mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

April 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.1

MLN Matters Number: MM11192
Related Change Request (CR) Number: 11192
Related CR Release Date: March 15, 2019
Effective Date: April 1, 2019
Related CR Transmittal Number: R4256CP
Implementation Date: April 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters Article is providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11192 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses

- Under the Outpatient Prospective Payment System (OPPS)
- For Non-OPPS hospital outpatient departments, community mental health centers and all non-OPPS providers
- For limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System
- For a hospice patient for the treatment of a non-terminal illness.

Make sure your billing staffs are aware of these changes.

BACKGROUND

CR11192 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the Centers for Medicare & Medicaid Services is updating the I/OCE for April 1, 2019. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. CMS will post the I/OCE specifications at http://www.cms.gov/OutpatientCodeEdit/.

The table below summarizes the modifications of the I/OCE for the April 2019 V20.1 release. Readers should review the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. CMS has added some I/OCE

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

modifications in the update retroactively to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

Effective Date	Edits Affected	Modification
4/1/2019		Updates to the following tables (additional details included in the tables): 3.1.1 Line Item Input Information Table - Add new field “Contractor bypass edit” - Add new field “CB payment APC” - Add new field “CB Status Indicator” - Add new field “CB Payment Indicator” - Add new field “CB Discounting Formula number” - Add new field “CB Line Item Denial or Rejection Flag” - Add new field “CB Packaging Flag” - Add new field “Payment Adjustment Flag” - Add new field “Payment Method Flag” 3.1.2 IOCE Control Block Table Increase size (bytes) of Pointer Field “Sgptr” to 76
4/1/2019		Add new Claim Processed Flag of 4 to be returned if a fatal error has occurred for any contractor bypass condition. Claim Return Buffer.
4/1/2019		Add new Payment Method Flag Z “Contractor bypass determines payment for services,” to be returned if a Contractor has applied a bypass condition for any line item submitted on a claim. NOTE: Only a contractor can apply bypass conditions.
4/1/2018	**106, 107, 108**	Update add-on code logic to return an add-on code edit if the primary procedure is not provided on the same day or day before. This change is being made retroactive to the inception of add-on code editing.
1/1/2017		Update current logic for conditional processing of laboratory procedures when a line item action flag of 2 or 3 is present on certain payable OPPS services (Status Indicator (SI) = Q1, Q3, S, T, V).
4/1/2019		Add new Value Code (QW) and value code amount to be returned on a Partial Hospitalization Program (PHP) interim claim when the total hours of services provided on the partial week do not add up to at least 20-hours. See Partial Hospitalization and Community Mental Health Processing Logic Section.
1/1/2017		Updated the program logic for payment adjustment flag assignment to return values 9, 21, 22, 23, and 24 when appropriate. There is no change to documentation as this is a program logic update only.
7/1/2012	**6**	Implement new logic to not return edit 6 when a procedure is effective on a HHA (32x) claim with dates of service that span between the annual (January) release and prior quarter. This change is retroactively effective to the earliest date of the component. See Hospice and Home Health Processing logic section.
4/1/2019		Add the following Revenue Codes to the Valid Revenue Code List: - 870, 871, 872, 873, 874, 875, and 891

Effective Date	Edits Affected	Modification
4/1/2019		Add new logic section in documentation for Contractor Defined Functions contained within the IOCE.
4/1/2019		Make all HCPCS/Ambulatory Payment Classification (APC)/SI changes as specified by CMS (quarterly data files). - Add-on Type I (edit 106) - Device and Device-Procedure lists (edit 92) - Terminated Device Procedures (offset for device credit) - Pass-through skin substitute product for offset APC (edit 99) - Pass-through contrast for offset APC (edit 99) - Edit 99 Exclusions list - Skin Substitute Hi and Low-Cost lists (edit 87) - Service not paid by Medicare (edit 13) - Not recognized by OPPS (edit 62) - Deductible Coinsurance N/A list - Comprehensive APC Exclusions list - FQHC non-covered list - All PHP services list - PH Addon list - PHnotMH list (edit 81) - Valid Revenue Code list (edit 41)
4/1/2019	**20**, **40**	Implement version 25.1 of the NCCI (as modified for applicable outpatient institutional providers).

ADDITIONAL INFORMATION

The official instruction, CR11192, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4256CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
March 15, 2019	Initial article released.