April 2024

Integrated Outpatient Code Editor Software

User's Manual for Java

v.25.1

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April 2024

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About this document

This manual contains the information needed to install version 25.1 of the Integrated Outpatient Code Editor Software - IOCE developed and run under the z/OS® operating system on a mainframe. The software edits hospital outpatient medical records for possible errors in coding and assigns APCs for Medicare's outpatient prospective payment system (OPPS).

The manual assumes that the person installing the software has experience working with z/OS Job Control Language (JCL), and USS (UNIX System Services) on the mainframe.

Appendix A contains a summary of changes in this release.

Chapter 1: Introduction to the Integrated OCE software

The Integrated Outpatient Code Editor (OCE) program edits patient data to help identify possible errors in coding, and assigns Ambulatory Payment Classification numbers based on Healthcare Common Procedure Coding System (HCPCS) codes for payment under the mandated outpatient prospective payment system (OPPS).

The Integrated OCE program also edits claims for hospitals not subject to OPPS.

Product background

The OPPS OCE (formerly called the Outpatient Code Editor with Ambulatory Payment Classification - OCE/APC) and the Non-OPPS OCE (formerly called the Outpatient Code Editor - OCE) were combined into a single program, the Integrated Outpatient Code Editor (IOCE) effective 7/1/07.

The OPPS functionality of the Integrated Outpatient Code Editor (IOCE) software was developed for the implementation of the Medicare outpatient prospective payment system mandated by the 1997 Balanced Budget Act. CMS released the proposed OPPS rules using the Ambulatory Payment Classification (APC) system in the September 8, 1998 Federal Register. Final regulations were published in the April 7, 2000 Federal Register and the system became effective for Medicare on August 1, 2000.

The APC-based OPPS developed by CMS is the outpatient equivalent of the inpatient, DRG-based PPS. The APC system establishes groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources.

Hospitals are required to use HCPCS when billing for outpatient services. HCPCS incorporates the following types of codes:

- Level I - The American Medical Association's Physicians' Current Procedural Terminology (CPT®)
- Level II - National codes developed by the Centers for Medicare & Medicaid Services (CMS)

Like the inpatient system based on Diagnosis Related Groups (DRGs), each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service.

Certain services (e.g., physical therapy, diagnostic clinical laboratory) are excluded from Medicare's prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.

Versions of the program

The following table lists the versions and date ranges of the program contained in the current release of IOCE software for OPPS processing. The third level in the version number (represented by an 'x' in the table) denotes the number of revisions created since the original OPPS release. For example, 7.1.7 would be the seventh revision of the released version 7.1 product.

Note: Separately installed versions of the non-OPPS OCE must be maintained for as long as necessary to process claims for all hospital outpatient services provided prior to August 1, 2000 when OPPS was implemented; and non-OPPS hospital outpatient services prior to July 1, 2007 when the non-OPPS program was integrated into the OPPS program.

Table 1. Program versions

Version	Effective date range
25.1.0	04/01/2024–03/31/2034[a]
25.0.x	01/01/2024–03/31/2024
24.3.x	10/01/2023–12/31/2023
24.2.x	07/01/2023–09/30/2023
24.1.x	04/01/2023–06/30/2023
24.0.x	01/01/2023–03/31/2023
23.3.x	10/01/2022–12/31/2022
23.2.x	07/01/2022–09/30/2022
23.1.x	04/01/2022–06/30/2022
23.0.x	01/01/2022–03/31/2022
22.3.x	10/01/2021–12/31/2021
22.2.x	07/01/2021–09/30/2021
22.1.x	04/01/2021–06/30/2021
22.0.x	01/01/2021–03/31/2021
21.3.x	10/01/2020–12/31/2020
21.2.x	07/01/2020–09/30/2020
21.1.x	04/01/2020–06/30/2020
21.0.x	01/01/2020–03/31/2020
20.3.x	10/01/2019–12/31/2019
20.2.x	07/01/2019–09/30/2019
20.1.x	04/01/2019–06/30/2019

Version	Effective date range
20.0.x	01/01/2019–03/31/2019
19.3.x	10/01/2018–12/31/2018
19.2.x	07/01/2018–09/30/2018
19.1.x	04/01/2018–06/30/2018
19.0.x	01/01/2018–03/31/2018
18.3.x	10/01/2017–12/31/2017
18.2.x	07/01/2017–09/30/2017

a. The ending date of the current version will be modified to the actual ending date with the next release.

Included versions

To maintain a reasonable size for the program and data files, the IOCE will include only seven years of programs and files in each update. The earliest supported version in the current release is 18.2.x (effective 07/01/17); subsequent updates will drop the version corresponding to the earliest quarter as each new quarter is added. The program version table (page 12) will be updated to reflect the versions of the program contained in the current release.

Purpose of the OPPS functionality

The IOCE software combines editing logic with the new APC assignment program designed to meet the mandated OPPS implementation. The software performs the following functions when processing a claim:

- Edits a claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated status indicators (page 27, page 34)
- Assigns payment indicators
- Computes discounts, if applicable
- Determines a claim disposition based on generated edits
- Determines if packaging is applicable
- Determines payment adjustment, if applicable

Purpose of the non-OPPS functionality

The IOCE program edits non-OPPS claims primarily for accuracy of submitted data.

Changes since OPPS

Prior to OPPS, the program focused solely on editing claims without specifying any action to take when an edit occurred. It also did not compute any information for payment purposes.

While the program has maintained the editing function of previous versions, assignment of APC numbers for services has been added to meet Medicare's mandated OPPS implementation. The revised program indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment. In this case, the line item cannot be resubmitted but can be appealed (page 36).

A major change is the processing of claims with service dates that span more than one day. Each claim is represented by a collection of data, consisting of all necessary demographic (header) data, plus all services provided (line items).

Note: It is the user's responsibility to organize all applicable services into a single claim record and pass them as a unit to the software.

The IOCE only functions on a single claim and does not have any cross claim capabilities. The software can accept up to 450 line items per claim.

Coding for outpatient services

Diagnoses are coded in ICD-10-CM classification; procedures are coded in HCPCS classification.

Program input

The data elements shown in the following table are entered into the program for claim processing. You are not required to have every element entered for every claim.

Data elements

Table 2. Data elements

Data element	UB-04 form locator
Type of bill	4
Period covered by statement, From, and Through dates	6
Birth date	10
Sex	11
Patient status	17
Condition codes	18-28
Occurrence codes	31-34
Value codes and value code amounts 2-character Value Code, left-aligned, followed by a Value Code amount (nnnnnnnnnnn.nn) zero-filled, right-justified	39-41
HCPCS/CPT procedure code(s) and modifier(s)	44
Service date	45
Revenue code	42
Service units	46
Charge	47
National provider indicator	56
CMS Certification Number (CCN)	57
ICD-10-CM diagnosis code(s) (principal dx/secondary dx)	67 (PDX) 67A-Q (SDX)
ICD-10-CM diagnosis code (patient's RVDX1, RVDX2, and RVDX3)	70A-C (patient's RVDX)

Dispositions

Occurrence of an edit can result in one of six dispositions that act at either the line or the claim level. For example, an edit can cause a line item rejection or return the claim to the provider (RTP). A single claim can have one or more edits across all types of edit dispositions. Edit

dispositions are described in more detail in OPPS program output (page 33) and Non-OPPS program output (page 131).

