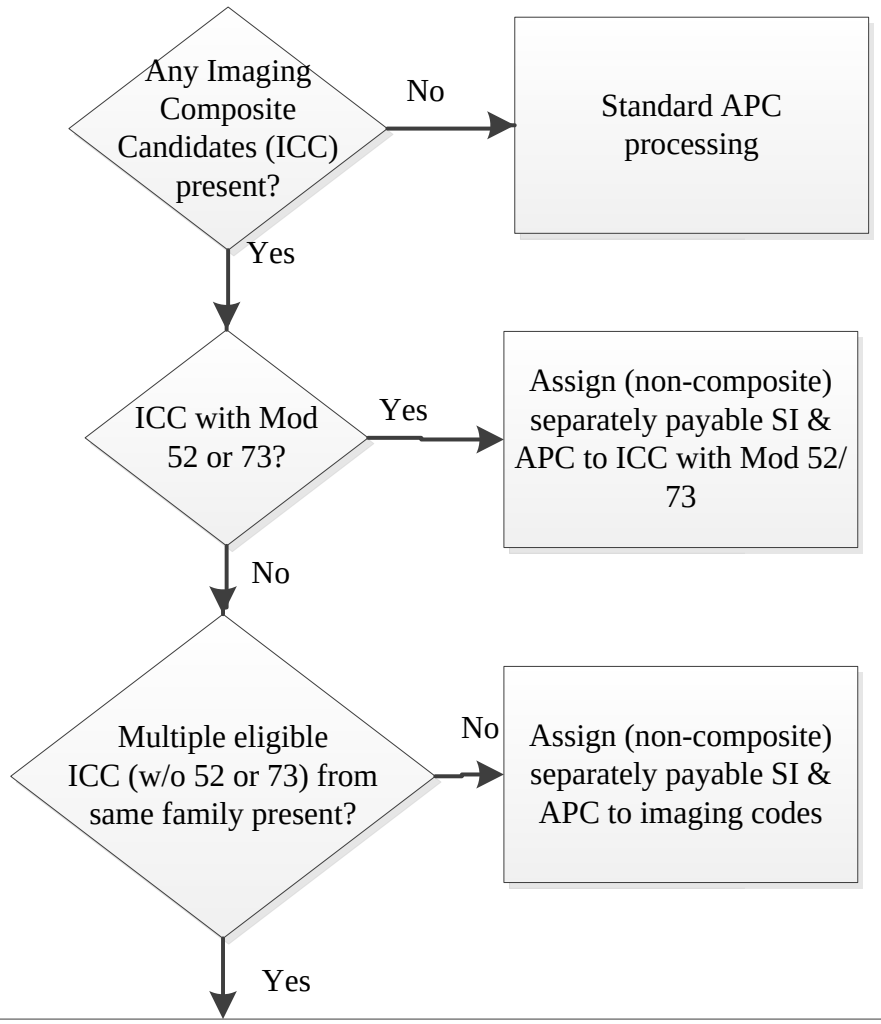


Notes:
1. Edit 57 is returned if G0378 is reported with service date of 1/1 and G0379 is not reported.
2. Edit 58 is returned if G0378 and G0379 are not reported on the same service date.
3. Effective v17.0, direct referral logic only applied if conditions not met for Comprehensive Observation APC.

5.5.9 Multiple Imaging Composite Assignment Rules & Criteria:

A. 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).
B. Within two of the imaging families (i.e, CT/CTA and MRI/MRA), 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 (8004, 8005, 8006, 8007, and 8008). For a list of procedures eligible for the composite assignment, refer to the report within the data files labeled, Multiple Imaging Composite APC's.
C. 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).
D. Multiple lines or multiple units of the same imaging procedure count to assign the composite APC; independent or conditional bilateral imaging procedures with modifier 50 count as 2 units.
E. 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.
F. 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).
G. 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.
H. 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.
I. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, the OCE re-assigns units of service = 1 and returns a payment adjustment flag = 11.
J. Effective 1/1/2016 (v17.0), certain CT scan codes performed on equipment not meeting NEMA standards are reported with modifier CT. If multiple CT scan codes reported with modifier CT are present, and contribute to the assignment of a composite APC, the first eligible line assigned to the composite APC receives payment adjustment flag 14, whether or not modifier CT is reported on the line. All other CT scan codes reported with modifier CT that are included for composite APC assignment are packaged (SI = N), and do not have payment adjustment flag 14 assigned.
K. Lines that are candidates for composite APC assignment that are present on a comprehensive APC claim do not have the composite adjustment flag applied; composite candidates are packaged with SI = N under comprehensive APCs.
L. Special consideration is given to code 75635, which is a current composite candidate under ultrasound with SI = Q2 which makes it eligible for conditional APC processing. If 75635 is present, consideration of separate payment under conditional APC processing is evaluated prior to composite candidate consideration. If composite conditions are not present, then 75635 is processed for separate payment or packaging under conditional APC processing.

5.5.9.1 Multiple Imaging Composite Flowchart



Assign Multiple Imaging Composite APC
(see multiple imaging composite APC report within the data files 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

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.

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.

5.6 Comprehensive APC Processing

Effective 1/1/2015 (v16.0), certain high cost procedures which have an SI=J1 are paid an all-inclusive rate to include all services submitted on the claim, except, for services excluded by statute. All allowed, adjunctive services submitted on the claim are packaged into the "comprehensive" APC payment rate (i.e., the status indicator is changed to N). Multiple comprehensive procedures, if present on the claim in specified combinations, may be assigned to a higher-paying comprehensive APC representing a complexity adjustment. Services that are excluded from the all-inclusive payment retain their standard APC and SI for standard processing.

5.6.1 General Comprehensive APC Assignment Rules and Criteria: V16.0- Current

A. Comprehensive APC processing is performed only for OPPS claims with bill type 13x or claims with bill type 12x with condition code W2.

B. Comprehensive APCs are assigned using the following hierarchy:
   1. Inpatient-Only Patient Expired (SI = J1)
   2. High-Cost Procedures (SI = J1)
   3. Comprehensive Observation (SI = J2)

C. If there are multiple comprehensive APC procedures existing on the same claim from the different categories listed above, the comprehensive APC procedures are packaged (SI = N) according to the hierarchy of services present; the procedure or service highest in the hierarchy is assigned the comprehensive APC for the claim. Additional processing conditions for each of the different categories is listed separately below.

D. Claims containing a payable inpatient procedure (modifier CA and patient status 20) suppress comprehensive APC processing for v16.0 – v16.3 and are processed under inpatient procedure processing previously in place.

E. Multiple service units reported on a comprehensive APC line are reduced to one for processing payment based on a single comprehensive APC payment rate; payment adjustment flag 11 is assigned.

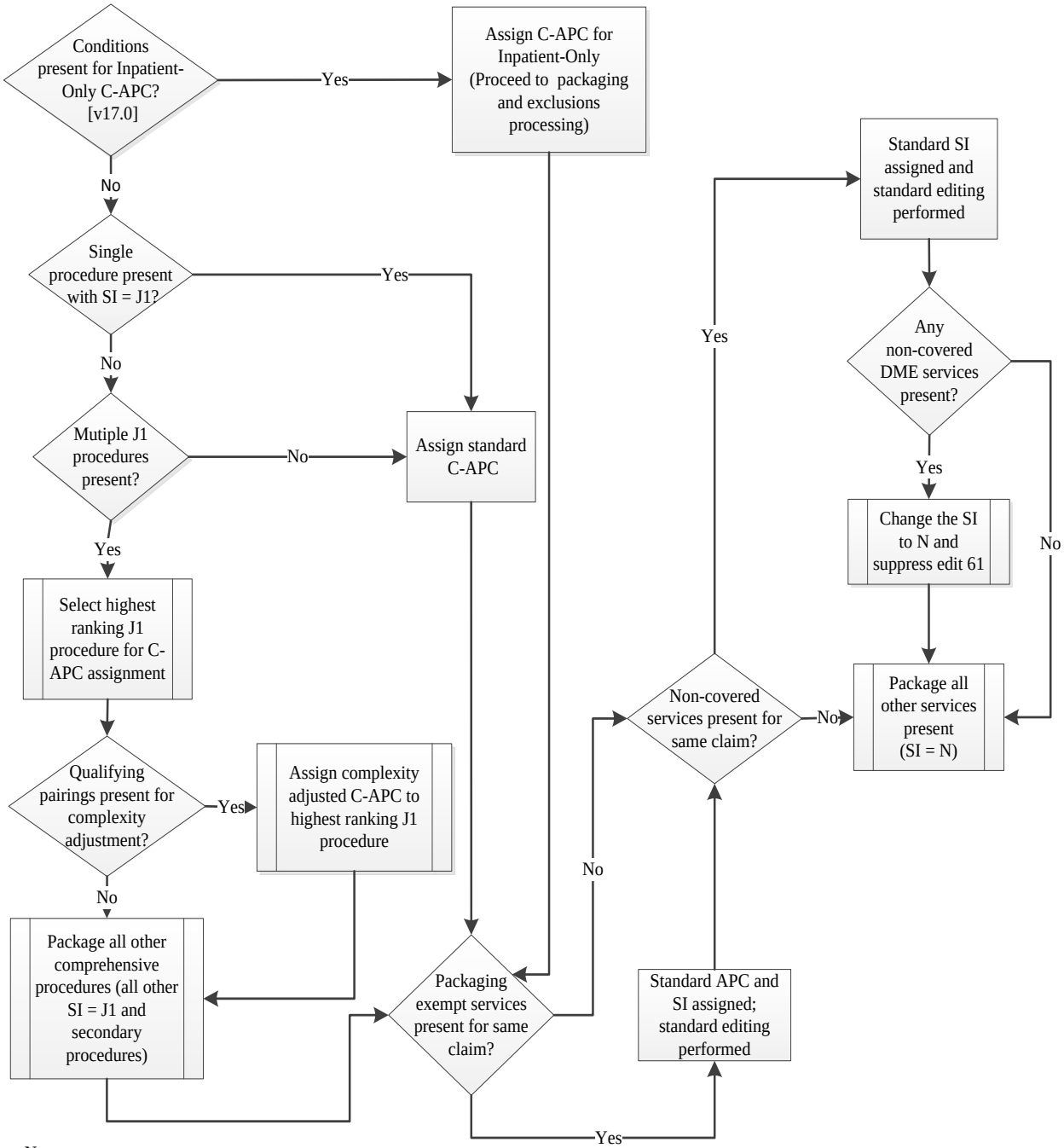
F. Services that are excluded by statute from packaging include; ambulance, brachytherapy (SI=U), mammography, pass-through drugs, biologicals and devices (SI= G or H), preventive care including influenza and pneumococcal vaccines (SI=L), corneal tissue acquisition, certain CRNA services, and Hepatitis B vaccines (SI = F). Certain blood products (i.e. packed red cells or whole blood) reported with the appropriate revenue code are also excluded from packaging under comprehensive APCs.

G. Certain wound care services identified as "sometimes therapy" when appended with a therapy modifier (GP for physical therapy, GO for occupational therapy, or GN for speech language pathology) or a therapy revenue code (042x, 043x, 044x), change the SI of the service to A, and are excluded from comprehensive APC packaging.

H. Procedures that are not allowed on OPPS claims (SI = B, C, E, E1, E2 or M) are edited as usual and retain the standard SI, with the exception of procedure codes representing DME services with SI = Y (Billable only to DMERC); DME codes with SI=Y are packaged into the comprehensive APC payment; edit 61 is not returned.

I. Comprehensive APC claims containing lines that may be composite APC candidates do not have the composite adjustment flag applied.

5.6.1.1 Comprehensive APC Processing Flowchart (SI= J1) (v16.0)



Notes:

1. C-APC = Comprehensive APC.
2. Units of service greater than one for a comprehensive APC procedure line are reduced to one. Payment adjustment flag = 11 is assigned indicating to Pricer that only a single comprehensive APC payment rate is calculated for lines reporting multiple units of service.
3. The highest ranked J1 procedure is where the C-APC is assigned; all other services are packaged with SI = N, except for non-covered services and services excluded from C-APC packaging logic.
4. Complexity adjusted comprehensive APC assignment occurs when there is a qualifying pair of comprehensive procedures with SI = J1, or a comprehensive procedure with a qualifying add-on procedure code with SI = N, or may be multiple occurrences or service units of the same comprehensive procedure.
5. Effective v17.0, conditions for inpatient-only procedures when the patient expires or transfers are assigned a C-APC with SI = J1. If this condition exists, no other C-APC is assigned for the claim.
6. Effective v17.0, if SRS planning and preparation codes are present on the same claim with the SRS C-APC, the planning and preparation codes are excluded from the C-APC packaging logic.

5.6.2 Comprehensive APC Assignment for High-Cost Procedures (v16.0 - Current)

A. If a single comprehensive procedure (SI = J1) is present on a claim, assign the standard comprehensive APC for all-inclusive claim payment.

B. If multiple comprehensive APC procedures are present, select the highest ranked comprehensive procedure for standard comprehensive APC assignment.

C. Once the highest ranked comprehensive procedure is determined, if there are multiple comprehensive procedures present with SI=J1 or there are qualifying add-on procedure codes present (SI = N), determine if there are any pairings that may qualify for a complexity adjustment. Multiple occurrences or service units of the same comprehensive procedure, or the reporting of modifier 50, may qualify for complexity adjustment. If there is a qualifying pair present associated with the highest ranked comprehensive procedure, assign the complexity-adjusted comprehensive APC.

D. If the highest ranked comprehensive procedure has service units greater than one, reduce the service units to one and assign payment adjustment flag 11.

E. If a comprehensive APC procedure is terminated by the reporting of modifier 52, 73 or 74, no complexity adjustment is performed for the claim; the standard comprehensive APC is assigned to the comprehensive procedure with the highest rank. Usual terminated procedure discounting is applied if modifiers 52 or 73 are reported (modifier 74 does not apply the terminated procedure discount).

