CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2320	**Date: July 8, 2019**
	Change Request 11183

Transmittal 2313, dated June 10, 2019, is being rescinded and replaced by Transmittal 2320, dated, July 8, 2019 to update the BR 11183.1 field name from "Error/Fatal Error Return Code" to match the IOCE attachment field name "Claim Return Code". All other information remains the same.

SUBJECT: FISS Integrated Outpatient Code Editor (IOCE) Claim Return Buffer Interface Changes Related to New Return Code Field Updates

I. SUMMARY OF CHANGES: This Change Request (CR) will implement a new return code field in the Claim Return Buffer Table.

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2320	Date: July 8, 2019	Change Request: 11183

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SUBJECT: FISS Integrated Outpatient Code Editor (IOCE) Claim Return Buffer Interface Changes Related to New Return Code Field Updates

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IMPLEMENTATION DATE: October 7, 2019

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to implement a new Return Code field in the Claim Return Buffer Table.

B. Policy: No new policy is being implemented.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11183.1	The Shared System Maintainer shall expand FISS interface with the IOCE Claim Return Buffer Table to include the "Claim Return Code" field when populated by the IOCE. This is populated when the "Claim processed flag" is a "4" or "9". This information is already produced by the IOCE, but is not received by FISS in the current interface.					X				
11183.2	The Shared System Maintainer shall create claim level edit Reason Codes for each of the current 27 responses received, except zero "0". A Return Code of zero "0" shall be ignored.					X				
11183.2.1	The contractor shall set the new Reason Codes created in the above Business Requirement to suspend.	X								
11183.3	A/B MAC Part A contractors shall resolve edits 12-27 to the best of their ability. A/B MAC Part A contractors shall notify CMS via their Contracting Officer's Representative (COR) when edits 1-11 are received for additional information on resolution. **NOTE**:	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Return codes 1-11 = system errors Return codes 12-25 = product-specific errors Return codes 26-27 = Contractor Bypass coding errors									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov, Yvonne Young, YVONNE.YOUNG@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 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.
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)

Item	Bytes	Number	Values	Description
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
Claim Return Code	2	1	0-28	Two-digit code that indicates additional information on how a claim processed either successfully or unsuccessfully. 0 - Claim processed 1 - Memory allocation error 2 - Not used 3 - Run time environment setup failed, could not initialize run-time environment 4 - Could not open Read-Only Table file 5 - Could not determine Read-Only Table size 6 - No memory for Read-Only Table 7 - Could not read Read-Only Table file 8 - Read-Only Table file corrupted 9 - Read-Only Table version does not match component version 10 - Could not link Read-Only Tables to base object 11 – OCEInit not called before call to OCECLM 12 - Invalid number of line items 13 - Invalid From date 14 - Invalid Through date 15 - Invalid date sequence 16 - Invalid line date 17 - From date outside of OCE version range 18 - Invalid bill type 19 - (Reserved) 20 - Claim was not processed, condition code 21 exists 21 – (Reserved) 22 – Claim processing terminated due to bill type 12X or 14X present with condition code 41 23 - (Reserved) 24 - (Reserved) 25 - (Reserved) 26 – Contractor bypass edit is not able to be bypassed 27 – Invalid format used for contractor bypass input values