In addition to individual dispositions, there is a claim disposition to summarize the overall status of the claim. For example, a claim can be paid with a line item denied or rejected, or the entire claim can be denied payment. Claim dispositions are also described in more detail in OPPS program output (page 33) and Non-OPPs program output (page 131).

Multiple day claims

The span of time represented by a claim is determined by the From and Through dates on the UB-04 form. The software subdivides the claim into separate days in order to determine discounting and multiple visits on the same calendar day.

For emergency room and observation claims, all services spanning more than one day are processed as separate days according to the dates of the entered line items.

If the From and Through dates span the effective date ranges for two program versions, the From date will determine which version is used for processing.

Edits

The extensive edits in the software, which are applied to claims as well as individual diagnoses and procedures, are described in more detail in OPPS program edits (page 53).

Information on APCs for OPPS

To better understand the IOCE product, this section provides general information on the APC system.

- Each HCPCS code that represents a service paid under OPPS is assigned to an APC. Other services are identified by a status indicator representing the method of payment.
- APCs are applied in the full range of ambulatory settings, including same day surgery, hospital ER, and outpatient clinics.
- Types of APCs are:
  - Significant procedure - In general, surgical APCs are specified by the T or J1 status indicator; the status indicator for non-surgical significant procedures is S.
  - Drug/Biological pass-through - The status indicator for drug/biological pass-throughs is G.
  - Device pass-through - The status indicator for device pass-throughs is H.
  - Brachytherapy sources - The status indicator for brachytherapy sources is U.

- Medical visit - HCPCS codes used to assign medical APCs are specified by (SI = V or J2).
- Ancillary service - HCPCS codes used in assigning ancillary APCs may have various conditional status indicator values (for example, SI of Q1).
- Non-pass-through drug or non-implantable biologicals - The status indicator for drug or biological non-pass-throughs, including therapeutic radiopharmaceuticals, is K.
- Blood and blood products - The status indicator for blood and blood products is R.
- Partial hospitalization - The status indicator for partial hospitalization services is P.

Payment information

APC assignment involves codes being examined together as a group, providing payers and providers with a common language and allowing meaningful comparative analyses. The IOCE software facilitates the classification of the coding input. The system used for payment is defined separately.

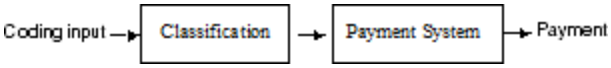

Figure 1: Logic flow for APC assignment and reimbursement

After APC group assignment, APC reimbursement is calculated using APC weights, a base rate, and payment policies. The APC weights represent the relative effort required to perform the specific procedure. The base rate is a dollar value that converts the relative weight to a reimbursement amount.

To help understand the way OPPS reimbursement is calculated, this section will explain some of the basic rules and policies mandated for OPPS using APCs.

Packaging

Ancillary packaging is the inclusion of certain ancillary services performed as part of a visit into the APC payment rate for a significant procedure or medical visit. APCs include some packaging; in some instances, the payment for services integral to the delivery of the procedure or medical visit will be packaged into the payment for the procedure or medical visit.

In addition to facility charges, other services, such as anesthesia and minor incidental services, are always packaged into the payment. Except in special circumstances (page 83), a facility will not receive additional reimbursement for packaged services.

Packaged services are specified by the N status indicator. However, OPPS logic sometimes requires packaging of services with a status indicator other than N. In these instances, a specific packaging flag may be used to indicate the packaged status or the SI may be changed to N. For more information, see the Integrated OCE Software Installation Manual.

Discounting

When multiple significant procedures are performed, or when the same service is performed multiple times, a discount may be applied. Multiple procedures done during the same operative session that will be discounted unless certain modifiers are present, are specified by the T status indicator.

The full payment amount is paid for the surgical procedure with the highest weight, and 50% of the payment amount is paid for other surgical procedures performed during the same visit. A T procedure terminated prior to anesthesia (modifier 52 or 73) is reimbursed at a discounted rate. All line items with SI other than T are subject to terminated procedure discounting when modifier 52 or 73 is present. The terminated procedure discount is 50%.

If the status indicator of a code changes during claim processing, the newly assigned indicator is used to compute the discount formula.

NCCI

The IOCE generates NCCI edits for OPPS and Non OPPS Facilities. All applicable NCCI edits are incorporated into the IOCE. Modifiers and coding pairs in the IOCE may differ from those in the NCCI because of differences between facility and professional services.

Effective January 1, 2006, NCCI edits apply to ALL services billed under bill types 12x, 13x, 14x, 22x, 23x, 34x, 72x, 74x, 75x, 76x, and 85x by the following providers: Skilled Nursing Facilities (SNFs), ESRD facilities (ESRDs), Community Mental Health Clinics (CMHCs), Outpatient Physical Therapy and Speech-Language Pathology Providers (ORFs), CORFs, Home Health Agencies (HHAs), and Critical Access Hospitals (CAHs).

The NCCI edits are applied to services submitted on a single claim, and on lines with the same date of service. NCCI edits address unacceptable code combinations based on coding rules, standards of medical practice, two services being mutually exclusive, or a variety of other reasons. In some cases, the edit is set to pay the higher-priced service, in other cases the lesser-priced service.

In some instances, both codes in a NCCI code pair may be allowed if an appropriate modifier is used that describes the circumstances when both services may be allowed. The code pairs that may be allowed with a modifier are identified with a modifier indicator of “1”; code pairs that are never allowed, whether or not a modifier is present, are identified with a modifier indicator of “0”. Modifiers that are recognized/used to describe allowable circumstances are: 24, 25, 27, 57, 58, 59, 78, 79, and 91, E1-E4, F1-F9, FA, LC, LD, LM, LT, RI, RC, RT, T1-T9, TA, XE, XP, XS, and XU.

All institutional outpatient claims, regardless of facility type, process through the Integrated Outpatient Code Editor (IOCE); however, not all edits are performed for all sites of service or types of claim. Please see the Edits by Bill Type (OPPS= 1) table, which contains IOCE edits that apply for each bill type under OPPS processing; please see the Edits by Bill Type (Non-OPPS= 2) table, which contains OCE edits that apply to claims from hospitals not subject to OPPS.

Critical Access Hospitals (bill type 085x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have NCCI editing applied across facility and professional services appearing on the same day; NCCI editing is applied for the professional services separately from facility services.

Add-on code editing

Effective April 1, 2018 (v19.1), claims with certain OPPS and Non-OPPS bill-types are subject to add-on code edits if the primary procedure for the add-on code is not on the same day or day before. Add-on codes describe procedures or services that are always provided "in addition to" other, related services or procedures. These add-on procedure codes cannot be reported stand alone as separately reportable services. One add-on code may have multiple primary procedures with which it can be reported. In addition, there may be circumstances where reporting multiple add-on procedure codes are necessary, and in this instance the primary procedure for both add-ons must be present on the claim. There are three different types of add-on codes defined by CMS for which the IOCE returns an edit(s) if the conditions to satisfy the edit(s) are not met.