F. If the comprehensive APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.

G. Effective 1/1/2016 (v17.0), when SRS (stereotactic radiosurgery) planning and preparation codes are reported on the same claim as the comprehensive APC for SRS (APC 5627), the planning and preparation codes are excluded from packaging; the standard SI and APC, or the composite APC and SI (if criteria is met for multiple CT scan imaging procedures) are assigned. If the SRS planning and preparation codes are reported on a claim with any other comprehensive APC procedure, the codes are packaged under the comprehensive APC packaging criteria.

H. Effective 1/1/2016 (v17.0), if conditions are present for pass-through device offset, a single device offset is provided for comprehensive APC claims only if the comprehensive APC procedure is paired with the pass-through device. Otherwise, no device offset is provided for device offset conditions that may be present for procedures that are packaged (SI = N) as a result of comprehensive APC processing.

I. Effective 1/1/2019 (v20.0), procedure codes assigned to New Technology APCs are excluded from packaging under C-APC processing logic; standard SI and APC are assigned.

5.6.3 Inpatient Procedure Processing under Comprehensive APCs

Effective January 1, 2016 (v17.0), if an inpatient-only procedure is present with modifier CA for a patient who expires or transfers to another hospital (patient status code is 2, 5, 20, 62, 63, 65, 66, 82, 85, 90, 91, 93 or 94), the inpatient procedure is assigned under a comprehensive APC (SI = J1), and all other services reported on the claim are packaged (SI= N), except for those items excluded under comprehensive APC processing. Excluded items with non-covered SI = B, E, E1, E2, C or M return the standard SI; any edits associated with the non-covered SI are not returned. If modifier CA is reported for an inpatient-only procedure and the discharge status does not indicate the patient expired or transferred, the claim is returned to the provider (edit 70). Additional comprehensive APC procedures (SI = J1 or J2) reported on the same claim as the inpatient-only procedure where the patient expired or transferred are packaged (SI = N). 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.

Inpatient-only procedures that are on the separate procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T, or effective 1/1/2015, if reported on a claim with a comprehensive APC procedure (SI = J1). The line(s) with the inpatient-separate procedure is rejected (edit 45) and the claim is processed per usual OPPS rules.

Effective January 1, 2018 if procedure code 01402 (Anesthesia for TKA) is reported on the same claim as procedure code 27447 (Total Knee Arthroplasty) the SI of 01402 changes from C to N and will always package. If code 01402 is reported with any other procedure without 27447 reported on the same claim, the SI remains its standard SI = C and will process as usual.

See Inpatient Procedure Processing through v16.3 for older logic in which Inpatient Procedures were not processed under Comprehensive APCs.

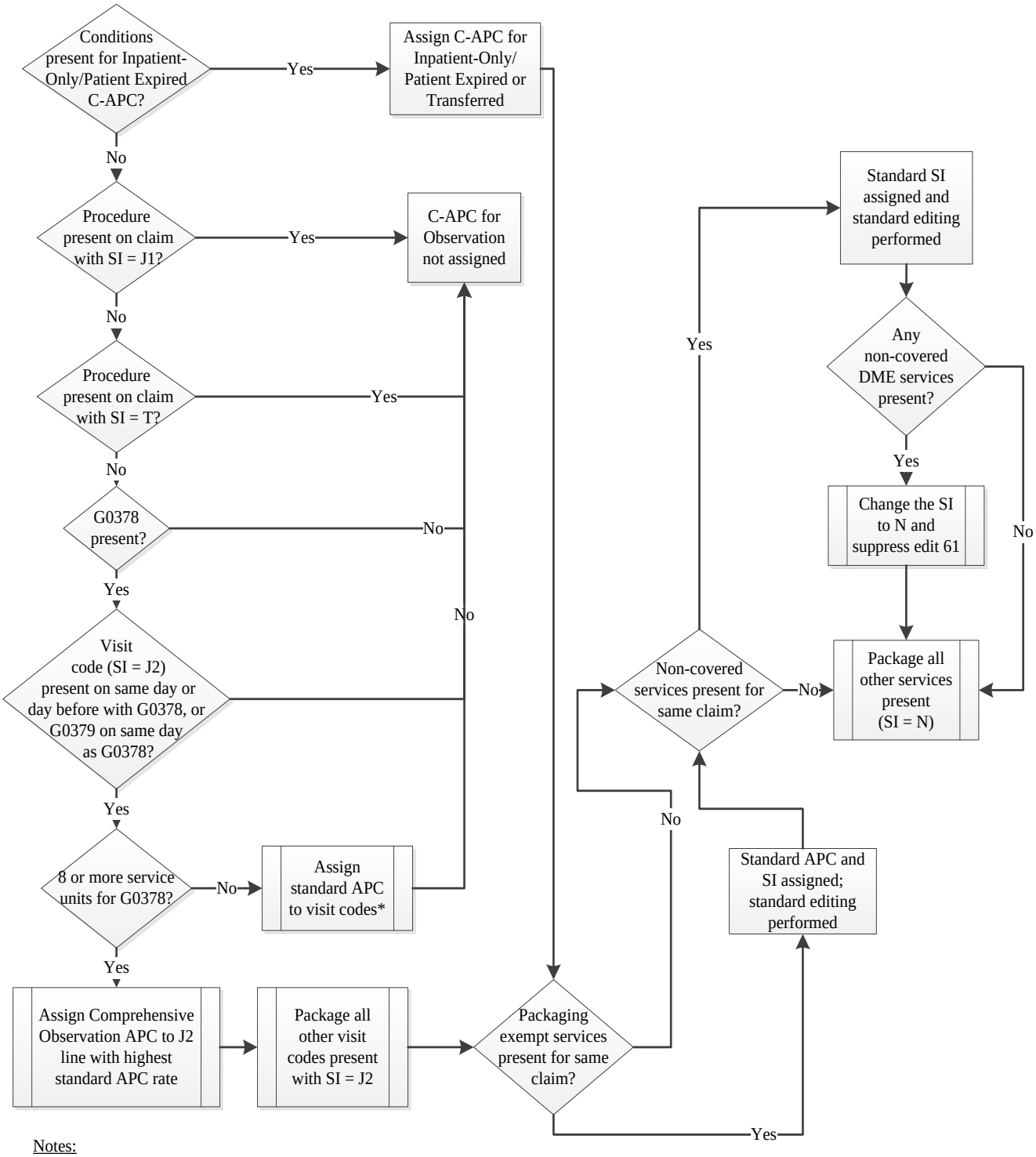
5.6.4 Observation Processing under C-APCs (v17.0)

Effective January 1, 2016 (v17.0), claims for observation services (SI = J2) meeting specified criteria are paid under a single Comprehensive Observation C-APC payment rate, to include all services submitted on the claim. The same exception criteria for excluded services under high cost procedure comprehensive APCs (SI = J1) apply to the Comprehensive Observation APC, and all allowed adjunctive services submitted on the claim with the Comprehensive Observation APC are packaged (SI is changed to N). If multiple visits are present for qualified Comprehensive Observation C-APC assignment, the visit code with the highest standard APC payment rate is assigned the Comprehensive Observation APC; all other visits are packaged.

5.6.4.1 Comprehensive Observation APC Assignment Criteria:

1. There is no procedure with SI = T present for the claim.
2. HCPCS G0378 is reported with 8 or more service units.
3. There is a visit code present from the following list on the same day or one day before HCPCS G0378: Type A/Type B emergency department visits, critical care, outpatient clinic visit, or HCPCS G0379 for direct referral is present on the same day as G0378.
4. The claim does not contain a comprehensive APC procedure with SI = J1.
5. If multiple visit codes with SI = J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged (SI = N).
6. If the claim does not meet the conditions for comprehensive observation APC assignment, the visit code(s) is/are assigned their standard APC and SI.
7. If HCPCS G0379 is present and criteria is not met for comprehensive observation APC, and there are other visit codes present (SI = J2 resulting in standard APC and SI = V), G0379 is packaged. Additional reporting (subsequent occurrences) of HCPCS G0379 are packaged (SI = N).

5.6.4.2 Comprehensive APC for Observation Processing Flowchart (SI = J2) (v17.0)



Notes:
1. C-APC = Comprehensive APC.
2. The visit code with SI = J2 and the highest standard APC rate is where the C-APC is assigned; all other services are packaged with SI = N, except for non-covered services and services excluded from C-APC packaging logic.
3. Conditions for inpatient-only procedures when the patient expires or transfers are assigned a C-APC with J1. If this condition exists, no other C-APC is assigned for the claim.
4. Observation claims not meeting the conditions for C-APC assignment are processed as visits under standard APC assignment (SI = V). *If G0379 is present and there is also a procedure present with SI = T or another SI = V procedure present, G0379 is packaged (SI = N).

5.7 Device-Dependent Procedure Editing and Processing

The use of a device, or multiple devices, is necessary to the performance of certain outpatient procedures. If any of these procedures is submitted without a code for the required device(s), the claim is returned to the provider. Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code. Conversely, some devices are allowed only with certain procedures, whether or not the specific device is required. If any of these devices is submitted without a code for an allowed procedure, the claim is returned to the provider (v6.1 – v15.3).

Effective 1/1/2015 (v16.0), the submission of a device-dependent procedure also requires that a device be submitted on the same claim/day. If any device-dependent procedure is submitted without a code for a device on the same claim with the same date of service, the claim is returned to the provider (edit 92). Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code.

Effective 1/1/2016 (v17.0), if there is a terminated device intensive procedure from a specified list reported with modifier 73, the device portion cost of the procedure APC is output by the IOCE with a Payer Value Code of QQ. The device portion amount is used by the OPPS Pricer program to reduce the APC payment rate prior to application of the terminated procedure discount. A unique payment adjustment flag value of 16 identifies the device intensive procedure reported with modifier 73. In the event there are multiple terminated device intensive procedures present with modifier 73, the device portion amounts are summed and the total device portion is provided; the payment adjustment flag of 16 is assigned for each terminated procedure. Terminated procedure lines present with modifier 73 that may be packaged (SI = N) do not contribute to the device portion amount, and a payment adjustment flag is not returned.

Note: Effective January 1, 2017 (v18.0), the device portion cost for the terminated procedure offset is determined at the individual HCPCS code level, regardless of the APC assignment.

Some implanted devices and some administered substances (SI = H, U), require an implantation or other associated procedure (SI = S, T or J1) to be billed on the same claim. If an associated procedure is not present, the claim is returned to the provider (edit 38).

Special conditions apply for a specified procedure pair, Cardioverter Defibrillator and Pacing Electrode, 33249 and 33225. Both codes have a default SI of Q3, however they are not components of a composite APC. The SIs for 33249 and 33225 is changed from Q3 to the specified SI/APC for standard OPPS processing when they do not appear on the same claim with the same date of service. When both procedures are submitted together on the same date of service, the primary procedure is assigned to the standard APC for payment and the secondary procedure is packaged. [v13.0 – v15.3]

5.7.1 Device Credit Conditional Processing

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 IOCE applies the appropriate payment adjustment flag (corresponding to the FB or FC modifier) to the procedure line. The IOCE also reduces the APC rate by the full offset amount (for FB), or by 50% of the offset amount (for FC) before determining the highest rate for multiple or terminated procedure discounting. If the modifier is used inappropriately (appended to procedure with SI other than S, T, X, V or Q3), the claim is returned to the provider [edit 75, v8.0 – 14.3]. If both the FB and FC modifiers are appended to the same line, the FB modifier takes precedence and the full offset reduction is applied [v10.0 - v14.3].

Effective 1/1/2014, if modifier FB or FC is reported on a claim with a device implantation procedure, the claim is returned to the provider [edit 75, v15.0 – 15.3].

Standard device requirements apply to both procedures under all circumstances; however, modifier FB or FC on the secondary procedure is ignored for offset reduction if the SI for the procedure is changed to N. (Device requirements changed; modifier FB/FC no longer used for offset reduction, effective v15.0).

Effective 1/1/2016 (v17.0), if conditions exist for full or partial device credit for a device intensive APC represented by the presence of Condition Code 49, 50 or 53, the device credit amount is output by the IOCE with Payer Value Code QU, which is used by the OPPS Pricer program to reduce the device intensive APC payment rate by the device credit amount. A unique payment adjustment flag value of 17 identifies the device intensive procedure for which the device credit applies. In the event there are multiple device intensive APCs present for device credit, the credits are summed and the total is provided in the value code amount field; the payment adjustment flag of 17 is assigned for each device intensive procedure associated with the device credit. Device intensive procedures that are packaged (SI = N) do not contribute to the device credit amount, and a payment adjustment flag is not returned. If the device intensive procedure is a comprehensive APC procedure and is also eligible for complexity-adjusted APC assignment under comprehensive APCs, the device credit amount for the complexity-adjusted comprehensive APC is provided.

Note: Effective January 1, 2017 (v18.0), the full or partial device credit amount is determined at the individual HCPCS code level, regardless of the APC assignment.

5.7.2 Pass-through Device Processing

Claims with pass-through device HCPCS codes (SI = H) furnished with certain device-intensive procedures require a payment offset to the APC payment rate for the procedure. Effective January 1, 2016 (v17.0), the IOCE shall identify the offset condition for the pass-through device HCPCS and associated device-intensive procedure by providing a unique claim level Payer Value Code (QN), with Value Code amount representing the payment offset in the claim return buffer. A payment adjustment flag is returned to identify the pass-through device HCPCS line(s) associated with the payment offset(s) multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through device HCPCS lines present that are associated with the same device-intensive procedure. An additional claim level Payer Value Code (QO) and payment adjustment flag value may be returned if there is an additional condition present for a separate device offset on the same claim (Payment adjustment flag values of 12 & 13 identify the pass-through devices which require offsets). Claims with pass-through devices reported without the associated device-intensive procedure are returned to the provider (edit 98).

