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April 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.1

MLN Matters Number: MM10514 Revised

Related Change Request (CR) Number: 10514

Related CR Release Date: March 21, 2018

Effective Date: April 1, 2018

Related CR Transmittal Number: R4006CP

Implementation Date: April 2, 2018

Note: This article was revised on March 22, 2018, to reflect an updated Change request (CR) that updated the status indicator for the drug code J0606 from SI=G to SI=K in the CR attachments. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 10514 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the I/OCE that will be used in the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital inpatient departments, Community Mental Health Centers (CMHCs), all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (HH PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR10514 informs the MACs, including the Home Health and Hospice (HH&H MAC) and the Fiscal Intermediary Shared System (FISS), that the I/OCE is being updated for April 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the April 2018 V19.1 update. Readers should also read through the entire CR10514 and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the

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

Effective Date	Edits Affected	Modifications
1/1/2018		Update the program to remove the logic that assigns HCPCS level modifier V3 to the line level output for OPPS claims submitted with drug HCPCS lines with Status Indicator (SI) = K that are reported with modifier JG.
4/1/2018	72	Implement program logic to bypass edit 72 when a HCPCS is present from a specified list for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) claims (see quarterly data files for HCPCS subject to edit 72 bypass).
4/1/2018	104	Implement new edit 104: Service not eligible for all-inclusive rate (LIR). Edit criteria: RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.
7/1/2017	105	Implement new edit 105: Claim reported with pass-through device prior to FDA approval for procedure (LID). Edit criteria: A procedure is reported with a pass-through device prior to the FDA approval date for the procedure paired with the device. The line item denial is returned on the device line.
4/1/2018	106	Implement new edit 106: Add-on code reported without required primary procedure code (LID). Edit criteria: A Type I add-on code is reported on a non-OPPS claim without any of its defined primary codes. The disposition is set to line item denial and is applied to the line with the add-on code.
4/1/2018	107	Implement new edit 107: Add-on code reported without required contractor-defined primary procedure code (LID). Edit criteria: A Type II add-on code is reported on a non-OPPS claim without any primary code from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.

Effective Date	Edits Affected	Modifications
4/1/2018	108	Implement new edit 108: Add-on code reported without required primary procedure or without required contractor-defined primary procedure code (LID). Edit criteria: A Type III add-on code is reported on a non-OPPS without any of its defined primary codes, or without any of the primary codes from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.
4/1/2018	22	Add the following new modifiers to the valid modifier list: • VM: Mdpp virtual make-up session • QA: Avg sta day/night o2 < 1 lpm • QB: Avg day/nite o2 > 4 lpm/port • QR: Avg sta day/night o2 > 4 lpm
4/1/2018	94, 103	Update the program logic to deactivate edits 94 and 103 associated with the reporting of biosimilar HCPCS codes with manufacturer modifier. Note: biosimilar manufacturer modifiers ZA, ZB and ZC are deleted.
4/1/2018		Update Section 6.1 of documentation (Medical Visit Processing) to include additional examples of conditions for claims containing multiple medical visits. Note: no change to logic.
4/1/2018		Update Section 6.12 of documentation (Special Processing for Drugs and Biologicals) by removing the paragraph regarding the assignment of the HCPCS level modifier, V3 for HCPCS with SI = K.

Effective Date	Edits Affected	Modifications
4/1/2018		Update the following lists for the release (see quarterly data files): • HCPCS modifier list • Biosimilar HCPCS list • Complexity-adjusted comprehensive Ambulatory Payment Classification (APC) code pairs • Skin substitute products (edit 87) • Device offset code pairs (Mid-Quarter effective date 8/25/2017) • Add on Type I (new code list for edit 106) • Add on Type II (new code list for edit 107) • Add on Type III (new code list for edit 108) • FQHC/RHC bypass edit 72 (new code list) • RHC CG modifier not payable list (new code list) • Services not recognized under OPPS (edit 62) • Services reportable to DMERC (edit 61) • Services not billable to the MAC (edit 72)
4/1/2018		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files)
4/1/2018	20, 40	Implement version 24.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).

ADDITIONAL INFORMATION

The official instruction, CR10514, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4006CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
March 22, 2018	This article was revised to reflect an updated CR that updated the status indicator for the drug code J0606 from SI=G to SI=K in the attachments. All other information remains the same.
March 2, 2018	Initial article released.

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