Note: Although the source tables include historical add-on code pair editing content, the add-on edits are not applied until 4/1/2018.

1. Type I add-on codes have a defined list of primary procedure codes. If one or multiple Type I add-on codes are reported without their primary procedure edit 106 is returned on the add-on procedure line(s) and line item denied (LID). See Map_Addon_Type1 table to review applicable code pairs.
2. Type II add-on codes do not have a defined list of primary procedures; individual contractors must define the list of primary procedure codes for Type II add-on codes. Type II add-on code editing in the IOCE is applied only to Critical Access Hospitals (bill type 085x) reporting professional service revenue codes (096x, 097x or 098x). Edit 107 is returned on all Type II add-on procedure line(s) for contractor review (LID). See Map_Addon_Type2 table to review applicable code pairs.
3. Type III add-on codes have defined primary procedures but there may be additional contractor defined primary procedures. Type III add-on codes act the same as Type I in how the edit is applied, with edit 108 (LID). See Map_Addon_Type3 table to review applicable code pairs.

For Critical Access Hospitals Add-on Code Editing, see Critical Access Hospital Processing (page 152).

Critical access hospitals add-on code editing

Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have add-on code editing applied across facility and professional services; add on code editing is applied for the professional services separately from facility services.

Drug administration add-on code editing

Drug administration add-on procedure codes do have an exception in how add-on code edits are applied. Drug administration add-on procedure codes are not edited by date of service (primary procedure on same day or day before), instead the add-on editing is applied only if the primary drug administration procedure is not present on the same claim. The add-on code edit continues to be returned at the line level for the add-on procedure code missing its primary procedure (LID). All drug administration add-on procedure codes are Type I add-on codes (edit 106) and are subject to all other editing conditions applicable for Type I add-on codes. See Map_Addon_Type1 table to review applicable code pairs.

Software as a service (SAAS) add-on code editing

Software as a Service, SAAS, are algorithm-driven services that assist practitioners in making clinical assessments and can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). Effective January 1, 2023 (v24.0), Software as a service add-on codes reported on hospital outpatient claims with bill type 013x are subject to add-on code edit 106 if the primary procedure is not present on the claim. Refer to Map_ADDON_SAAS for the list of impacted code pairs.

Note: Additional add-on content associated with edit 106 applied to non-OPPS and other OPPS bill types is not included for bill type 013x (see section 4.2).

Remote mental health (RMH) add-on code editing

Effective January 1, 2023 (v24.0), when Remote Mental Health add-on code, C7902, is reported on Partial Hospitalization claims (013x w/ CC41) or Daily Mental Health claims (013x) without a primary code on the same date of service, the line is line-item denied with edit 106. See the Partial Hospitalization and Daily Mental Health sections for more information.

COVID-19 lab add-on code editing: v22.0 - v24.1

Effective July 1, 2023 (v24.2), the logic for COVID-19 Lab add-on editing is deactivated and HCPCS codes U0003, U0004, and U0005 are deleted effective May 11, 2023. See Public Health Emergency (PHE) Processing (page 26) for more information.

Effective January 1, 2021 (v22.0), claims submitted with add-on code U0005 must also report one of its primary procedure codes U0003 or U0004 on the same date of service, otherwise, edit 115 is applied (LID). HCPCS code U0005 is an add-on code used for providing an additional payment for providers that can complete and release the results of their clinical diagnostic laboratory tests used to detect the virus that causes COVID-19 and that also utilize high through put technologies, within 2 calendar days. It is expected that if a provider has met the requirements for receiving the add-on payment that they report U0005 on the same day as either of its primaries U0003 or U0004 to receive the appropriate payment.

Validation editing

Standard validation edits are returned by the IOCE to recognize instances of invalid entries of diagnosis codes, procedure codes, revenue centers, modifiers, patient identifiers (such as age and sex), date inputs, and claim receipt dates.

Diagnosis code validation

Invalid diagnosis editing

Effective with the July 1, 2021 (v22.2) release, the IOCE examines claims with From and Through dates spanning any quarterly boundary (e.g., 09/29-10/01), in order to apply a bypass of edit 1 if the diagnosis does exist in at least one of the two quarters represented by the Claim From and Through dates. Diagnosis codes that exist or existed within the first quarter represented on a spanning quarter boundary claim, have all other diagnosis code editing applied (e.g., edits 2, 3, 5). However, diagnosis codes that exist only within the second quarter of the spanned claim bypass edit 1 as well as all other diagnosis code editing. Claims that have From and Through dates that do not span quarterly boundaries continue to have all diagnosis code editing applied as appropriate.

Prior to the July 1, 2021 (v22.2) release, the IOCE validates ICD-10-CM diagnosis codes based on the quarter that corresponds with the From date of the claim (edit 1). If a claim has From and Through dates that span a quarterly boundary, no cross-claim editing or validation is performed, except for Home Health claims (bill type 32x) where a bypass is applicable.

Diagnosis and age/sex conflict editing

Effective with the earliest version of the IOCE software, when a diagnosis code, that has a designated age range, is reported on a claim with an age outside the designated age range applicable for the code, the claim is returned to the provider with edit 2. Diagnosis codes, when applicable, are identified as appropriate only for specific age groups (i.e., newborn, pediatric, adult, maternity). Refer to the LO and HI AGE designations within the Data_DX10 table for applicable codes.

Effective April 1, 2024 (v25.1), the logic for sex restriction editing is deactivated.

Prior to April 1, 2024 (v25.1), when a diagnosis code, is designated as a male (1) or female (2) sex restriction, and is reported on a claim in which the sex designation does not match, the claim is returned to the provider with edit 3. Refer to the SEX column within the Data_DX10 table for applicable codes. This edit is bypassed if condition code 45 (Gender Incongruous) is present on the claim.

Principal diagnosis code editing

The IOCE also validates the principal diagnosis (pdx) which is the condition established after study to be chiefly responsible for the encounter or admission.

External cause of injury/morbidity code editing

External Cause of Injury codes describe the circumstances that cause an injury and not the nature of the injury. These codes are not to be reported as the reason for visit. The IOCE flags all ICD-10-CM diagnosis codes that begin with the letter E, and as of October 1, 2015, all ICD-10-CM diagnosis codes that begin with V, W, X or Y. When a diagnosis code is designated as an External cause of injury code and reported in the pdx position for a claim, the claim is returned to the provider with edit 5.

Manifestation code editing

Diagnosis codes identified as manifestations, are conditions that describe the symptoms of an underlying disease and not the disease itself. These codes are typically identified with "in diseases classified elsewhere" in the code description. For Hospice (081x, 082x) and Home Health (032x) bill types when a diagnosis code, designated as a manifestation code, is reported in the pdx position for a claim, the claim is returned to the provider with edit 86.

Non-mental health diagnosis and code first editing for partial hospitalization claims

Partial hospitalization (PHP) services are only allowed for mental health disorder diagnoses. The pdx for a PHP claim must be designated as Mental Health. When a PHP claim is submitted without a mental health diagnosis reported as the principal diagnosis the claim is returned to the provider with edit 29.