Effective April 1, 2018 (v19.1), certain procedure and pass-through device pairings may have a mid-quarter activation date associated with its FDA approval. Claims reporting a pass-through device with a procedure prior to its mid-quarter activation date are line item denied (edit 105). The edit is returned on the line containing the pass-through device.

Note: Effective January 1, 2017 (v18.0), the pass-through device offset amounts are determined at the HCPCS code level, regardless of the APC assignment.

If there is a comprehensive APC procedure present (SI = J1) and there are conditions present on the claim for pass-through device payment offset, if there is a pass-through device associated (paired) with the primary comprehensive APC procedure, then a single device offset condition is identified for the claim (Payer Value Code QN only with corresponding offset amount). Conditions that may be present for pass-through device offset on a claim with a comprehensive APC that result in packaging of the device intensive procedure (SI = N) paired with the pass-through device do not produce a pass-through device payment offset.

An exception is made for claims containing the comprehensive APC for an inpatient-only procedure reported with modifier CA for a patient who expires that also contain conditions for pass-through device payment offset; the pass-through device payment offset is provided.

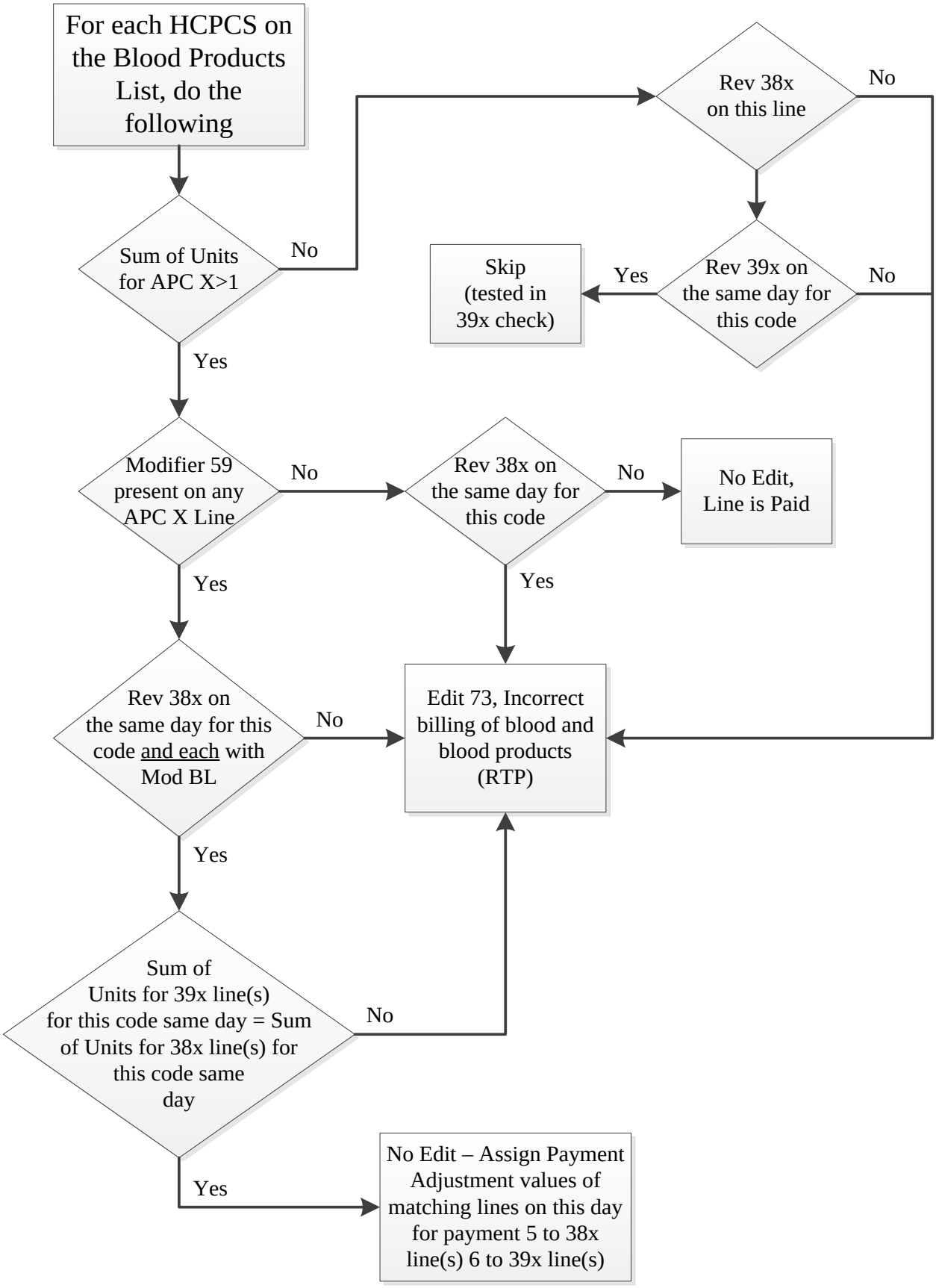
5.8 Blood and Blood Storage Processing

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. 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 (edit 79) (HCPCS codes with descriptions that include packed red cells or whole blood may be billed with either revenue code).

Effective 1/1/2015, packed red cells reported with revenue code 381 and whole blood reported with revenue code 382 that appear on a claim with a comprehensive APC procedure (SI = J1) are excluded from packaging; the standard SI is retained.

See blood and blood storage processing flowchart on the page that follows.

5.8.1 Billing for Blood/ Blood Products



5.9 Nuclear Medicine Procedure Processing

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

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 (edit 78) (v9.0 – v14.3).

5.10 Managed Care Processing

OPPS claims for Managed Care beneficiaries, as identified by the MAC (Payer only condition code MA – Managed Care enrollee), are not subject to line level deductible. Payment adjustment flag 4 is applied to all line items except for those that are packaged (SI = N) with line item charges = $0.00.

5.11 Preventive Services Processing

Deductible and co-insurance may be waived for certain preventive services (See HCPCS Map within the data files for services flagged as preventive) and for any services submitted with modifier Q3 (Live kidney donor surgery and related services) on the line. A payment adjustment flag value of 9 or 10 is applied to preventive services to specify that either the deductible/ co-insurance is not applicable (PAF 9) or that the Co-insurance is not applicable (PAF 10) (v12.0 - Current). Preventive services or services reporting modifier Q3 that are packaged (SI = N) with line item charges = $0.00 do not have a payment adjustment flag assigned for deductible and/ or coinsurance waiver.

Deductible is waived for all services coded in the CPT range 10000 – 69999, on any day/date of service when modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) is also present on a valid code in the same range on the claim. The IOCE sets the specified payment adjustment flag of 4 on the line, except when any other payment adjustment flag is already applied to the same line. If a line reporting modifier PT is packaged (SI = N) with charges = $0.00, the payment adjustment flag for deductible waiver is not applied.

5.12 Special Processing for Drugs and Biologicals

Effective April 1, 2016 (v17.1), claims containing specified pass-through drugs or biologicals furnished with an associated procedure require pass-through payment offset. If conditions exist for pass-through drug or biological payment offset, the IOCE shall provide a unique Payer Value Code with Value Code amount representing the amount of the payment offset. A payment adjustment flag will be assigned to the pass-through drug or biological to identify which line(s) is associated with the corresponding Payer Value Code and Value Code amount; PAF 18, identify the first pass-through drug or biological, while PAFs 19 and 20 identify the second and third pass-through drug or biologicals. Multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through drugs or biologicals present that are associated with the same offset condition. Claims that may contain multiple conditions eligible for pass-through drug or biological offset return additional Payer Value Codes.

Conditions that may be present for pass-through drug or biological payment offset on a claim with a comprehensive APC that result in packaging of the associated procedure (SI = N) paired with the pass-through drug or biological continue to produce a pass-through drug or biological payment offset. Specific pass-through drugs and biologicals that are not reported with an associated procedure for APC payment offset do not have coinsurance applied. Each PT drug present must be paired with an associated procedure (APC) in order to complete processing (edit 98).

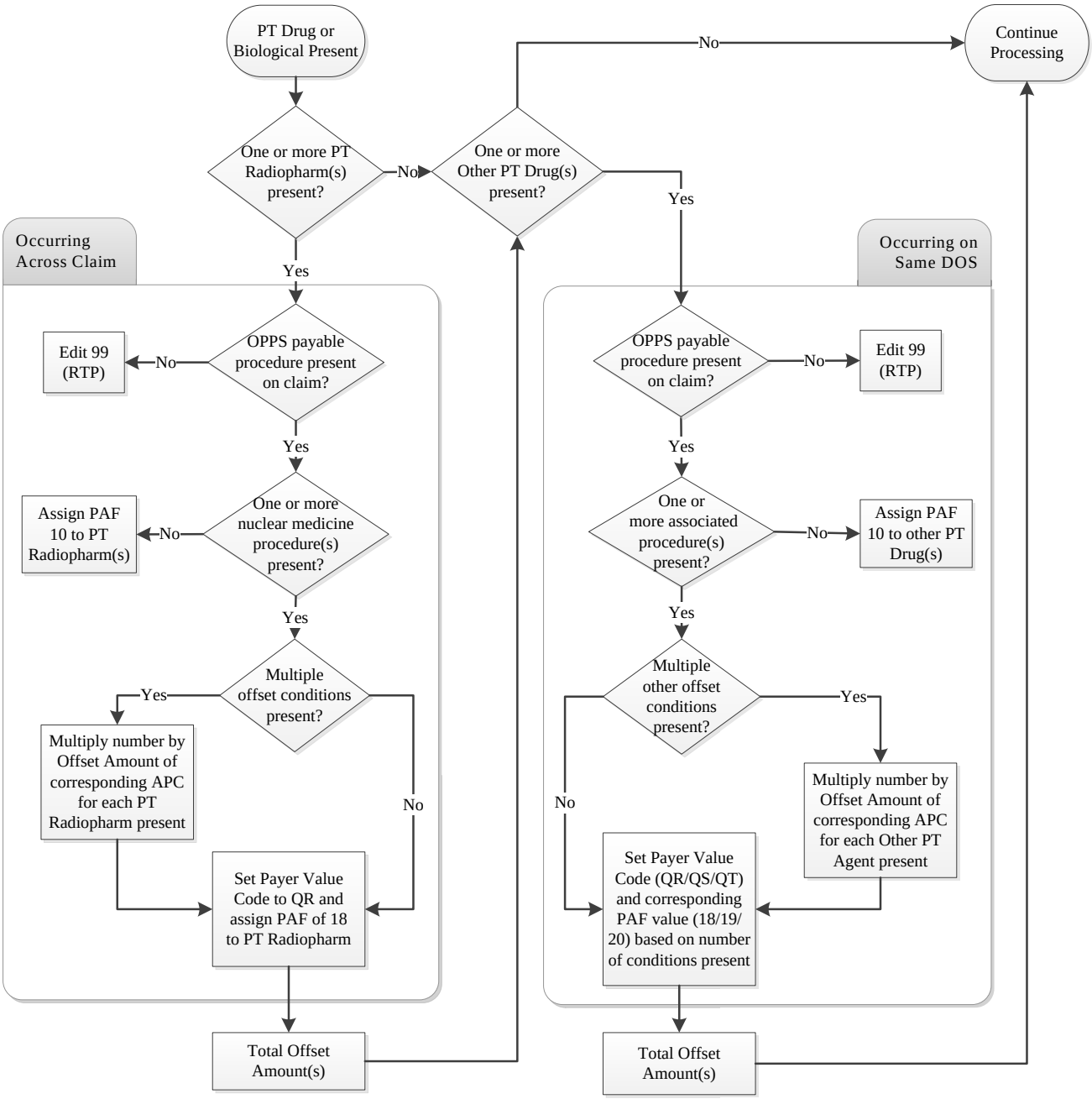
There are four categories of pass-through drug and biological conditions eligible for payment offset: radiopharmaceuticals, skin substitute products, contrast agents and stress agents. Conditions for payment offset for pass-through radiopharmaceuticals reported with an associated nuclear medicine procedure are considered across the claim; otherwise conditions for payment offset for other pass-through drug and biological categories reported with an associated procedure are performed for the same service date.

Effective October 1, 2016 (v17.3), claims containing drugs and biological HCPCS codes with pass-through status (SI =G) or non-pass-through status (SI = K) that are reported without an OPPS payable procedure (SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V) are returned to the provider (edit 99). There are exceptions for blood clotting factor HCPCS which may be self-administered, and certain biologic response modifier HCPCS, which do not require that an OPPS procedure is present. Additionally, payment for pass-through and non-pass-through drugs is no longer determined by the OPPS Pricer; the IOCE assigns payment indicator value of 2 for pass-through and non-pass-through drug HCPCS codes, representing drugs HCPCS priced by fee schedule (e.g. ASP drug file), although the final payment APC is provided.

Effective January 1, 2018 (v19.0), any service that is identified as a method used in manufacturing a drug or biological are not paid separately; these services are bundled into the total cost of the drug or biological. Claims submitted using these bundled services

(HCPCS) are line item rejected with edit 111, indicating that the service cost is duplicative. If the service identified as being bundled into the cost of the biological has a SI=B, edit 62 is not returned and instead edit 111 is applied. Additionally, if revenue code 870, 871, 872, or 873 (Cell/Gene Therapy) are reported with blank HCPCS, edit 111 is returned (LIR) to identify that the charges associated with the revenue center are bundled into the cost of a drug or biological.

5.12.1 Pass-through Drugs and Biologicals Processing



Notes:
1) PT = Pass-through; PAF = Payment Adjustment Flag
2) Pass-through drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents.
3) Radiopharmaceutical (radiopharm) pass-through processing occurs across the claim. "Other" PT drugs refers to contrast, skin substitute products and stress agents, which are processed across each day of service for a multiple day claim.
4) Each PT drug present must be paired with an associated procedure (APC) in order to complete processing (edit 98).
5) The setting of the Payer Value Code is dependent upon the type and number of PT conditions present. PT radiopharms are processed first if present, and occupy the first QR position with PAF 18 assigned to the radiopharm. "Other" PT drug conditions occupy the subsequent Payer Value Code positions and PAF 19 and 20 depending upon the number of conditions present.
6) OPPS payable procedures include those with SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V.
7) If the PAF is set to 10, the payment offset is not applicable.
8) Note: Edit 99 is also applicable for non-pass-through drugs and biologicals (SI = K).

