July 2018 Integrated Outpatient Code Editor (I/OCE) Specification Version 19.2

MLN Matters Number: MM10699 Revised

Related Change Request (CR) Number: 10699

Related CR Release Date: June 15, 2018

Effective Date: July 1, 2018

Related CR Transmittal Number: R4074CP

Implementation Date: July 2, 2018

Note: This article was revised on June 18, 2018, to reflect an updated Change Request (CR) that made revisions to the Summary of Changes and Summary of Modifications documents. In the article "**Service Not Paid by Medicare (edit 13)**" was added in the table on page 3. All other information remains the same

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for 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 10699 provides the I/OCE instructions and specifications for the I/OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health PPS (HH PPS) or to a hospice payment for the treatment of a non-terminal illness. Please make sure your billing staffs are aware of these updates.

BACKGROUND

CR10699 informs the Part A/B MACs Part A, the A/B MACs Part Home Health and Hospice (HHH) and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for July 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single I/OCE.

The I/OCE is used under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under HH PPS or to a hospice patient for the treatment of a non-terminal illness.

The modifications of the I/OCE for the July 2018 V19.2 release are summarized in the table below. Readers should also read through the entire specifications document and note the highlighted sections, which also indicate changes from the prior release of the software. The I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/OutpatientCodeEdit/.

Table 1: July 2018 I/OCE Modifications

Effective Date	Edits Affected	Modification
1/1/2018	18	Implement new program logic retroactively (1/1/18) to allow Anesthesia code 01402 (Status Indicator (SI) = C) reported with procedure code 27447 to package by changing its SI from C to N. If 01402 is reported with any other procedure the SI remains a C and will process as usual.
1/1/2016	38	Update program logic retroactively (1/1/16) to exclude procedures with SI=J2 from satisfying edit 38.
4/1/2018	106,107,108	Update logic for Add-on Code Editing to apply the applicable edits on both add-on procedure line items, if reporting multiple add-on codes without one or both primary procedures.
7/1/2018	6,20,22,40, 106,107,108	Update the program logic to include edits (6, 20, 22, 40, 106, 107, and 108) to applicable bill types retroactively to the edits activation date. This includes the documentation update to the edits applied by bill type tables, see table for updates.
7/1/2018	6,22	Implement logic to include a condition in which lines submitted on a 32x bill type (HHA) with revenue code 0023 do not have edit 6 or 22 applied.
7/1/2018	22	Add the following new modifier to the valid modifier list QQ – Qualified cdsm consulted
7/1/2018		Update the Add-on Code Editing section to include additional conditions for editing. This includes an update to the Edit Descriptions and Reason for Edit Generation table.
7/1/2018		Update the I/OCE Execution and Processing Flowchart to include Rural Health Clinic (RHC) in the Federally Qualified Health Center (FQHC) objects mentioned in processing.
7/1/2018		Update to Hospice Processing section to note the logic that is discontinued by edit 61 and 72 being removed from bill type 81x and 82x (1/1/14).
7/1/2018		Update the Pass-through Device Processing section to change language from device-intensive procedure pairing to procedure and pass-through device pairings.

Effective Date	Edits Affected	Modification
7/1/2018		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
7/1/2018		Update the following lists for the release (see quarterly data files): - Add on Type I (edit 106) - Add on Type II (edit 107) - Add on Type III (edit 108) - Comprehensive Ambulatory Payment Classification (APC) Ranking - Comprehensive APC Exclusions - Procedure and Sex Conflict (edit 8) - RHC CG Modifier not Payable - Skin Substitute Product (edit 86) - Non-covered service (edit 9) - **Service Not Paid by Medicare (edit 13**)
7/1/2018	20, 40	Implement version 24.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).

ADDITIONAL INFORMATION

The official instruction, CR10699, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4074CP.pdf.

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

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DOCUMENT HISTORY

Date of Change	Description
June 18, 2018	This article was revised to reflect an updated CR that made revisions to the Summary of Changes and Summary of Modifications documents. In the article "**Service Not Paid by Medicare (edit 13**)" was added in the table on page 3.
June 1, 2018	Initial article released.

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