Note: Edit 29 is suppressed from being returned if a code first diagnosis is present in the pdx position.

Diagnosis codes flagged as Code First, are codes that when reported as the pdx, require a mental health diagnosis be reported in the first secondary dx position. When a PHP claim is submitted with a Code First diagnosis without a mental health diagnosis in the first secondary diagnosis position, the claim is returned to the provider with edit 109. Note that if the first secondary diagnosis position is blank edit 109 is still returned. Refer to the Data_DX10 table within the data files for diagnoses flagged as CODE_FIRST and/or MENTAL_HEALTH. See also, the Partial Hospitalization sections for additional information.

Unacceptable diagnosis code editing

When diagnosis codes are considered as supplementary or additional codes for reporting, they are unacceptable to be reported as principal diagnoses. The unacceptable pdx list is defined by the Medicare Code Editor (MCE) and in the event that an unacceptable pdx is reported as the pdx for a claim, the claim is returned to the provider with edit 113. Of note, there are some exclusions to the MCE list due to current OPPS coding requirements and guidelines. Any diagnosis code flagged as an OPPS exclusion to the Unacceptable Pdx list, does not return edit 113. Refer to the Data_DX10 to reference the list of diagnosis codes applicable to the MCE Unacceptable principal diagnosis list and to reference the diagnosis codes that are exclusions.

Procedure code validation

The IOCE maintains a table of valid HCPCS codes that is updated annually/quarterly by the AMA (CPT©) and by CMS (level II HCPCS). Each reported procedure code is checked against the table of valid codes. For all valid procedure codes in the IOCE, refer to the Data_HCPCS table. In the instance a code is reported on a claim, that is not considered to be a valid code (either the characters entered do not constitute a valid code or the code entered is not valid for the selected version of the software), the claim is returned to the provider with edit 6.

Procedure and age/sex conflict editing

Edit 7 is an information only edit that sets the Line Item Denial Rejection flag = 3 and identifies when a procedure code, that has a designated age range, is reported on a claim with an age outside the designated age range applicable for the code. Procedure codes, when applicable, are identified as appropriate only for specific ages as designated by published CMS/AMA information. Refer to the LO and HI AGE designations within the Data_HCPCS table for applicable codes.

Effective April 1, 2024 (v25.1), the logic for sex restriction editing is deactivated.

Questionable Covered Procedures

Questionable Covered Procedures are procedures that CMS has determined may be covered, depending upon medical circumstances. When services identified as Questionable are reported, the IOCE suspends the claim with edit 12.

Revenue code validation

Effective with the July 1, 2021 (v22.2) release, all revenue codes are validated based on the claims processing receipt date. The claims processing receipt date is meant to be utilized by CMS for validation of non-medical code sets. Revenue Codes and their effective dates are maintained by the NUBC and are implemented in the IOCE versioning, per the NUBC's revenue code reporting effective/deactivation dates. Providers are responsible for submitting claims with active revenue codes. If a claim contains a revenue code that is not yet effective as determined by the NUBC, providers must hold claims until that effective date. Edit 41 is applied, if a claim is submitted with a revenue code prior to/ exceeding the NUBC effective/deactivation date. Once a revenue code is effective for reporting, the held claims can be submitted to Medicare and the new revenue code is validated through the IOCE based on the "Claims processing receipt date". By using the claims processing receipt date, it allows these appropriately held claims to process through the IOCE successfully and according to the effective reporting date and timely filing requirements.

If using the IOCE for purposes outside the Medicare claims processing system, the claims processing receipt date can be manually input based on the date in which the claim is projected to be sent for payment. The claims processing receipt date can also be left blank, if left blank, the IOCE will auto-populate the field with a date that matches the claim "Through date". This

allows users that do not know the official claims processing receipt date to continue to process their claims through the IOCE without disruption.

For specific bill types as noted in the Edits by Bill type tables, edit 48 returns the claim to the provider when the HCPCS field is blank and the revenue code status indicator is not N or F. Note that this edit is bypassed if the revenue code is flagged as "Bypass_E48" in the Data_Revenue table.

Of note, not all revenue codes are recognized by Medicare. There are certain revenue codes, while on the valid revenue code list, that are not recognized by Medicare and are therefore not appropriate for use on hospital outpatient department (HOPD) claims. If revenue codes are submitted on the specified bill types, without a HCPCS code, an SI of E1 is assigned and the line is rejected with edit 65.

Note: Edit 48 (rev code requires HCPCS) is not triggered. Refer to the Data_Revenue table for revenue codes flagged as "Not_ Recognized" for applicable codes.

Modifier validation

The IOCE accepts all valid CPT© and HCPCS Level II modifiers on OPPS claims. For a list of valid modifiers, refer to the Data_MODIFIER reference table. In the instance a modifier is reported that is not on the valid modifiers list, the claim is returned to the provider with edit 22.

Note: Revenue code 0540 (Ambulance services) uses a different list of valid modifiers than OPPS; therefore, lines with revenue code 0540 are not checked for modifier validity to avoid conflict with the OPPS list.

Date validation

The IOCE software maintains 28 prior quarters (7 years) of programs in each release. Each new version of a release removes an older version. See the Summary of Quarterly Release Modifications, item #1, to view the earliest date/version included for the current release. To view all applicable version dates maintained within a release, refer to the Version_Range table provided in the Report table data files. To aid in the prevention of claims processing errors, all date fields in the IOCE are checked for a valid entry. All line item dates on a claim must be reported within the dates specified in the From and Through dates for the claim, otherwise the claim is returned to the provider with edit 23. Effective January 2021 (v22.0), edit 23 is provided consistently across all bill types, for both OPPS and non-OPPS bill types.

Effective April 2021 (v22.1), edit 23 is bypassed for HH claims submitted on bill type 32x, for the HIPPS code line submitted with revenue code 0023. If a claim has From and Through dates that span a quarterly boundary, no cross-claim editing or validation is performed, except for Home Health claims (bill type 032x) where a bypass is applicable (see Home Health Processing Logic). Note: The From date on a claim is used to select the IOCE version used for processing the claim.

In the instance that the from date reported on a claim prior to OPPS implementation, or outside the current version range of the IOCE, the claim cannot be processed and is suspended with edit 24.

Additionally, if the Claims processing/receipt date is invalid, occurs prior to the from date or the date falls outside the date range of any version of the IOCE program, the IOCE returns the claim to the provider with edit 119. This edit is an IOCE program error and is applicable to being returned on all programmed bill types. The claim processed flag value 1 and return code 29 are provided if edit 119 is applied.

If using the IOCE for purposes outside the Medicare claims processing system, the claims processing receipt date can be manually input based on the date in which the claim is projected to be sent for payment. The claims processing receipt date can also be left blank. If left blank, the IOCE auto-populates the field with a date that matches the claim "Through date". This allows users that do not know the official claims processing receipt date to continue to process their claims through the IOCE without disruption.

Note: In the instance that the receipt date of the claim occurs prior to the From date, the from date is used to process the claim and return edit 119.