5.13 Skin Substitute Editing and Processing

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

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

Effective 10/1/2015 (v16.3), if a skin substitute product code is present with line item action flag value of 2 representing an external line item denial, the line is not ignored by the IOCE for the purposes of applying edit 87. If the denied skin substitute product is on the list of skin substitute products and the skin substitute application procedure is also present, edit 87 is not returned.

5.14 Biosimilar HCPCS Processing

Effective January 1, 2016 (v17.0), OPPS and non-OPPS claims containing biosimilar HCPCS codes without a corresponding modifier representing the biosimilar manufacturer, are returned to the provider (edit 94).

Effective July 1, 2017, certain modifiers used for biosimilar HCPCS reporting may have a mid-quarter activation date associated with the FDA approval. Claims reporting these specific modifiers prior to the mid-quarter activation date are line item denied (edit 103). **Note:** Edits 94 and 103 are discontinued effective April 1/2018 (v19.1). These edits are returned on claims submitted within their respective effective dates.

5.15 HSCT and Donor Acquisition Services Processing

Effective January 1, 2017 (v18.0), claims containing HSCT (hematopoietic stem cell transplantation) allogenic transplantation procedure 38240 require the reporting of a separate line representing donor acquisition costs with revenue code 815. If the separate line with revenue code 815 is not present, the claim is returned to the provider (edit 100).

5.16 Radiological Processing

5.16.1 CT Scan Equipment Not Meeting NEMA Standards

Effective January 1, 2016 (v17.0), if modifier CT is reported for certain imaging codes for CT scans performed on equipment not meeting NEMA standards, a payment adjustment flag value of 14 is passed to the OPPS Pricer indicating the line is subject to payment reduction. Codes from the specified list that are reported with modifier CT and are packaged (SI = N) due to multiple imaging composite APC assignment or comprehensive APC assignment, do not receive payment adjustment. The first code assigned to a multiple imaging composite APC receives the payment adjustment flag if there are CT scan codes reported with modifier CT that are constituents of the composite APC (i.e., the composite APC line may or may not have modifier CT reported).

Note: Modifier CT should not be reported on the same HCPCS line with X-ray modifiers FX or FY as they are conflicting modifiers, edit 102 is returned to the provider.

5.16.2 Film X-Ray HCPCS Processing

Effective January 1, 2017 (v18.0), if modifier FX (X-ray taken using film) is reported with a film x-ray HCPCS code, a payment adjustment flag value of 21 is passed to the OPPS Pricer program indicating the line is subject to payment reduction. If the film x-ray reported with modifier FX is packaged (SI = N), no payment adjustment flag is assigned. If a film x-ray HCPCS code is reported with modifier FX and is also on the coinsurance deductible N/A procedure list, payment adjustment flag 23 is returned to Pricer, indicating that the line is subject to a payment reduction as well as the coinsurance/ deductible being not applicable.

5.16.3 Computed Radiography Technology HCPCS Processing

Effective January 1, 2018 (v19.0), if modifier FY (X-ray using computed radiography technology/cassette-based imaging) is reported with an x-ray HCPCS code using computed radiography technology, a payment adjustment flag value of 22 is passed to the OPPS Pricer program indicating the line is subject to payment reduction. If the computed radiography x-ray reported with modifier FY is packaged (SI = N), no payment adjustment flag is assigned. If an x-ray HCPCS code is reported with modifier FY and is also on the coinsurance deductible N/A procedure list, payment adjustment flag 24 is returned to Pricer indicating that the line is subject to a payment reduction as well as the coinsurance/ deductible being not applicable.

Note: Effective January 1, 2018 (v19.0), edit 102 is returned if modifiers FX and FY are reported together on the same line as they are identified as conflicting modifiers. To review the list of modifier conflicts subject to edit 102, please reference the data files and the report named Modifier Pairs.

5.17 Hospice and Home Health Processing

In order to allow the 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 have the status indicator changed from M to A; the claim is not returned to the provider. Note: This logic is discontinued effective 1/1/2014 as edit 61 and 72 are excluded from hospice claims processing (bill type 81x, 82x).

Home health claim submissions are episode-based with dates of service that can span a maximum of 60 days. To allow for the claims to be processed through the IOCE, diagnosis codes reported on a claim with dates of service that span the annual October diagnosis update and the previous release are not edited (edit 1).

Effective 10/1/2014, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis on hospice claims and effective 1/1/2015 for home health claims submitted with bill type 32x. Hospice and Home Health claims submitted with a manifestation code as principal diagnosis are returned to the provider with (edit 86).

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.

Effective January 1, 2017 (v18.0), Negative Pressure Wound Therapy (NPWT), reported with procedure codes 97607 or 97608, are separately payable OPPS services for HHAs when submitted on claims with bill type 34x, not under the Home Health PPS. If the NPWT codes are reported as a therapy service (therapy modifier and/or therapy revenue code present for the line), the codes are not processed as "sometimes therapy" and changed to SI=A by the IOCE; the standard SI and APC are retained for payment purposes. For the specified lists of services mentioned above please refer to the HCPCS map within data files.

Effective with the July 2018 release (v19.2), HHA claims (bill type 32x) are subject to procedure based edits 6 (Invalid Procedure) and 22 (Invalid Modifier); except in the instance of reporting a HIPPS code with revenue code 0023. Effective with the April 2019 release (v20.1), HHA's (32x) submitting claims with dates of service that span the annual (January) release and the previous quarter do not return edit 6 if the service provided is effective for the reported line item date of service.

5.18 Non-Excepted Items or Services in Off-Campus Provider-Based Hospitals (Section 603)

Effective January 1, 2017 (v18.0), certain items and services, when provided in an off-campus provider-based hospital outpatient department, may be considered non-excepted under Section 603 of the Bipartisan Budget Act of 2015. Non-excepted services are reported with modifier PN (Non-excepted off-campus svc), and are subject to special processing in the IOCE for determination of whether or not payment is to be made or reduced under an alternative method (i.e. Physician Fee Schedule (PFS)). Claims containing certain services that are not allowable with modifier PN are returned to the provider (edit 101). Claims that are reported with two of the following modifiers (PO, PN, or ER) on the same line item are returned to the provider, (edit 102).

5.18.1 Criteria for non-excepted services reported with modifier PN:

1. Special processing occurs only for hospital outpatient claims with bill type 13x with and without condition code 41, and bill type 76x (CMHC).
2. Non-excepted processing logic occurs after all other IOCE processing.
3. Services reported with modifier PN are identified using the Payment Method Flag for determination of payment method or reduction by the OPPS Pricer. (PMF 7 or PMF 8)

5.18.2 Hospital outpatient claims with bill type 13x without condition code 41:

1. Emergency department visits and critical care encounters that have standard assignment under SI = V or S (critical care) are not allowed with modifier PN. Edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.
2. Payment Method Flag Value 7 is applied for the following:
   - Services with SI = F, H, L, R and U that are excepted under Section 603
   - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T and V that have Payment Adjustment Flag Value 4, 9 or 10 assigned (preventive services)
   - Certain HCPCS codes for radiation treatment with SI = B when reported with modifier PN have the SI changed to S and are assigned a special APC (see quarterly data file reports for the list of radiation procedure codes)
3. Payment Method Flag Value 8 is applied for the following:
   - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T, and V, except for emergency department visits with SI = V and critical care encounters with SI = S. **Note:** HCPCS G0463 for clinic visit with SI = J2 (for comprehensive observation APC) or

standard SI = V is always assigned Payment Method Flag 8; it is not included in the list of emergency department visit codes or critical care encounters that are subject to edit 101.

- Services with SI = A, G, K and N have no impact; Payment Method Flag values 7 and 8 are not applicable.

5.18.3 Hospital off-campus provider-based outpatient departments submitting claims with Modifier PO:

1. Effective January 1, 2015, modifier PO is added as a valid modifier to voluntarily report items or services furnished in an off-campus provider-based outpatient department of a hospital (bill type 13x w/ or w/o CC 41). Effective January 1, 2016, reporting modifier PO is required to be reported for items or services performed in a hospital off-campus provider-based outpatient department.
2. Effective January 1, 2019, off-campus provider-based outpatient departments submitting clinic visit HCPCS code G0463 with modifier PO have payment method flag A returned, to apply a payment reduction in the OPPS Pricer. Note: Modifiers PO, PN, or ER cannot be submitted on the same HCPCS line item, edit 102 is returned to the provider.

5.18.4 Hospital outpatient claims with bill type 13x with condition code 41 (PHP):

1. PHP services with SI = P have a change in APC assignment to the CMHC PHP APC, with Payment Method Flag 7 applied.
2. **Note:** Non-PHP services reported with modifier PN that may be present on a hospital PHP claim are subject to the logic listed above for claims with bill type 13x without condition code 41.

5.18.5 CMHC PHP outpatient claims with bill type 76x:

1. PHP services with SI = P are not allowed with modifier PN. Edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.

5.19 FQHC Processing Under FQHC PPS

Effective for claims with From Dates on or after October 1, 2014, claims submitted through the IOCE with bill type 77x, and without condition code 65, for Federally Qualified Health Centers (FQHC) are processed under FQHC PPS. Processing occurs for each date of service if the claim contains multiple dates. FQHC claims are paid under a per encounter basis for qualified clinic visits. Any supporting ancillary services provided on the day of the FQHC visit are packaged into the encounter payment. If the FQHC claim contains multiple dates of service, each day is processed separately through the IOCE. Special output flag values are assigned during FQHC processing under the IOCE to facilitate identification of FQHC payment processing by the Pricer program.

5.19.1 Criteria for Processing FQHC PPS Claims Through the IOCE:

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

Specific revenue code to FQHC payment code requirements are as follows:

a. Medical visit codes require revenue code 52x or 519
b. Mental health visit codes require revenue code 900 or 519

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

Payable FQHC payment code lines are flagged with a Payment Indicator (PI) = 10, unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported, PI= 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. If multiple visits are reported, only one new patient FQHC payment HCPCS is assigned PI=13 per day. Any additional FQHC payment codes present for the same day are assigned PI=10. Qualifying visit codes that accompany the FQHC payment code are flagged with PI=12 and are packaged with Packaging Flag =5.

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

If there is an additional FQHC payment code for an established medical visit reported on the same day with modifier 59, this indicates that the visit is a subsequent, unrelated illness or injury provided on the same day as another FQHC visit. The subsequent visit may be

eligible for FQHC encounter payment, provided the appropriate FQHC visit criteria are met for the established patient FQHC visit reported with modifier 59. Any additional FQHC visits reported on the same day, reported with or without modifier 59, are packaged.

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

5.19.2 Additional Criteria for FQHC Processing

Effective January 1, 2016 (v17.0), Grandfathered Tribal FQHC providers are identified by the presence of payer only condition code MG passed to the IOCE on a claim for FQHC PPS services. Claims submitted for Grandfathered Tribal FQHC providers have different encounter requirements than other FQHC PPS providers. Only one visit is payable per day; if multiple visits are present for the same day, the first medical visit (or first mental health visit if no medical visits are reported) is identified to OPPS Pricer for payment with a payment indicator (PI=14); all other visits are packaged.

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

Effective January 1, 2016, Advance Care Planning services reported with code 99497 are considered a preventive service under FQHC PPS when reported with an annual wellness visit (initial or subsequent). If advance care planning is reported with the annual wellness visit it is identified as a packaged preventive service. If advance care planning is reported without the annual wellness visit, it is treated as a qualifying visit code to satisfy the FQHC encounter requirements and is packaged as a qualifying visit code.

Influenza and pneumococcal vaccines and associated vaccine administration services continue to be paid under reasonable cost through the cost report, and are not packaged into the FQHC encounter payment. If influenza and/or pneumococcal vaccine and vaccine administration is reported on the FQHC claim, the services are identified for the Pricer program as non-packaged services that are excluded from the FQHC encounter payment (PI=11).

Telehealth facility fees continue to be paid by the Medicare physician fee schedule, and are not packaged into the FQHC encounter payment. If telehealth facility fees are reported on the FQHC claim, the service is processed through the IOCE and identified as a non-packaged service for the Pricer program in order to be processed for fee schedule payment (packaging flag = 0). Effective July 1, 2015 (v16.2), Telehealth facility fees reported without a FQHC payment code and qualifying visit code are not returned to the provider.

Items or services that are not covered under the FQHC are line item rejected PPS (DME, ambulance, laboratory, and other non-covered services). Non-covered lines are assigned line item action flag 5 and PI=3, and although SI is ignored under FQHC, all non-covered lines are assigned to SI=E1. If line items with non-covered charges are passed into the IOCE with Line Item Action flag 5 previously assigned, these lines are not line item rejected. **Note:** All line items submitted on a claim with bill type 770 (No payment claim) are submitted to the IOCE with Line Item Action Flag 5 assigned; edit 91 is not returned for claims with bill type 770, nor is any other FQHC editing performed.

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

Effective October 1, 2015 (v16.3), claims containing only FQHC non-covered services reported without a FQHC payment code and qualifying visit code are not returned to the provider.

