DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9754 **Related Change Request (CR) #: CR 9754**

Related CR Release Date: August 12, 2016 **Effective Date: October 1, 2016**

Related CR Transmittal #: R3591CP **Implementation Date: October 3, 2016**

October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.3

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospices (HH+H) MACs, for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9754 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be used 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 (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

The I/OCE specifications will be posted at **http://www.cms.gov/OutpatientCodeEdit/**. These specifications contain the appendices mentioned in the table below.

Key Changes for October 2016 I/OCE

The modifications of the I/OCE for the October 2016 release are 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 I/OCE

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

Effective Date	Edits Affected	Modification
10/1/2016	1, 2, 3, 86	Updated diagnosis code editing for validity, age, gender, and manifestation based on the FY 2017 ICD-10-CM code revisions to the Medicare Code Editor (MCE).
10/1/2016	29	Updated the mental health diagnosis list based on the FY 2017 ICD-10-CM code revisions.
1/1/2016	99	Implement new edit 99: Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure (Return to Provider (RTP)). Criteria: There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with Status Indicator (SI) = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V. Note: refer to special OPPS processing logic and Appendix P.
1/1/2016	98	Revise the logic for edit 98 to remove the pass-through drugs and biologicals; editing for pass-through devices remains. The revised description is “Claim with pass-through device lacks required procedure (RTP)” (refer to special OPPS processing logic and Appendix P).
7/1/2016	95, 96, 97	Deactivate edits 95, 96, and 97 retroactive to the implementation date (refer to special OPPS processing logic and Appendix C for weekly Partial Hospitalization Program (PHP) processing).
10/1/2013	41	Add revenue code 953 (Chemical Dependency) to the list of valid revenue codes.
1/1/2016		Assign payment adjustment flag 10 (Coinsurance not applicable) for pass-through drugs and biologicals when reported with an OPPS payable procedure that is not subject to payment offset (refer to Appendix G).
1/1/2016		Update the Payment Indicator assignment for pass-through (SI=G) and non-pass-through (SI=K) drugs to a value of 2 (Services not paid under OPPS; paid under fee schedule or other payment system); update the Payment Method Flag assignment to a value of 2 (refer to special OPPS processing logic, Table 7 and Appendix E).
1/1/2015		Update the conditional Ambulatory Payment Classification (APC) processing logic for STV-packaged (SI=Q1) and T-packaged (SI=Q2) codes to ignore already packaged codes from the selection of highest paying service for the day (refer to special OPPS processing logic).

Effective Date	Edits Affected	Modification
1/1/2015		Correct the program logic to remove complexity-adjusted comprehensive APC values from the claim output of non-OPPS claims (OPPS flag = 2).
1/1/2015		Update the comprehensive APC exclusion list to correct the omission of certain laboratory and non-covered services (see quarterly data files).
10/1/2016		Updated the following lists for the release (see quarterly data files): - Deductible/coinsurance not applicable (see also Appendix O) - Comprehensive APC exclusions - Federally Qualified Health Center (FQHC) preventive and FQHC qualifying visit code pairs (see also Appendix M) - Conditional bilateral list - PHP duration list - Valid revenue codes
10/1/2016		Make all HCPCS/APC/SI changes as specified by the Centers for Medicare & Medicaid Services (CMS) (quarterly data files).
10/1/2016	20, 40	Implement version **22.3** of the NCCI (as modified for applicable outpatient institutional providers).
10/1/2016		Update Appendix F-a to add new edit 99.
10/1/2016		Updated effective versions for payment adjustment flag values, and reformatted table in Appendix G.

Additional Information

The official instruction, CR 9754 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3591CP.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html**.