Mid-quarter date editing

To identify and ensure proper reporting for codes that become approved after the start of a quarter, the IOCE assigns edits (67, 68, 69, 83, 110, or 134), when applicable, for products and services reported prior to their approval dates, or outside of their coverage periods. Examples of products and/or services can include but are not limited to drugs, vaccines, or laboratory tests. For a more detailed list of codes applicable, refer to the Mid_Quarter_Date_Edit column in the Data HCPCS table. For reference, the approval date lists the date in which the product/service is approved for use and reporting, while the terminated date refers to the last validation date for use or reporting of the code.

FDA Approval: Coverage of products/services after Food and Drug Administration (FDA) approval

Medicare covers new drugs code from the date that they receive FDA approval. The reporting of new drug HCPCS on claims dated prior to FDA approval are not allowed as HCPCS codes for newly approved drugs need to be added to the valid code list at the beginning of the quarter; therefore, when the date of FDA approval occurs mid-quarter, any claims with lines submitted for payment prior to the FDA approval date must be identified and line-item denied with edit 67.

NCD Approval: Coverage of services after National Coverage Determination (NCD) approval

Medicare is required to cover new services from the date that they receive NCD approval. Claims with lines for new services that are dated prior to NCD approval are not allowed. HCPCS codes for newly approved services need to be added to the valid code list at the beginning of the quarter; therefore, when the date of NCD approval occurs mid-quarter, any claims submitted for

payment with lines reported prior to the NCD approval date must be identified and are line-item denied with edit 68. Note: In the instance that services are reported after the date of NCD non-coverage determination, the lines are line-item denied with edit 83.

Approval Periods: Coverage of products/services for specified approval periods

Occasionally, Medicare covers certain services only for a specified time (e.g., Influenza demonstration project covered from 12/1/2004 to 5/31/2005). HCPCS codes need to be added to/deleted from the valid code list at the beginning of the quarter; therefore, when the beginning or end date of an approved service occurs mid-quarter, any claims submitted for payment with lines reporting certain services, prior to the start date or after the end date, must be identified and line-item denied, (edit 69).

Effective 4/1/2023, any claims submitted for payment with lines reporting services prior to the start date or after the end date of the designated approval period by CMS are subject to line-item rejection (edit 134). See the Mid_Quarter_Date_Edit column in Data_HCPCS for applicable codes.

Initial Marketing Date Coverage

In addition to the requirement that drugs or certain products should not be reported prior to the FDA's approval (edit 67), drugs also, should not be reported before their initial marketing dates. The marketing date, which is often a mid-quarter date, is the date in which the product has entered commercial distribution. Effective July 1, 2018 (v72), edit 110 identifies and denies lines reported on a date of service prior to the initial marketing date for which it can be reported.

Public Health Emergency (PHE) processing

When a public health emergency (PHE) is enacted, logic is implemented in the IOCE to ensure applicable procedures, services and products adhere to the policies and procedures enacted during the PHE.

Once CMS determines that the PHE has terminated, many of the waivers for treatments and services are no longer applicable to the PHE policies and procedures. When a claim is submitted with payer value code Z9 (CMS determined mid-quarter termination) and a code identified by CMS as not reportable after the PHE termination is determined, the claim is returned to the provider with edit 124. Please refer to the CMS Mid-Quarter Termination column in DATA_HCPCS for a list of applicable codes. Additionally, when a HCPCS modifier identified by CMS as applicable to the PHE only is reported on a claim and Payer Value code Z9 is present, the claim is returned to the provider with edit 123. In the instance that payer value code Z9 is not provided on input, and the claim is reported with a code or a modifier that is identified on the CMS Mid-Quarter Termination list, the default date of May 11, 2023 is used to determine if editing is applicable. If Z9 is present and the Value Code Amount field is blank or has an invalid date, the From Date of the claim is used.

Note: In the instance that a code reported is flagged as a "CMS Mid-Quarter Termination" code and is also reported with modifier CS in the presence of Payer Value code Z9, the IOCE assigns both edits 123 and 124 (RTP).

Codes identified as applicable to the CMS Midquarter Termination bypass list removes the service from CAPC exclusion logic and allows the coinsurance and deductible to apply after the PHE end date. Note that this list is not associated with an edit.

Telehealth claims processing

Telehealth, also referred to as telemedicine, is the electronic exchange of medical information from one site to another, in the efforts to improve a patient's health outcome. These services are typically done with general audio or internet access via a computer, tablet, smartphone and more recently can even now involve Virtual Reality (VR) consoles. To report services provided as telehealth, the service must be identified on the list of Medicare telehealth services and reported with an appropriate Telehealth modifier. For a list of applicable Telehealth codes, see the Telehealth column in the Data_HCPCS table. Additionally, for a list of modifiers appropriate for use when reporting a Telehealth service, see the Telehealth column in the Data_Modifier table.

Effective July 1, 2023 (v24.2), For critical access hospitals, bill type 085x, if a HCPCS code, not on the Telehealth list, is reported with modifiers 95, GT, or GQ, the IOCE returns edit 126 (RTP).

Fee schedule

Certain services currently paid for are not assigned to an APC, but continue to be paid according to a fee schedule. Services paid by fee schedule include, but are not limited to, ambulance, diagnostic clinical laboratory, and occupational therapy.

Status indicators

Medicare has assigned each HCPCS/CPT code a letter that signifies whether they will reimburse the service, how it will be reimbursed, and to whom the claim should be submitted, e.g., MAC (Medicare Administrative Contractor), Carrier, DMERC (durable medical equipment regional carrier), etc. This indicator also helps in determining whether policy rules, such as packaging and discounting, apply.

Table 3. List of status indicators

Value	Description
A	Services not paid under OPPS; paid under fee schedule or other payment system, including unclassified drugs and biologicals reportable under HCPCS code C9399

Value	Description
B	Non-allowed item or service for OPPS
C	Inpatient procedure
E1	Non-allowed item or service
E2	Items and services for which pricing informatio(discontinued 01/01/2017)n and claims data are not available
F	Corneal tissue acquisition; certain CRNA services
G	Drug/Biological pass-through
H	Pass-through device categories
J1	Outpatient department services paid through a comprehensive APC
J2	Hospital Part B services that may be paid through a comprehensive APC
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine; Hepatitis B Vaccines; Covid-19 Vaccine; Monoclonal Antibody Therapy Product
M	Service not billable to the MAC
N	Items and Services packaged into APC rates
P	Partial Hospitalization or Intensive Outpatient Program
Q1	STV-packaged codes
Q2	T-packaged codes
Q3	Codes that may be paid through a composite APC
Q4	Conditionally packaged laboratory services
R	Blood and blood products
S	Procedure or service, not discounted when multiple
T	Procedure or service, multiple reduction applies
U	Brachytherapy sources
V	Clinic or emergency department visit

Value	Description
W	Invalid HCPCS or Invalid revenue code with blank HCPCS
Y	Non-implantable DME
Z	Valid revenue code with blank HCPCS and no other SI assigned

Modifiers

The significance of modifiers increases in coding under OPPS. Modifiers add clarification and specificity to procedures and are edited in the software. Failure to use them or use of an incorrect modifier may adversely affect the payment decision for some outpatient services.