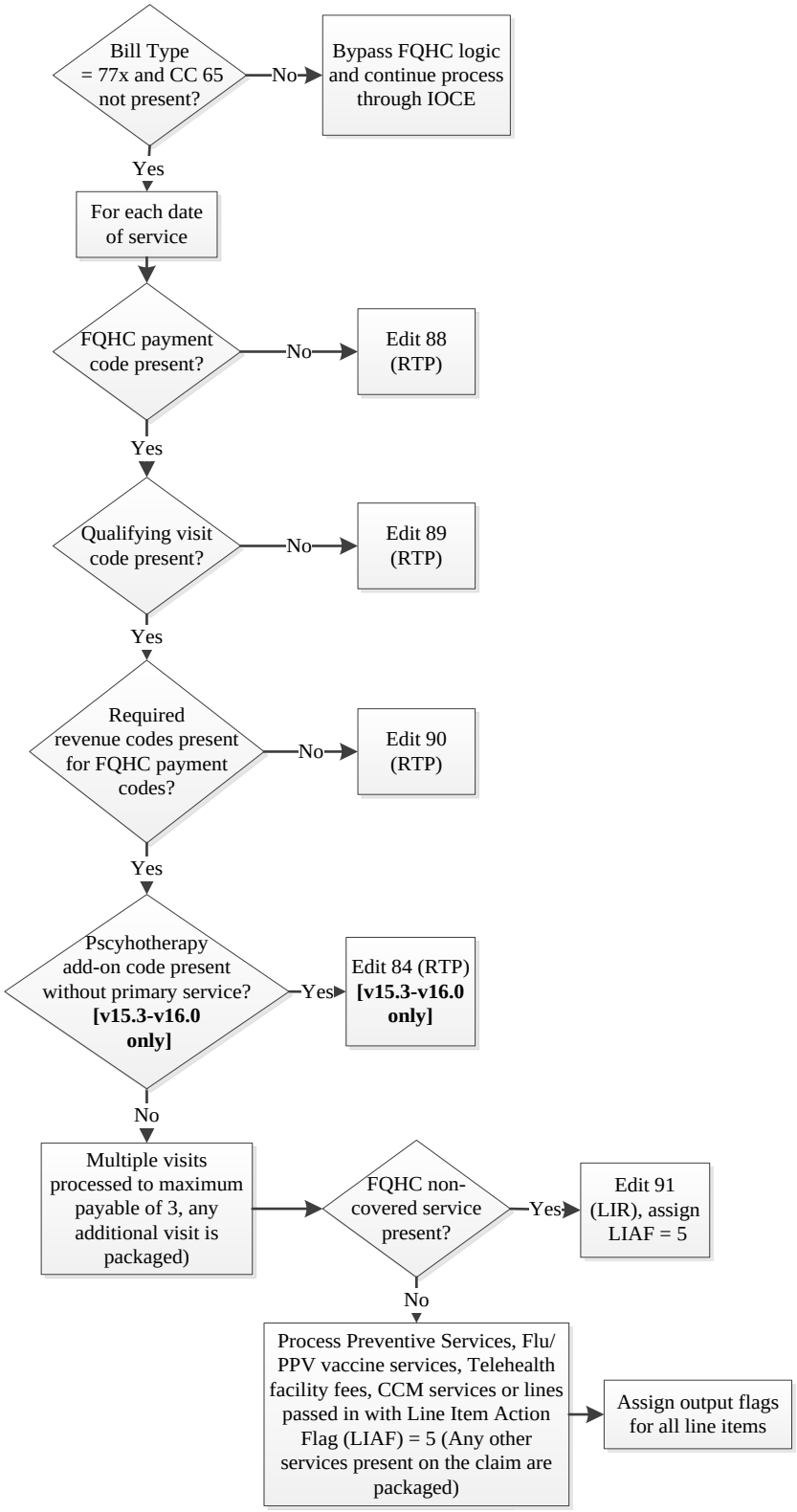
Effective 1/1/2016 (v17.0), Chronic Care Management (CCM) services are not packaged under FQHC PPS. If Chronic Care Management is reported, PI = 2 is assigned, indicating that it is paid under the Medicare Physician Fee Schedule. CCM services reported without a FQHC payment code or qualifying visit code bypass edits 88 and 89.

For claims with From dates on or after October 1, 2014 through March 31, 2015 (v15.3 – v16.0), mental health visits reporting psychotherapy services that are add-on codes require the reporting of a primary service code. A subset of the primary service codes for psychotherapy are also considered qualifying visit codes under the FQHC PPS. In order to satisfy the criteria for a FQHC mental health visit reporting a psychotherapy add-on code, if a psychotherapy add-on code is present with a mental health FQHC payment code, the psychotherapy add-on code is paired to a qualifying visit code that represents a primary service for the psychotherapy add-on code. If the primary service code is missing from a claim containing a FQHC mental health visit with a psychotherapy add-on code, the claim shall be returned to the provider (edit84). If there are multiple visits present for the day, once the criteria for a FQHC mental health visit with psychotherapy is satisfied for the add-on code, the paired qualifying visit code cannot be used as a qualifying visit code for other FQHC payment codes that may be present. However, the processing of psychotherapy add-on codes occurs after the

assignment of any new patient, IPPE/AWV, or other medical visit processing; qualifying visit codes that are utilized for previous medical visit assignment are not available for pairing with the psychotherapy add-on code for FQHC mental health clinic visits. For claims with From dates on or after April 1, 2015 (v16.1), mental health visits reporting psychotherapy add-on codes are no longer considered qualifying visits under the FQHC PPS. The psychotherapy add-on codes are packaged into the FQHC encounter payment when reported with a qualifying visit.

Services with SI = M are not billable to the MAC and are subject to edit 72. Effective 4/1/2018 (v19.1), there is a list of HCPCS codes with SI = M that are reportable for FQHC claims and therefore bypass edit 72 processing. For the list of HCPCS applicable to the edit 72 bypass condition, see the HCPCS Map within the quarterly data files.

5.19.2.1 FQHC Logic Flowchart (v15.3)



Notes:
1. Effective v16.2, if only Telehealth facility fees are reported, edits 88 and 89 are not returned.
2. Effective v16.3, if only FQHC non-covered services are present, edits 88 and 89 are not returned.
3. Effective v17.0, if condition code MG is present for Grandfathered Tribal FQHC provider, only a single FQHC encounter is eligible for payment.
4. Effective v17.0, Advanced Care Planning services may be treated as a qualifying visit code or if reported with an annual wellness visit, is treated as a packaged preventive service.

5.20 Rural Health Clinic Processing

Effective 4/1/2016 (v17.1), the non-covered services list for FQHC is applied to RHC (Rural Health Clinic) claims with bill type 71x. Program logic associated with the execution of edit 91 and the return of line item action flag 5 is included for RHC claims (Note: RHC claims are not subject to any additional FQHC PPS logic.)

Services with SI = M are not billable to the MAC and are subject to edit 72. Effective 4/1/2018 (v19.1), there is a list of HCPCS codes with SI = M that are reportable for RHC claims and therefore bypass edit 72 processing. For the list of HCPCS applicable to the edit 72 bypass condition, see the HCPCS Map within the quarterly data files.

Effective 4/1/2018 (v19.1), certain services deemed incorrectly reported with modifier CG (Policy criteria applied) for RHC claims are line item rejected (edit 104) as not being included in the RHC all-inclusive rate.

6 Edit Application within the IOCE

6.1 Introduction to Edits

As specified in the introduction to the IOCE, one of the three major functions provided by the IOCE is the application of edit(s) to identify errors. Each edit is unique, as it directly links the reason the edit is returned, any related information at the line or claim level, and the action required indicated by the edit disposition. For example, an edit can cause a line item rejection or return the claim to the provider. It is possible for a claim to have one or more edits in all 6 dispositions. The table below lists and describes each edit disposition.

6.1.1 Edit Dispositions Table

Disposition	Description
Claim Rejection	There are one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.
Claim Denial	There are one or more edits present that cause the whole claim to be denied. A claim denial means that the provider cannot resubmit the claim but can appeal the claim denial.
Claim Return to Provider (RTP)	There are one or more edits present that cause the whole claim to be returned to the provider. A claim returned to the provider means that the provider can resubmit the claim once the problems are corrected.
Claim Suspension	There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not returned to the provider, but is not processed for payment until the MAC decides or obtains further information.
Line Item Rejection (LIR)	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 Denial (LID)	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.

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.

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

6.1.2 Edit Return Buffer Table

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	0, 1-5, 29, 86, 109	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 28 diagnoses.
Procedure edit return buffer	3	30	0, 6, 8-9, 11-18, 20-21, 28, 30, 35, 37-38, 40, 42-45, 47, 49-50, 52-58, 60-64, 66 -74, 76-85, 87, 88, 89, 91, 92, 93, 94-98, 99-102, 104, 105, 106, 107, 108, 110, 111	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, 75,103	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, 41, 48, 50, 65, 90, 111	Three-digit code specifying the edits that applied to revenue centers.	There is one 5x3 buffer for each of up to 450-line items

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, 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.

Each of the edit 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.

Some of the IOCE edits are inactive for the current version of the program. Each edit is assigned a number and description which can be found in the Edit Description and Reason for Edit Generation Table. The Claim Return Buffer summarizes the edits that occurred on the claim.

6.2 Edit Descriptions and Reason for Edit Generation Table

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non OPPS	Disposition
1	Invalid diagnosis code	The principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid.	1.0 – present	8/1/00 - present	Yes	RTP
2	Diagnosis and age conflict	The diagnosis code includes an age range, and the age reported is outside that range.	1.0 – present	8/1/00 - present	Yes	RTP
3	Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.	1.0 – present	8/1/00 - present	Yes	RTP
4	Medicare secondary payer alert	The procedure code has a MSP alert warning indicator. This edit applies to v1.0 and v1.1 only, and is not applicable for reason for visit diagnosis	1.0 – 1.1	8/1/00 – 12/31/00	No	Suspend
5	External cause of morbidity code cannot be used as principal diagnosis	The diagnoses reported is considered a morbidity code and cannot be used as the principal diagnoses	1.0 – present	8/1/00 - present	Yes	RTP
6	Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.	1.0 – present	8/1/00 - present	Yes	RTP
7	Procedure and age conflict (inactive)	N/A	N/A	N/A	No	RTP
8	Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure code reported. This edit is bypassed if condition code 45 is present on the claim.	1.0 – present	8/1/00 - present	Yes	RTP
9	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	The procedure code is flagged as Non-covered for reasons other than statute exclusion or Revenue code is 099x with SI of E1 and is submitted without a HCPCS code. This edit is bypassed when code G0428 is present with SI of E.	1.0 – present	8/1/00 - present	Yes	LID
10	Service submitted for denial (condition code 21)	The claim submitted has condition code 21 present	1.0 – present	8/1/00 - present	Yes	Claim Denial
11	Service submitted for MAC review (condition code 20)	The claim has condition code 20 present.	1.0 – present	8/1/00 - present	Yes	Suspend
12	Questionable covered service	The procedure reported is flagged as a Questionable covered service.	1.0 – present	8/1/00 - present	Yes	Suspend
13	Separate payment for services is not provided by Medicare	The claim is OPPS and the bill type is 12/14x without condition code 41 or the bill type is 13x, and the HCPCS code is on the 'Separate payment for service not provided by Medicare' list (SI= E2) or The claim is non-OPPS and the bill type is any other than those defined for OPPS claims (above), the HCPCS code is on the 'Separate payment for service not provided by Medicare' list and the status indicator is not B.	1.0 – 6.3, 18.0- Present	8/1/00 – 12/31/05, 1/1/2017 - Present	No	LIR
14	Code indicates a site of service not included in OPPS	This procedure code has a Not included in OPPS indicator. This edit applies to v1.0-v6.3 only.	1.0 – 6.3	8/1/00 – 12/31/05	No	RTP
15	Service unit out of range for procedure (inactive)	The maximum units allowed is greater than zero and the sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure and Modifier 91 is not present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit.	1.0 – 9.1	8/1/00 – 6/30/08	Yes	RTP
16	Multiple bilateral procedures without modifier 50	The same bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant procedure lines for dates of service prior to 10/01/05 only	1.0 – 6.2	8/1/00 – 6/30/05	No	RTP
17	Inappropriate specification of bilateral procedure	The same inherent bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant bilateral procedure lines, except when modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code. Note: For codes with an 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. This edit is also bypassed if the bill type is 85x.	1.0 – present	8/1/00 – present	Yes	RTP
18	Inpatient procedure	A line has a C status indicator and is not on the 'separate procedure' list or A line has a C status indicator and is on the 'separate procedure' list, but there are no type T lines on the same day. All other line items on the same day as the line with a C status indicator are denied (line item denial/rejection flag = 1, APC return buffer) and edit 49 is assigned on all line items. *This is the only edit that can cause one or more days of a multiple-day claim to be denied, or single day claim with all lines denied. No other edits are performed on any lines with edits 18 or 49.	1.0 – present	8/1/00 – present	No	LID
19	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present	A pair of procedures reported on a claim in which one of the procedures is identified by NCCI to be mutually exclusive and cannot be reported together on the same day. The second procedure within the NCCI pair will obtain edit 19.	1.0 – 13.1	8/1/00 – 6/30/12	No	LIR