Same day medical and procedure APC

Significant procedure visits and medical visits will not usually occur on the same day. However, if a medical visit identified by an E&M (status indicator V) code with modifier 25 occurs on the same date as a significant procedure, an additional payment will be made. Modifier 25 indicates that the medical visit was significant and separately identifiable from the procedure performed. When the E&M code does not have a modifier of 25, the claim will be returned to provider.

Contractor (MAC) actions impacting IOCE processing

The Medicare Administrative Contractor may on occasion require an override or bypass of IOCE grouping or editing results, to apply payment adjustment outside of the IOCE process or for reprocessing OPPS/ Non-OPPS adjusted claims. This may be accomplished by the following actions, which may only be applied by the MAC; these actions are not meant to be input by an end-user or provider.

- Line item action flag. A value passed as input to the IOCE to override a line item denial or rejection or to allow the MAC to indicate the line item should be denied or rejected, even if no IOCE edits are present. Note: If a Line item action flag is present on any line item that also contains a contractor bypass, the line item action flag logic takes precedence and no contractor bypass is applied to the line.
- Contractor Bypass: Values passed as input to bypass IOCE edits and any payment value which may need adjusted by the MAC for payment determination. The presence of an IOCE edit in the Contractor Bypass edit field allows the bypass to execute, as defined by the contractor. A line level edit bypass for an OPPS claim requires all contractor bypass fields to be provided on input. A claim level edit bypass for an OPPS claim requires only the Contractor Bypass edits field to be populated with an applicable edit(s) in addition to providing an appropriate PMF value of V, W, X, Y, or Z in the CB Payment Method Flag field.

A Non-OPPS claim with either a line level or claim level edit only require the edit(s) to be populated in the Contractor Bypass edit field with the appropriate PMF of V, W, X, Y, or Z in the CB Payment Method Flag Field. A line item where a contractor bypass is applied returns a payment method flag of V, W, X, Y, or Z to indicate that the line(s) payment is set by the Contractor. If the contractor does not supply a PMF value of either V, W, X, Y, or Z, by default a Z is supplied on output to identify that a line(s) has a contractor bypass applied.

Line item action flag (LIAF) processing

Line Item Action Flags, primarily, are values passed as input to the IOCE to override a line item denial or rejection flag assigned or to allow the MAC to indicate the line item should be denied or rejected, even if no IOCE edits are present.

For return to the provider (RTP) edits, if the RTP is due to line-item information such as the HCPCS code, revenue code or modifier, the edit can be bypassed with LIAF = 1. However, if the edit assigned is due to claim level information such as a condition code, value code, occurrence code or the principal diagnosis, the edit cannot be bypassed with LIAF= 1.

Note that if a Line item action flag is present on any line item that also contains a contractor bypass, the line item action flag logic takes precedence and no contractor bypass is applied to the line.

Contractor bypass processing

Contractor Bypass values are passed as input to bypass IOCE edits and any payment value which may need adjusted by the MAC for payment determination. The presence of an IOCE edit in the Contractor Bypass edit field allows the bypass to execute as defined by the contractor. A line level edit bypass for an OPPS claim requires all contractor bypass fields to be provided on input. A claim level edit bypass for an OPPS claims requires only the Contractor Bypass edits field to be populated with an applicable edit(s) in addition to providing an appropriate PMF value of V, W, X, Y or Z in the CB Payment Method Flag field. A Non-OPPS claim with either a line level or claim level edit, only require the edit(s) to be populated in the Contractor Bypass edit field with the appropriate PMF of V, W, X, Y, or Z in the CB Payment Method Flag Field. A line item where a contractor bypass is applied returns a payment method flag of V, W, X, Y, or Z to indicate that the line(s) payment is set by the Contractor. If the contractor does not supply a PMF value of either V, W, X, Y, or Z, by default a Z is supplied on output to identify that a line(s) has a contractor bypass applied.

Payer only bypass of deductible and/or coinsurance on part B institutional claims

Effective July 1, 2023 (v24.2), for both OPPS and Non-OPPS bill types 012x, 012x w/CC41, 013x, 013x w/CC41, 013x w/CC89, 014x, 014x w/CC41, 022x, 023x, 032x, 034x, 071x, 072x, 073x, 074x, 075x, 076x, 077x, 085x, 085x w/CC89, and 087x, new payer only modifiers and condition codes are allowed to be input by the MAC to allow systematic bypasses for coinsurance and/or

deductible. Modifiers are reported at the line level and when a line is reported with an applicable modifier (see Payer Only Modifiers and Condition codes to bypass Deductible and/or Coinsurance table below), the IOCE assigns the appropriate payment adjustment flag (PAF), in the priority order of 9, 4, or 10; for the line(s) to bypass either the deductible (PAF= 4), the coinsurance (PAF= 10) or both deductible and coinsurance (PAF= 9).

Condition codes are reported at the claim level and when an applicable condition code is appended to the claim, the IOCE bypasses either the deductible, the coinsurance or both deductible and coinsurance for all payable lines (lines that provide a payable SI and /or APC, excluding those that are packaged (SI= N)). The appropriate PAF, in the priority order of 9, 4, or 10; is provided for the applicable line(s). Note: In the instance of multiple condition codes present for the claim, the payer only condition code takes precedence.

Note that the logic for payer only modifiers and condition codes to bypass the deductible and/or coinsurance takes priority of any other payment adjustment flag logic. Additionally, although the payer only modifiers or condition codes can be applied to a non-OPPS bill type, there is no action by the IOCE.

Table 4. Payer only modifiers and condition codes to bypass deductible and/or coinsurance

Payer Only Modifier (Line level)	Payer Condition code (Claim Level)
@1 – System Bypass deductible	M7 – Medicare Deductible bypass (System)
@4 – MAC Bypass deductible	MH – Medicare Deductible bypass (MACs)
@2 – System Bypass coinsurance	M8 – Medicare Coinsurance bypass (System)
@5 – MAC Bypass coinsurance	MI – Medicare Coinsurance bypass (MACs)
@3 – System Bypass both deductible and coinsurance	AJ – Payer responsible for co-payment
@6 – MAC Bypass both deductible and coinsurance	M9 – Medicare Deductible/Coinsurance bypass (System)
	MJ – Medicare Deductible/Coinsurance bypass (MACs)

Payer only value code Z9 for CMS mid-quarter termination processing

Payer Value Code, Z9 (CMS determined mid-quarter termination date), is input by the MAC to identify claims in which CMS has determined there is a mid-quarter termination date. Z9 is reported with a date in the Value Code Amount field formatted with a blank or a space in front of the date, for example: ___YYYYMMDD (“_” represents the blank space). When Z9 is input with a date and a code identified on the CMS Mid-Quarter Termination list in DATA_HCPCS is reported, the claim is returned to the provider with edit 124. Additionally, when a HCPCS modifier is reported that has been identified by CMS as applicable to the CMS Mid-Quarter

Termination list and Payer Value code Z9 is present, the claim is returned to the provider with edit 123.