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non OPPS	Disposition
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The second procedure reported is part of an NCCI pair, which will cause the generation of edit 20 to LIR even in the presence of a modifier.	1.0 – present	8/1/00 – present	Yes	LIR
21	Medical visit on the same day as a type T or S procedure without modifier 25	One or more type T or S procedures occur on the same day as a line item containing an E&M code, without modifier 25. See Medical Visit Processing logic for more information.	1.0 – present	8/1/00 – present	No	RTP
22	Invalid modifier	The modifier is not in the list of valid modifier entries and the revenue code is not 540.	1.0 – present	8/1/00 – present	Yes	RTP
23	Invalid date	The service date and/or the from and through dates are invalid. Or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim.	1.0 – present	8/1/00 – present	Yes	RTP
24	Date out of OCE range	The From/Through date falls outside the date range of any version of the program. Presence of this edit condition terminates processing for the claim.	1.0 – present	8/1/00 – present	Yes	Suspend
25	Invalid age	The age is non-numeric or outside the range of 0-124 years.	1.0 – present	8/1/00 – present	Yes	RTP
26	Invalid sex	The sex is non-numeric or outside the range of 0-2.	1.0 – present	8/1/00 – present	Yes	RTP
27	Only incidental services reported	All line items are incidental (status indicator N). If edit 27 is present no other edits are performed.	1.0 – present	8/1/00 – present	No	Claim Rejection
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare' indicator.	1.0 – present	8/1/00 – present	Yes	LIR
29	Partial hospitalization service for non-mental health diagnosis	The principal diagnosis is not related to mental health.	1.0 – present	8/1/00 – present	No	RTP
30	Insufficient services on day of partial hospitalization	If less than 3 PHP services are reported for any one day, the day is denied and the lines return edit 30. See Partial Hospitalization Processing logic for more information.	1.0 – present	8/1/00 – present	No	LID
31	Partial hospitalization on same day as ECT or type T procedure	Electroconvulsive therapy or a significant procedure (SI=T) occurs on the same day as partial hospitalization, and APC 33 partial hospitalization) is assigned to a mental health service on the same day.	1.0 – 6.3	8/1/00 – 12/31/05	No	Suspend
32	Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days	A claim suspended for medical review (edit 30) does not span more than three days.	1.0 – 9.3	8/1/00 – 12/31/08	No	Suspend
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	A claim suspended for medical review (edit 30) spans more than three days. However, partial hospitalization services were not provided on at least 57% 4/7) of the days.	1.0 – 9.3	8/1/00 – 12/31/08	No	Suspend
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	A claim suspended for medical review (edit 30) spans more than three days and partial hospitalization services were provided on at least 57% 4/7) of the days. However, on the days when partial hospitalization services were provided, less than 75% of the days met the partial hospitalization day of service criteria i.e., edit 30 occurred on the line item).	1.0 – 9.3	8/1/00 – 12/31/08	No	Suspend
35	Only Mental Health education and training services provided	Only education and training services are present without other mental health service; the claim fails mental health status.	1.0 – present	8/1/00 – present	No	RTP
36	Extensive mental health services provided on day of type T procedure	Electroconvulsive therapy or a non-mental health type T procedure APC is present on the same day as extensive mental health service.	1.0 – 6.3	8/1/00 – 12/31/05	No	Suspend
37	Terminated bilateral procedure or terminated procedure with units greater than one	A modifier 52 or 73 is present, as well as: an independent or conditional bilateral procedure with modifier 50 or a procedure with units greater than 1.	1.0 – present	8/1/00 – present	No	RTP
38	Inconsistency between implanted device or administered substance and implantation or associated procedure	The status indicator is H, U, or APC 987-997 (Implant) is present, but no type S, T, or non-implant type X procedures are present on the claim (v1.0-15.3 only). There is a code with status indicator H or U present, but no type S, T, or J1 procedures are present on the same claim. See Device-Dependent Procedure Editing and Processing for more information.	1.0 – present	8/1/00 – present	No	RTP

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non OPPS	Disposition
39	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (deleted, combined with edit 40 retroactive to earliest included version)	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.	1.0 – 13.1	8/1/00 – 6/30/12	No	LIR
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.	1.0 – present	8/1/00 – present	Yes	LIR
41	Invalid revenue code	The revenue code is not in the list of valid revenue code entries.	1.0 – present	8/1/00 – present	Yes	RTP
42	Multiple medical visits on same day with same revenue code without condition code G0	Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other. See Medical Visit Processing for more information	1.0 – present	8/1/00 – present	No	RTP
43	Transfusion or blood product exchange without specification of blood product	A blood transfusion or exchange is coded but no blood product is reported.	1.1 – present	10/1/00 - present	No	RTP
44	Observation revenue code on line item with non-observation HCPCS code	A 762 (observation) revenue code is used with a HCPCS other than observation 99217-99220, 99234-99236, G0378, reported.	2.0 – present	1/1/01 - present	No	RTP
45	Inpatient separate procedures not paid	On the same day, all lines with status indicator C are on the 'separate procedure' list, and there is at least one type T or J1 line. (Note: Lines with SI=C if reported on a claim with a C-APC procedure SI=J1, the lines with the inpatient-separate procedure return edit 45.)	2.3 – present	8/1/00 - present	No	LIR
46	Partial hospitalization condition code 41 not approved for type of bill	Bill type 12x or 14x is present with condition code 41. Edit 46 terminates processing only for those bill types where no other edits are applied	2.0 – present	1/1/01 – present	Yes	RTP
47	Service is not separately payable	The claim consists entirely of a combination of lines that: are denied or rejected or have a status indicator N Edit 47 is assigned to all lines with status indicator N, or that change from Q to N, that are not already denied or rejected and have no other service on the claim.	2.2 – present	8/1/00 - present	No	LIR
48	Revenue center requires HCPCS	The bill type is 13x, 74x, 75x, 76x, or 12x/14x without condition code 41, HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed when the revenue code is 100x, 210x, 310x, 099x, 0905-0907, 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932, 0521, 0522, 0524, 0525, 0527, 0528, 0637, or 0948; see also edit 65.	2.2 – present	8/1/00 – present	No	RTP
49	Service on same day as inpatient procedure	A service is reported on the same day as a C status indicator.	3.0 - present	8/1/00 – present	No	LID
50	Non-covered under any Medicare outpatient benefit, based on statutory exclusion	The Code reported is on 'statutory exclusion' list or the Revenue code is 0637 with SI of E when submitted without a HCPCS code.	3.0 - present	8/1/00 – present	Yes	RTP
51	Multiple observations overlap in time (inactive)	N/A	N/A	N/A	No	RTP
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions	The observation period is less than 8 hours or there is no diagnosis of CHF, chest pain or asthma or there is a T procedure (except 90780) on the same or previous day.	3.0 – 6.3	4/1/02 – 12/31/05	No	RTP
53	Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.	3.0 – present	4/1/02 – present	Yes	LIR
54	Multiple codes for the same service	Any of the following three pairs of codes appear on the same claim; C1012 and P9033, C1013 and P9031, or C1014 and P9035.	3.0 – 4.1	4/1/02 – 4/1/03	Yes	RTP
55	Non-reportable for site of service	The procedures reported are non-reportable for the site of service indicated.	3.0 – present	8/1/00 – present	No	RTP
56	E/M condition not met and line item date for obs code G0378 is not 12/31/ or 1/1	There is no specified E/M code the day of or the day preceding the observation and the date of observation is not 12/31/yyyy or 1/1/yyyy.	4.0 – 6.3	1/1/03 – 12/31/05	No	RTP
57	E/M condition not met for observation and line item date for code G0378 is 1/1	There is no specified E/M or critical care visit the day of or the day preceding the observation and the date of observation is 01/01/yyyy.	4.0 – present	1/1/03 – present	No	Suspend
58	G0379 only allowed with G0378	Code G0379 is present without code G0378 for the same line item date.	4.1 – present	4/1/03 – present	No	RTP

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non OPPS	Disposition
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis (deleted, retroactive to the earliest included version)	Code G0292, G0293 or G0294 is present and Diagnosis code V70.7 is not present as admit or secondary diagnosis.	4.1 – 11.1	1/1/03 – 6/30/10	No	RTP
60	Use of modifier CA with more than one procedure not allowed	Modifier CA is present on more than one line or Modifier CA is submitted on a line with multiple units. (see Inpatient Procedure Processing)	4.1 – present	1/1/03 – present	No	RTP
61	Service can only be billed to the DMERC	The procedure code has a 'DME only' indicator.	5.0 – present	8/1/00 – present	Yes	RTP
62	Code not recognized by OPPS; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare for OPPS' indicator. Services with a status indicator of B always return edit 62.	5.0 – present	1/1/04 – present	No	RTP
63	This OT code only billed on partial hospitalization claims	Occupational therapy services are present and the bill type is 12x or 13x without condition code 41.	1.0 – 13.3	8/1/00 – 12/31/12	No	RTP
64	AT service not payable outside the partial hospitalization program	Activity therapy services are present and the bill type is 12x or 13x without condition code 41.	1.0 – 13.3	8/1/00 – 12/31/12	No	LIR
65	Revenue code not recognized by Medicare	The revenue code is 100x, 210x, 310x, 0500, 0509, 0583, 0660-0663, 0669, 0905-0907, 0931, or 0932; see also edit 48.	5.2 – present	8/1/00 – present	Yes	LIR
66	Code requires manual pricing	The HCPCS code is an unclassified drug code.	5.2 – present	1/1/04 – present	No	Suspend
67	Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.	5.2 – present	1/1/04 – present	Yes	LID
68	Service provided prior to date of National Coverage Determination (NCD) approval	The line item date of service of a code is prior to the code activation date.	6.0 – present	7/1/04 – present	Yes	LID
69	Service provided outside approval period	The service was provided outside the period approved by CMS.	6.0 – present	10/1/04 – present	Yes	LID
70	CA modifier requires patient discharge status indicating expired or transferred	CA modifier requires patient discharge status indicating expired or transferred. (See Inpatient Procedure Processing)	6.1 – present	4/1/05 – present	No	RTP
71	Claim lacks required device code	A specified procedure is submitted on a claim without the code (s) for the required devices). This edit is bypassed if the procedure is terminated - modifier 52, 73, or 74.)	6.1 – 15.3	4/1/05 – 12/31/14	No	RTP
72	Service not billable to the Medicare Administrative Contractor	A code has a status indicator M. This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x. This edit is also bypassed when the bill type is 81x or 82x and the revenue code is 657.	6.1 – present	1/1/05 – present	Yes	RTP
73	Incorrect billing of blood and blood products	Blood product claims lack two identical lines (of HCPCS code, units, and modifier BL), one line with revenue code 38x and the other line with revenue code 39x. See Blood and Blood Storage Processing for more information.	6.2 – present	7/1/05 – present	No	RTP
74	Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same line.	7.3 – present	10/1/06 – present	Yes	RTP
75	Incorrect billing of modifier FB or FC	Modifier FB or FC is present and SI is not S, T, V or X.	8.0 – 15.3	1/1/07 – 12/31/14	No	RTP
76	Trauma response critical care code without revenue code 068x and CPT 99291	Trauma response critical care code is present without revenue code 068x and CPT code 99291 on the same date of service.	8.0 – present	1/1/07 - present	No	LIR
77	Claim lacks allowed procedure code	A specified device is submitted on a claim without a code for an allowed procedure, and the bill type is not 12x.	8.1 – 15.3	1/1/07 – 12/31/14	No	RTP
78	Claim lacks required radiolabeled product	A specified nuclear medicine procedure is submitted on a claim without the code for a required radiopharmaceutical.	9.0 – 14.3	1/1/08 – 12/31/13	No	RTP
79	Incorrect billing of revenue code with HCPCS code	The revenue code is 381 with a HCPCS code other than packed red cells (P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9057, P9058) or The revenue code is 382 with a HCPCS code other than whole blood P9010, P9051, P9054, and P9056). See Blood and Blood Storage Processing for more information.	9.3 – present	10/1/08 – present	No	RTP
80	Mental health code not approved for partial hospitalization	Mental health HCPCS codes that are not approved for partial hospitalization program submitted on bill type 13x with condition code 41, or bill type 76x.	9.3 – present	1/1/08 – present	No	RTP
81	Mental health service not payable outside the partial hospitalization program	Mental health HCPCS codes that are not payable outside the partial hospital program submitted on bill type 12x or 13x without condition code 41.	10.0 – present	1/1/09 – present	No	RTP
82	Charge exceeds token charge ($1.01)	Code C9898 is billed with charges greater than $1.01.	10.0 – present	1/1/09 – present	No	RTP
83	Service provided on or after effective date of NCD	The line item date of service of a code is on or after the date of non-coverage determination.	10.0 – present	1/1/09 – present	Yes	LID

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non OPPS	Disposition
84	Claim lacks required primary code	Certain claims are returned to the provider if a specified add-on code is submitted without a code for a required primary procedure on the same date of service (edit 84). Add-on codes 33225, 90785, 90833, 90836 or 90838 are submitted without one of the required primary codes on the same day. (Note: PHP add-on codes are editing with 84 until version 18.1 where PHP add-on code editing is terminated).	13.0 - present	1/1/12 – present	No	RTP
85	Claim lacks required device code or required procedure code	Code C9732 and C1840 not submitted together on the same day. (Code for insertion of ocular telescopic lens submitted without the code for the intraocular lens, or vice versa). Discontinued insertion procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing telescopic lens code.	13.0 – 14.3	1/1/12 – 12/31/13	No	RTP
86	Manifestation code not allowed as principal diagnosis	A diagnosis code considered to be a manifestation code from the Medicare Code Editor (MCE) manifestation diagnosis list is reported as the principal diagnosis code on a hospice bill type claim 81X, 82X).	15.3 – present	10/1/14 – present	No	RTP
87	Skin substitute application procedure without appropriate skin substitute product code	A List A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service. See Skin Substitute Editing and Processing logic for more information.	15.0 – present	1/1/14 – present	No	RTP
88	FQHC payment code not reported for FQHC claim	FQHC payment code not reported for a claim with bill type 77x and without Condition Code 65. Note: If the bill type is 770 (No payment claim), edit 88 is not applicable. Note: Edit 88 is bypassed for FQHC PPS claims when Telehealth originating site services HCPCS code Q3014 or Chronic Care Management HCPCS 99490 is reported and there is no FQHC payment code; also edit 88 is bypassed for FQHC when only FQHC non-covered services are present with edit 91. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	No	RTP
89	FQHC claim lacks required qualifying visit code	FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS. Note: Edit 89 is bypassed for FQHC PPS claims when Telehealth originating site services HCPCS code Q3014 or Chronic Care Management HCPCS 99490 is reported and there is no FQHC payment code or qualifying visit code present; also edit 89 is bypassed for FQHC when only FQHC non-covered services are present with edit 91. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	No	RTP
90	Incorrect revenue code reported for FQHC payment code	FQHC payment code not reported with revenue code 519, 52X or 900. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	No	RTP
91	Item or service not covered under FQHC PPS or for RHC	A service considered to be non-covered under FQHC PPS or for RHC is reported. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	No	LIR
92	Device-dependent procedure reported without device code	A device-dependent procedure is reported without a device code. See Device-Dependent Procedure Editing and Processing for more information.	16.0 – present	1/1/15 – present	No	RTP
93	Corneal tissue processing reported without cornea transplant procedure	Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date.	17.0 – present	1/1/16 - present	No	LIR
94	Biosimilar HCPCS reported without biosimilar modifier	A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier which represents the biosimilar manufacturer. See Biosimilar HCPCS processing for more information.	17.0 – 19.0	1/1/16 – 3/31/18	Yes	RTP
95	Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care	A PHP claim contains weekly PHP services that total less than 20 hours per 7-day span. This edit applies to v17.2 with a disposition of RTP, and effective v18.3- Present, with a disposition of LIR. See Partial Hospitalization Processing logic for more information. This edit is an information only edit it has a LIR disposition but it will not perform the line rejection due to being defined as information only.	17.2, 18.3-present	7/1/16 – 9/30/16, 10/1/17 - present	No	LIR (Information only edit)
96	Partial hospitalization interim claim from and through dates must span more than 4 days	An interim PHP claim (bill type 763 or 133 with condition code 41) From and Through date spans less than 5 days. See Partial Hospitalization Processing logic for more information.	17.2 only	7/1/16 – 9/30/16	No	RTP
97	Partial hospitalization services are required to be billed weekly	A PHP claim From and Through date spans more than 7 days. See Partial Hospitalization Processing logic for more information.	17.2 only	7/1/16 – 9/30/16	No	RTP
98	Claim with pass through device lacks required procedure	A pass-through device is present without an associated, required procedure. See Pass-Through Device Processing for more information.	17.2 – present	1/1/16 - present	No	RTP