If Z9 is present and the Value Code Amount field is blank or has an invalid date, the From Date of the claim is used for processing.

Note: If Z9 is not present, the default termination date is May 11, 2023. See the Public Health Emergency (PHE) Processing section (page 26) for additional information.

Chapter 2: OPPS program output

This chapter describes Integrated Outpatient Code Editor (IOCE) program output for OPPS claims, including edit information, status indicators, and payment indicators. For input data elements, see "Program input" on page 14.

Line item information

The program processes input data and generates the following information for each line item on the claim:

- Healthcare Common Procedure Coding System (HCPCS) procedure code
- HCPCS APC
- Payment APC
- Status indicator
- Payment indicator
- Discounting factor
- Line item denial or rejection flag
- Packaging flag
- Payment adjustment flag 1
- Payment method flag
- Service units
- Charge
- Line item action flag
- Composite adjustment flag
- Payment adjustment flag 2

APCs

Except when specified otherwise (e.g., partial hospitalization, mental health, observation logic, codes with an SI of 'Q#', etc.), the payment APC and the HCPCS APC are the same. For more information on APCS, see "Information on APCs for OPPS" on page 16. Appendix C contains a complete list of current APCs with their status indicators and descriptions.

Status indicators

Medicare has assigned each HCPCS/CPT code a letter that signifies whether Medicare will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. The status indicator values generated in program output are shown in the following table.

Table 5. List of status indicators

Value	Description
A	Medicare has assigned each HCPCS/CPT code a letter that signifies whether Medicare will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy
B	Non-allowed item or service for OPPS
C	Inpatient procedure
E1	Non-allowed item or service
E2	Items and services for which pricing information and claims data are not available
F	Corneal tissue acquisition; certain CRNA services
G	Drug/Biological pass-through
H	Pass-through device categories
J1	Outpatient department services paid through a comprehensive APC
J2	Hospital Part B services that may be paid through a comprehensive APC
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine; Hepatitis B Vaccines; Covid-19 Vaccine; Monoclonal Antibody Therapy Product
M	Service not billable to the MAC
N	Items and Services packaged into APC rates
P	Partial Hospitalization or Intensive Outpatient Program
Q1	STV-packaged codes
Q2	T-packaged codes
Q3	Codes that may be paid through a composite APC
Q4	Conditionally packaged laboratory services

Value	Description
R	Blood and blood products
S	Procedure or service, not discounted when multiple
T	Procedure or service, multiple reduction applies
U	Brachytherapy sources
V	Clinic or emergency department visit
W	Invalid HCPCS or Invalid revenue code with blank HCPCS
Y	Non-implantable DME
Z	Valid revenue code with blank HCPCS and no other SI assigned

Payment indicators

The payment indicator values generated in program output are shown in the following table.

Table 6. List of payment indicators

Value	Description
1	Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V)
2	Services not paid by OPPS Pricer; paid under fee schedule or other payment system (status indicator A, G, K)
3	Not paid (status indicators E, M, Q, Q1, Q2, Q3, W, Y), or not paid under OPPS (status indicators B, C, Z)
4	Paid at reasonable cost (status indicator F, L)
5	Paid standard amount for pass-through drug or biological (status indicator G) (discontinued 10/01/2016)
6	Payment based on charge adjusted to cost (status indicator H)
7	Additional payment for new drug or new biological (status indicator J; service dates prior to 04/01/2002 only)
8	Paid partial hospitalization or Intensive outpatient program per diem (status indicator P)
9	No additional payment, payment included in line items with APCs (status indicator N; or no HCPCS code and certain revenue codes; or HCPCS codes G0176 - activity therapy, G0129 - occupational therapy, or G0177 - patient education and training services)

Value	Description
10	Paid FQHC encounter payment
11	Not paid or not included under FQHC encounter payment
12	No additional payment, included in payment for FQHC encounter
13	Paid FQHC encounter payment for New patient or IPPE/AWV
14	Grandfathered tribal FQHC encounter payment
15	FQHC IOP encounter payment
16	Wrap-around payment for FQHCs that contract with Medicare Advantage (MA) organizations

Dispositions

Each edit is associated with a disposition. For example, there can be a rejection of the line item itself or a rejection of the entire claim. In addition to edit dispositions, the program assigns an overall disposition to the claim. Edit and claim dispositions are discussed in the sections that follow.

Edit disposition

A disposition is assigned based on the presence of any edits on a line. The meaning of each edit disposition is described in the table below. It is possible for a claim to have one or more edits in all dispositions.

Edit disposition definitions

Table 7. Edit disposition definitions

Disposition	Definition
Claim rejection	The provider can correct and resubmit the claim but cannot appeal the rejection.
Claim denial	The provider cannot resubmit the claim but can appeal the denial.
Claim returned to provider (RTP)	The provider can resubmit the claim once the problems are corrected.

Disposition	Definition
Claim suspension	The claim is not returned to the provider, but it is not processed for payment until the Medicare Administrative Contractor (MAC) makes a determination or obtains further information.
Line item rejection	The claim can be processed for payment with some line items rejected for payment (i.e., the line item can be corrected and resubmitted but cannot be appealed).
Line item denial	There are one or more edits that cause one or more individual line items to be denied. The claim can be processed for payment with some line items denied for payment (i.e., the line item cannot be resubmitted but can be appealed).

For a complete list of program edits and edit dispositions, see Edit disposition summary (see "Edit disposition summary" on page 41).

Claim disposition

Since a claim can have several edit dispositions assigned to line items, the claim is assigned an overall disposition. Claim disposition values are shown in the following table.

Table 8. List of claim dispositions

Value	Description
0	No edits are present on the claim.
1	The only edits present are for line item denial or rejection.
2	Claim is for multiple days with one or more days denied or rejected.
3	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only post-payment edits.
4	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only pre-payment edits.
5	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with both post- and pre-payment edits.

Payment information

Discounting, packaging, and payment adjustment information are included in the program output, which is then passed to a pricer program for payment. For more detailed information about payment see "Payment information" on page 17.

Table 9. Packaging flag

Value	Description
0	Not packaged
1	Packaged service (status indicator N, or no HCPCS code and certain revenue codes)
2	Packaged as part of partial hospitalization per diem or daily mental health service per diem (v1.0 - v9.3 only)
3	Artificial charges for surgical procedures (submitted charges for surgical HCPCS < $1.01)
4	Packaged as part of drug administration APC payment (v6.0–v7.3 only)
5	Packaged as part of FQHC encounter payment
6	FQHC packaged preventive or other reported service not subject to coinsurance payment

Table 10. Payment adjustment flag

Value	Description
0	No payment adjustment
1	Paid standard amount for pass-through drug or biological (status indicator G) (v3.0-v16.2 only)
2	Payment based on charge adjusted to cost (status indicator H) (v1.0-v10.3 only)
4	Deductible not applicable (specific list of HCPCS codes) or condition code "MA" is present on the claim
5	Blood/blood product used in blood deductible calculation
6	Blood processing/storage not subject to blood deductible
7	Item provided without cost to provider (deactivated 01/01/2014, v.15.0)