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99	Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V. See Special Processing for Drugs and Biologicals for more information.	17.3 - present	1/1/16 – present	No	RTP
100	Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition service. See HSCT and Donor acquisition services processing.	18.0 – present	1/1/17 - present	No	RTP
101	Item or service with modifier PN not allowed under PFS	Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603. See Section 603 Logic for more information.	18.0 – present	1/1/17 – present	No	RTP
102	Modifier pairing not allowed on the same line	A line item is reported with a pair of modifiers that have conflicting meaning and should not be reported together. Please reference the data files for a report named Modifier Pairs, which contains an up to date list of modifiers not allowed to be reported on the same line. **Note:** Edit 102 is updated in v20.0 retroactively to inception (1/1/17) , to not allow any conflicting modifiers to be reported on the same line item reporting HCPCS.	18.0 – present	1/1/17 – present	Yes	RTP
103	Modifier reported prior to FDA approval date	A modifier is reported before its activation date for reporting. See biosimilar HCPCS processing.	19.0 only	7/1/17 – 3/31/18	Yes	LID
104	Service not eligible for all-inclusive rate	An RHC claim (71x) is reported with a line containing the CG modifier.	19.1 – present	4/1/18 – present	No	LIR
105	Claim reported with pass-through device prior to FDA approval for the procedure	A procedure is reported with a device before the FDA approval date. The edit is returned on the line containing the device. See Device Pass-Through processing	19.1 – present	7/1/17 – present	No	LID
106	Add-on code reported without required primary procedure code	A claim is submitted with a Type I add-on code(s) without the applicable defined primary procedure(s). The edit is returned on the add-on code line(s) when conditions of the edit are not met. See Add-on Code Edit Processing for more information.	19.1 – present	4/1/18 – present	Yes	LID
107	Add-on code reported without required contractor-defined primary procedure code	A claim with bill type 85x (CAH) is submitted with a Type II add-on code(s) reported with a professional services revenue code (96x, 97x or 98x), to allow for contractors to review and define the primary procedure on the claim. See Add-on Code Edit Processing for more information.	19.1 – present	4/1/18 – present	Yes	LID
108	Add-on code reported without required primary procedure or required contractor-defined primary procedure code	A claim is submitted with a Type III add-on code(s) without a defined primary(s) or contractor defined primary(s) procedure. This edit is returned on the add-on code line(s) when conditions are not met. See Add-on Code Edit Processing for more information.	19.1 – present	4/1/18 – present	Yes	LID
109	Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	A PHP claim is submitted with a Code First Diagnosis without a mental health diagnosis in the first secondary diagnosis position. If the first secondary diagnosis position is blank edit 109 is still returned. Note: Edit 29 is suppressed from being returned if a code first diagnosis is present in the pdx position. See PHP processing section for more information.	20.0-present	10/1/18-present	No	RTP
110	Service provided prior to initial marketing date	The reported line item date of service of a code is prior to the initial marketing date, for which it can be reported.	20.0-present	7/1/18-present	Yes	LIR
111	Service cost is duplicative; included in cost of associated biological.	The reported line item is considered duplicative as the routine costs of all steps in creating a biological are bundled into the covered benefit, the biological. Any procedure identified as being "bundled into biological" and reported as a line item are rejected. Additionally, this edit is returned if revenue codes 870-873 are submitted as line items with blank HCPCS.	20.2 -present	1/1/18-present	Yes	LIR

6.3 OCE Edits Applied by OPPS Bill Type Table [OPPS Flag =1]

Row #	Provider/Bill Types	Edits Applied (by edit number)	APC buffer
1	12x or 14x with condition code 41	46	Buffer not completed
2	12x or 14x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52-54, 56-58, 60-79, 81-85, 87, 92, 93, 94, 98, 99, 100, 102, 103, 105, 110, 111	Buffer completed
3	13x with condition code 41	1-9, 11-18, 20-23, 25-28, 29-34, 37, 38, 40-45, 47-50, 52, 54, 56-58, 60-62, 65-80, 82–85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 105, 109, 110, 111	Buffer completed
4	13x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52, 54, 56-58, 60-79, 81, 82-85, 87, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105, 110, 111	Buffer completed
5	76x (CMHC)	1-9, 11-13, 15, 18, 20, 22, 23, 25, 26, 29-34, 38, 40, 41, 43-45, 47-50, 53-55, 61, 65, 69, 71-73, 75, 77- 80, 82, 84, 85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 105, 109, 110, 111	Buffer completed
6	34x (HHA) with Vaccine Administration, Antigens, Splints, Casts or NPWT	1-5,7-9, 11-13, 15, 18, 20, 25-26, 28, 38, 40, 41, 43-45, 47, 49-50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105, 110, 111	Buffer completed
7	34x (HHA) without Vaccine Administration, Antigens, Splints, Casts or NPWT	1-5, 7-9, 11-13, 20, 25, 26, 40-41, 44, 50, 53-55, 65, 69, 94, 110, 111	Buffer not completed
8	43x (RNHCI)	25, 26, 41, 44, 46, 55, 65	Buffer not completed
9	71x (RHC), 77x (FQHC through v15.2)	1-5, 6, 25, 26, 41, 61, 65, 72, 91, 94, 104, 110, 111	Buffer not completed
10	77x (FQHC PPS) [v15.3 -]	1-6, 25, 26, 41, 65, 72, 84, 88, 89, 90, 91, 94, 110, 111	Buffer not completed
11	Any bill type except 12x, 13x, 14x, 34x, 43x, 71x, 73x/77x, 76x, with CC 07, with Antigen, Splint, or Cast	1-9, 11-13, 18, 20, 23, 25, 26, 28, 38,40, 41, 43-45, 47, 49, 50, 53-55, 62, 65, 69, 71, 73, 75, 77 -79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105, 106, 108, 110, 111	Buffer completed
12	75x (CORF)	1-9, 11-13, 15, 20, 22, 23, 25, 26, 40, 41, 44, 48, 50, 53-55, 61, 65, 69, 72, 94, 106, 102, 108, 110, 111	Buffer not completed
13	22x, 23x (SNF),	1-9, 11-13, 20, 23, 25, 26, 28, 40-41, 44, 50, 53, 54, 55, 61, 62, 65, 69, 72, 94, 106, 108, 110, 111	Buffer not completed
14	32x, (HHA) 33x [33x: v1.0 – 14.2 only]	1-9, 11, 12, 20, 22, 25, 26, 40, 41, 44, 50, 53-55, 65, 69, 86, 94, 102 106, 108, 110, 111	Buffer not completed
15	72x (ESRD)	1-9, 11, 12, 20, 22,25, 26, 40,41, 44, 50, 53, 54, 55, 61, 65, 69, 72, 94, 102, 106, 108, 110, 111	Buffer not completed
16	74x (ORF)	1-9, 11-13, 20, 22, 25, 26, 40-41, 44, 48, 50, 53, 54, 55, 61, 65, 69, 72, 94, 102, 106, 108, 110, 111	Buffer not completed
17	81x (Hospice), 82x	1-9, 11, 12, 20, 22, 25, 26, 40, 41, 44, 50, 53-55, 65, 69, 86, 94, 102, 106, 108, 110, 111	Buffer not completed

6.4 OCE Edits Applied by Non-OPPS Hospital Bill Type Table [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, 17,20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 53, 54, 61, 65, 67-69, 72, 83, 94, 102, 103, 106, 108, 110, 111	Buffer not completed
3	13x with condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17,20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 102, 103, 106, 108, 110, 111	Buffer not completed
4	13x without condition code 41, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 102, 103, 106, 108, 110, 111	Buffer not completed
5	85x, and OPPS flag = 2	1-3, 5, 6, 8, 9, 11, 12, 15, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 74, 83, 94, 102, 106, 107, 108, 110, 111	Buffer not completed

7 IOCE APC Processing

7.1 Standard APC Processing

As stated in the introduction the second main function of the IOCE is to assign an APC (Ambulatory Payment Classification) number for each service covered under OPPS (the APC is only returned for claims from HOPDs that are subject to OPPS), as well as return information within the APC return buffer to be used as input to the OPPS PRICER program for payment. There are two types of APCs assigned within the IOCE output. The HCPCS APC is the default APC given to a HCPCS/ CPT code. The Payment APC when assigned, is the APC given to the line(s) that determines payment for the line. The Payment APC may be different from the HCPCS APC based on additional processing logic that determines the final APC. The APC Return Buffer contains the APC output information for each line item along with the relevant information for computing OPPS payment for OPPS hospital claims. A series of flags and editing will affect which APC is assigned for the final payment APC. When all criteria within the APC return buffer is filled, the IOCE passes information to the OPPS PRICER to apply the payment amount to any paying lines of service on the claim.

The OPPS PRICER computes the standard APC payment for a line item as the product of the payment amount corresponds 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 indicator has a value of 1
- Packaging flag has a value of zero or 3
- Line item denial or rejection flag is zero or the line item action flag is 1
- Line item action flag is not 2, 3 or 4
- Payment adjustment flag is zero
- Payment method flag is zero
- 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. The line item action flag if passed on input to the IOCE can override a line item denial or rejection or allow the line item to be denied or rejected for reasons outside IOCE editing. The LIAF also impacts the computation of the discounting factor. The Payment Method flag identifies which services are paid under OPPS depending on the site of service. 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. Component Initialization summarizes the process of filling in the APC return buffer.

If a claim spans more than one day, the IOCE 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 IOCE 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.

7.1.1 Claim Return Buffer Table

Item	Bytes	Number	Values	Description
Claim processed flag	1	1	0-4, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, 46*, TOB 83x or other invalid bill type). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted; exit immediately. 9 - Fatal error; OCE cannot run - the environment cannot be set up as needed; exit immediately.
Num of line items	3	1	nnn	Up to 450 total line items
National provider identifier (NPI)	13	1	aaaaaaaaaaaaa	Transferred from input, for Pricer.
OSCAR Medicare provider number	6	1	aaaaaa	Transferred from input, for Pricer.
Overall claim disposition	1	1	0-5	0 - No edits present on claim. 1 - Only edits present are for line item denial or rejection. 2 - Multiple-day claim with one or more days denied or rejected. 3 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only post payment edits. 4 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only pre-payment edits. 5 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w both post-payment and pre-payment edits.
Claim rejection disposition	1	1	0-2	0 - Claim not rejected. 1 - There are one or more edits present that cause the claim to be rejected. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be rejected.
Claim denial disposition	1	1	0-2	0 - Claim not denied. 1 - There are one or more edits present that cause the claim to be denied. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be denied, or single day claim with all lines denied
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 that caused the claim to be rejected. There is currently only one edit that causes a claim to be rejected
Claim denial reasons	3	8	10	Three-digit code specifying edits that caused the claim to be denied. There is currently one active edit that causes a claim to be denied.

Item	Bytes	Number	Values	Description
Claim returned to provider reasons	3	30	1-3, 5-6, 8, 14 -17, 21-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 50, 52, 54-56, 58, 60-63, 70-75, 77-82, 84- 90, 92, 94, 96-102, 109	Three-digit code specifying edits that caused the claim to be returned to provider.(Table 6.2)
Claim suspension reasons	3	16	4, 11, 12, 24, 31 -34, 36, 57, 66	Three-digit code specifying the edits that cause the line item to be suspended .(Table 6.2)
Line item rejection reasons	3	12	13, 20, 28, 40, 45, 47, 53, 64, 65, 76, 91, 93, 95, 104, 110, 111	Three-digit code specifying the edits that caused the line item to be rejected .(Table 6.2)
Line item denied reasons	3	6	9, 18, 30, 49, 67-69, 83, 103, 105, 106, 107, 108	Three-digit code specifying the edits that caused the line item to be denied .(Table 6.2)
APC return buffer flag	1	1	0-1	0 - No services paid under OPPS. 1 - One or more services paid under OPPS. APC return buffer filled in with APC.
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 *A blank, zero or any other value is defaulted to 1
Non-OPPS bill type flag	1	1	2	2 = Bill type should not be 83x
Payer Value Code and Payer Value Code Amount	11	10	2-character Value Code (QN-QW) followed by amount (nnnnnnn.nn*)	Assigned by IOCE based on criteria for APC payment offset. QN – First APC device offset QO – Second APC device offset QP – Reserved for future use QQ –Terminated procedure with pass-through device QR – First APC pass-through drug or biological offset QS – Second APC pass-through drug or biological offset QT – Third APC pass-through drug or biological offset QU – Condition for device credit present QV – (Reserved for future use) Assigned by IOCE based on PHP weekly processing criteria QW – Partial week present on interim PHP claim Note: The value code amount following Payer Value Code QW, zero-fill the first 4 values, the next 5 values represent an IOCE calculated amount for total days and hours of PHP services. One byte for days and 4 bytes to record full and partial hours. For example, 2 days and 8 and ½ hours converts to the following value code amount 000020850. QA is a copy of QW to be supplied on input to the IOCE. Note: If offset conditions do not exist, the value code label (QN-QW) is blank; the amount is zero-filled.
Payer Condition Code	2	10	2-character Condition Code	2-character Payer Only Condition Code assigned by IOCE based on PHP weekly processing criteria MP – PHP claim contains initial admit week MQ – PHP claim contains final discharge week MV – Second portion of combined PHP week is not 20 hours

7.1.2 APC Return Buffer Table

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, and other 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 (SI) *No Longer Applicable	2	Alpha	A – Services not paid under OPPS; paid under fee schedule or other payment system B – Non-allowed item or service for OPPS C – Inpatient procedure E – Non-allowed item or service* (Replaced by SI E1 & E2 eff. V18.0) E1 – Non-allowed item or service E2 - Items and services for which pricing information and claims data are not available F – Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines G – Drug/Biological Pass-through H – Pass-through device categories J – New drug or new biological pass-through * (Replaced by SI G eff. V3.0) J1 – Hospital Part B services paid through a comprehensive APC J2 – Hospital Part B services that may be paid through a comprehensive APC K – Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals L – Flu/PPV vaccines M – Service not billable to the MAC N – Items and Services packaged into APC rates P – Partial hospitalization service Q – Packaged services subject to separate payment based on payment criteria* (Replaced by SI Q# v10.0) Q1 – STV-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC Q4 – Conditionally packaged laboratory services R – Blood and blood products S – Procedure or service, not discounted when multiple T – Procedure or service, multiple reduction applies U – Brachytherapy sources V – Clinic or emergency department visit W – Invalid HCPCS or Invalid revenue code with blank HCPCS X – Ancillary service* (Deactivated as of v16.0) Y – Non-implantable DME Z – Valid revenue code with blank HCPCS and no other SI assigned
Payment Indicator	2	Numeric (1-nn)	1 – Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V, X) 2 – Services not paid by OPPS Pricer; paid under fee schedule or other payment system (SI of A, G, K) 3 – Not paid (Q, Q1, Q2, Q3, Q4, M, W,Y, E), or not paid under OPPS (B, C, Z) 4 – Paid at reasonable cost (status indicator F, L) 5 – Paid standard amount for pass-through drug or biological (status indicator G)* 6 – Payment based on charge adjusted to cost (status indicator H) 7 – Additional payment for new drug or new biological (status indicator J)* 8 – Paid partial hospitalization per diem (status indicator P) 9 – No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes G0176, G0177 or G0129) 10 – Paid FQHC encounter payment 11 – Not paid or not included under FQHC encounter payment 12 – No additional payment, included in payment for FQHC encounter 13 – Paid FQHC encounter payment for New patient or IPPE/AWV 14 – Grandfathered tribal FQHC encounter payment
Discounting Formula Number	1	1-9	See Discounting formula for discounting fraction values 1-9
Line Item Denial or Rejection Flag	1	0-3	0 - Line item not denied or rejected 1 - Line item denied or rejected 2 – The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/1/2002 - v3.0) 3 - Line item not denied or rejected; identified for informational alert only
Packaging Flag	1	0-6	0 – Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of PH per diem or daily mental health service per diem (v1.0-v9.3 only) 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01) 4 – Packaged as part of drug administration APC payment (v6.0 – v7.3 only) 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment

Name	Size (bytes)	Values	Description
Payment Adjustment Flag	2	0-nn [Right justified, blank filled]	0 – No payment adjustment 1 – Paid standard amount for pass-through drug or biological 2 – Payment based on charge adjusted to cost 3 – Additional payment for new drug or new biological applies to APC 4 – Deductible not applicable (specific list of HCPCS codes) 5 – Blood/blood product used in blood deductible calculation 6 – Blood processing/storage not subject to blood deductible 7 – Item provided without cost to provider 8 – Item provided with partial credit to provider 9 – Deductible/co-insurance not applicable 10 – Co-insurance not applicable 11 – Multiple service units reduced to one by OCE processing; payment based on single payment rate 12 – Offset for first device pass-through 13 – Offset for second device pass-through 14 – PAMA Section 218 reduction on CT scan 15 – *Reserved for future use* 16 – Terminated procedure with pass-through device 17 – Condition for device credit present 18 – Offset for first pass-through drug or biological 19 – Offset for second pass-through drug or biological 20 – Offset for third pass-through drug or biological 21 – CAA Section 502(b) reduction on film X-ray 22 – CAA Section 502(b) reduction on computed radiography technology 23 – Co-insurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b) 24 – Co-insurance deductible n/a, as well as subject to a reduction due to computed radiography technology (CAA Section 502b) 91 – 99 Each composite APC present, same value for prime and non-prime codes (v 9.0 – v9.3 only)
Payment Method Flag	1	0-x	0 - OPPS Pricer determines payment for service 1 - Service not paid based on coverage or billing rules 2 - Service is not subject to OPPS 3 - Service is not subject to OPPS, and has an OCE line item denial or rejection 4 - Line item is denied or rejected by MAC; OCE not applied to line item 5 - Payment for service determined under FQHC PPS 6 - CMHC outlier limitation reached 7 - Section 603 service with no reduction in OPPS Pricer 8 - Section 603 service with PFS reduction applied in OPPS Pricer 9 - CMHC outlier limitation bypassed A - Payment reduction for off-campus clinic visit Z - Contractor bypass determines payment for services
Service Units	9	1-x	Transferred from input, for Pricer. For line items assigned to APCs for daily mental health, PHP, composite APC or comprehensive APC, the service units are assigned a value of one by the IOCE even if the input service units were greater than one, and payment adjustment flag 11 is provided (v16.1). Service units are also assigned to one for payable conditionally packaged lines (SI = Q1, Q2) and FQHC payment codes; payment adjustment flag 11 is provided (v16.2). Input service units also may be reduced for some Drug administration APCs (v6.0 – v7.3 only).
Charge	10	nnnnnnnnn	Transferred from input for Pricer; COBOL pic 9(8)v99
Line Item Action Flag	1	0-5	Transferred from input to Pricer, and can impact selection of discounting formula. 0 – OCE line item denial or rejection is not ignored 1 – OCE line item denial or rejection is ignored 2 – External line item denial. Line item is denied even if no OCE edits 3 – External line item rejection. Line item is rejected even if no OCE edits 4 – External line item adjustment. Technical charge rules apply 5 – Non-covered service excluded from payment under FQHC PPS
Composite Adjustment Flag	2	Alphanumeric	00 – Not a composite 01 – ZZ: First thru the nth composite APC present; same composite flag identifies the prime and non-prime codes in each composite APC group. For FQHC PPS claims (bill type 77x) only, the following values are defined for composite adjustment flag: 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC medical clinic visit (modifier 59 reported)
HCPCS Modifier	4	Alphanumeric	Assigned by IOCE for final payment determination (Note: Up to 2 occurrences of 2 characters each may be returned, currently only one 2-character modifier is returned) Reserved for future use

7.2 Payment Method Flag (PMF) Value Table

PMF Value	PMF Value Description
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 IOCE line item denial or rejection
4	Line item is denied or rejected by MAC; IOCE not applied to line item
5	Payment for service determined under FQHC PPS
6	CMHC outlier limitation reached
7	Section 603 service with no reduction in OPPS Pricer
8	Section 603 service with PFS reduction applied in OPPS Pricer
9	CMHC outlier limitation bypassed
A	Payment reduction for off-campus clinic visit
Z	Contractor bypass determines payment for services

7.2.1 Payment Method Flag (PMF) Value Condition Settings:

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 is 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 Payment APC to 00000; except for PMF values 6, 7, 8, 9 and effective 1/1/16 if PMF of 2 is set to Drug HCPCS with SI of G or K.
6. Lines that have packaging flag = 3 with line item charges < $1.01 do not set the payment adjustment flag to 4, 9, 10, if applicable.
7. Note that PMF A is assigned only for specific HCPCS code G0463 reported with modifier PO for OPPS claims with bill type 13x w/ or w/o CC 41 and is not represented in table 7.2.2.
8. PMF Z is assigned to identify line items that have a contractor defined bypass condition applied. NOTE: PMF Z is not represented in table 7.2.2., as the contractor bypass can be applicable to all Status Indicators and Bill Types if the edit is on the Contractor Bypass list.

7.2.2 Payment Method Flag Assignment by Status Indicator and Bill Type Table

Type Of Bill	PMF = 0	PMF = 1	PMF = 2	PMF = 6	PMF = 7	PMF = 8	PMF = 9	Comments
HOPD 13x w or w/o Condition Code 41	H, J, J1, J2, N, P, R, S, T, U, V, X	B, C, E, M, Q, Q1, Q2, Q3, Q4, W, Y, Z	A, F, G, K, L	Not set	SI = F, H, L, R, U; SI = J1, J2, Q1, Q2, Q3, Q4, S, T and V if PAF set to 4, 9 or 10; SI = P w/ APC changed to CMHC APC	J1, J2, Q1, Q2, Q3, Q4, S, T and V	Not set	PMF 7 also applies to certain radiation treatment HCPCS
HOPD 12x, 14x with CC41	Not set	Not set	Not set	Not set	Not set	Not set	Not set	PMF not set, edit 46 generated, claim processed flag set to 1; no further processing occurs
HOPD 12x, 14x Without CC 41	H, J, J1,J2, N, P, R, S, T, U, V, X	B, C, E, M, Q, Q1, Q2, Q3, Q4, W, Y, Z	A, F, G, K, L	Not set	Not set	Not set	Not set	N/A
CMHC 76x	PHP services and Non-PHP w/SI =N	Non-PHP, not Telehealth service: A, B, C, E, F, G, H, J, J1, J2, K, L, M, R, S, T, U, V, X, Q, Q1, Q2, Q3, Q4, W, Y, Z	Telehealth (Q3014)	PHP services and Non-PHP w/SI = N that have reached the CMHC outlier payment limitation	Not set	Not set	PHP services and Non-PHP w/SI = N; MAC bypass of the CMHC outlier payment limitation	N/A
CORF 75x	Vaccine [v1- 6.3]	C,E,M, W, Y, Z	A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	Not set	Not set	Not set	Not set	N/A
Home Health 34x	Vaccine, Antigen, Splint, Cast or NPWT	Not vaccine, Antigen, splint, cast or NPWT: C, E, M, W, Y, Z	Not vaccine, Antigen, splint, cast or NPWT: A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	Not set	Not set	Not set	Not set	N/A
RNHC (43x) RHC (71x) FQHC (73x/77x)	Not set	C, E, M, W, Y, Z	A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	Not set	Not set	Not set	Not set	N/A
Any OPPS bill type not listed above, with Condition Code 07	Antigen, Splint, Cast:	Not Antigen, Splint, Cast: C, E, M, W, Y, Z	Not Antigen, Splint, Cast: A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	Not set	Not set	Not set	Not set	N/A
Any OPPS bill type not listed above, without Condition Code 07	Not set	C, E, M, W, Y, Z	A, B, F, G, H, J, J1, J2, K, L, N, P, Q, Q1, Q2, Q3, Q4, R, S, T, U, V, X	Not set	Not set	Not set	Not set	N/A

7.3 Payment Adjustment Flag Values Table

The payment adjustment flag for a line item is set based on the criteria in the description and is defined within the specific processing logic sections.

Criteria/Description	Value	Applicable Versions
No payment adjustment (all others)	**0**	v1.0-current
Paid standard amount for pass-through drug or biological (SI=G)	**1**	v3.0-v16.2
Code is flagged as 'deductible not applicable' or condition code "MA" is present on the claim	**4**	v1.0-current
Blood product with modifier BL on RC 38X line	**5**	v6.2-current
Blood product with modifier BL on RC 39X line	**6**	v6.2-current
Item provided without cost to provider	**7**	v8.0-v14.3
Item provided with partial credit to provider	**8**	v9.0-v14.3
Deductible/co-insurance not applicable	**9**	v12.0-current
Co-insurance not applicable	**10**	v12.0-current
Multiple service units reduced to one by OCE processing; payment based on single payment rate, (PAF 11 is not assigned if another PAF value has been set preciously during processing) (Description Updated 4/1/15)	**11**	v16.0-current
Offset for first device pass-through	**12**	v17.0-current
Offset for second device pass-through	**13**	v17.0-current
PAMA Section 218 reduction on CT scan	**14**	v17.0-current
Placeholder reserved for future use	**15**	n/a
Terminated procedure with pass-through device	**16**	v17.0-current
Condition for device credit present	**17**	v17.0-current
Offset for first pass-through drug or biological	**18**	v17.0-current
Offset for second pass-through drug or biological	**19**	v17.0-current
Offset for third pass-through drug or biological	**20**	v17.0-current
CAA Section 502b reduction on film x-ray	**21**	v18.0-current
CAA Section 502b reduction on computed radiography technology	**22**	v19.0-curent
Co-insurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b)	**23**	v18.0-current
Co-insurance deductible n/a, as well as subject to a reduction due to computed radiography technology (CAA Section 502b)	**24**	v19.0-current