Value	Description
8	Item provided with partial credit to provider (deactivated 01/01/2014, v.15.0)
9	Deductible/co-insurance not applicable
10	Co-insurance not applicable
11	Multiple service units reduced to one by IOCE processing; payment based on single payment rate
12	Offset for first device pass-through
13	Offset for second device pass-through
14	PAMA Section 218 reduction on CT scan
15	Placeholder reserved for future use
16	Terminated procedure with pass-through device
17	Condition for device credit present
18	Offset for first pass-through drug or biological
19	Offset for second pass-through drug or biological
20	Offset for third pass-through drug or biological
21	CAA Section 502(b) reduction on film X-ray
22	CAA Section 502(b) reduction on computed radiography technology
23	Co-insurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b)
24	Co-insurance deductible n/a, as well as subject to a reduction due to computed radiography technology (CAA Section 502b)
25	Deductible not applicable and Coinsurance reduced

Table 11. Payment method flag

Value	Description
0	OPPS pricer determines payment for service
1	Service not paid based on coverage or billing rules
2	Service is not subject to OPPS
3	Service is not subject to OPPS and has an OCE line item denial or rejection

Value	Description
4	Line item is denied or rejected by MAC; OCE not applied to line item
5	Payment for service determined under FQHC PPS
6	CMHC outlier limitation reached
7	Section 603 service with no reduction in OPPS Pricer
8	Section 603 service with PFS reduction applied in OPPS Pricer
9	CMHC outlier limitation bypassed
A	Payment reduction for off-campus clinic visit
B	Payer only testing
C	Payment made by FQHC PPS and coinsurance is n/a (COVID-19)
V	Contractor bypass applied to FQHC PPS service and coinsurance is n/a (COVID-19)
W	Contractor bypass applied to off-campus clinic visit for payment reduction
X	Contractor bypass applied to Section 603 service with no reduction applied in OPPS Pricer
Y	Contractor bypass applied to Section 603 service with reduction applied in OPPS Pricer
Z	Contractor bypass determines payment for services

Table 12. Composite adjustment flag

Value	Description
00	Not a composite
01-ZZ	First thru the 'nth' composite APC present; same composite flag identifies the prime and non-prime codes in each composite APC group

Table 13. Composite adjustment flags for FQHC claim processing (bill type 77X)

Value	Description
01	FQHC medical clinic visit
02	FQHC mental health clinic visit
03	Subsequent FQHC medical clinic visit (modifier 59 reported)
04	FQHC Intensive Outpatient Program visit

Edit disposition summary

The following table lists each edit in the program with its disposition. For the meaning of each disposition, see "Edit disposition" on page 36. For information on what conditions will generate an edit, as well as relevant important comments for specific edits, see "OPPS program edits" on page 53.

Table 14. Edit disposition summary

Edit	Edit disposition
1. Invalid diagnosis code	Claim returned to provider
2. Diagnosis and age conflict	Claim returned to provider
3. Diagnosis and sex conflict (v1.0–v25.1 only)	Claim returned to provider
4. Medicare secondary payer alert (v1.0 and v1.1 only)[a]	Claim suspension
5. External cause of morbidity code can not be used as principal diagnosis	Claim returned to provider
6. Invalid procedure code	Claim returned to provider
7. Procedure and age conflict	Line item rejection (Informational Only, no impact to payment)
8. Procedure and sex conflict (v1.0–v25.1 only)	Claim returned to provider
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial
10. Service submitted for denial (condition code 21)	Claim denial
11. Service submitted for FI/MAC review (condition code 20)	Claim suspension

Edit	Edit disposition
12. Questionable covered service	Claim suspension
13. Separate payment for services is not provided by Medicare (v1.0–v6.3 and for v.18.0- for codes with SI = E2)	Line item rejection
14. Code indicates a site of service not included in OPPS (v1.0–v6.3 only)[a]	Claim returned to provider
15. Service unit out of range for procedure(v1.0–9.1 only)[a]	Claim returned to provider
16. Multiple bilateral procedures without modifier 50 (v1.0–v6.2 only)[a]	Claim returned to provider
17. Inappropriate specification of bilateral procedure	Line item rejection
18. Inpatient procedure	Line item denial
19. Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (*deleted, combined with edit 20 retroactive to earliest included version*)[a]	Line item rejection
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
21. Medical visit on same day as a type T or S procedure without modifier 25	Claim returned to provider
22. Invalid modifier	Claim returned to provider
23. Invalid date	Claim returned to provider
24. Date out of OCE range	Claim suspension
25. Invalid age	Claim returned to provider
26. Invalid sex	Claim returned to provider
27. Only incidental services reported	Claim rejection
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Line item rejection
29. PHP/IOP service for non-applicable diagnosis	Claim returned to provider
30. Insufficient services on day of partial hospitalization (v1.0–v24.3 only)[a]	Line item denial
31. Partial hospitalization on same day as ECT or type T procedure (v1.0–v6.3 only)[a]	Claim suspension
32. Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days (v1.0–v9.3 only)[a]	Claim suspension

Edit	Edit disposition
33. Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services (v1.0–v9.3 only)[a]	Claim suspension
34. Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria (v1.0 - v9.3 only)[a]	Claim suspension
35. Only Mental Health education and training services provided	Claim returned to provider
36. Extensive mental health services provided on day of ECT or type T procedure (v1.0–v6.3 only)[a]	Claim suspension
37. Terminated bilateral procedure or terminated procedure with units greater than one	Claim returned to provider
38. Inconsistency between implanted device or administered substance and implantation or associated procedure	Claim returned to provider
39. Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (*deleted, combined with edit 40 retroactive to earliest included version*)[a]	Line item rejection
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection
41. Invalid revenue code	Claim returned to provider
42. Multiple medical visits on same day with same revenue code without condition code G0	Claim returned to provider
43. Transfusion or blood product exchange without specification of blood product	Claim returned to provider
44. Observation revenue code on line item with non-observation HCPCS code	Claim returned to provider
45. Inpatient separate procedures not paid	Line item rejection
46. Partial hospitalization condition code 41 not approved for type of bill	Claim returned to provider
47. Service is not separately payable	Line item rejection
48. Revenue center requires HCPCS	Claim returned to provider
49. Service on same day as inpatient procedure	Line item denial
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Claim returned to provider
51. Observation code G0378 not allowed to be reported more than once per claim	Claim returned to provider

Edit	Edit disposition
52. Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions (v3.0–v6.3 only)[a]	Claim returned to provider
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Line item rejection
54. Multiple codes for the same service (inactive)[a]	Claim returned to provider
55. Non-reportable for site of service	Claim returned to provider
56. E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1 (v4.0–v6.3 only)[a]	Claim returned to provider
57. E/M condition not met for observation and line item date for code G0378 is 1/1	Claim suspension
58. G0379 only allowed with G0378	Claim returned to provider
59. Clinical trial requires diagnosis code V707 as other than primary diagnosis (*deleted, retroactive to the earliest included version*)[a]	Claim returned to provider
60. Use of modifier CA with more than one procedure not allowed	Claim returned to provider
61. Service can only be billed to the DMERC	Claim returned to provider
62. Code not recognized by OPPS; alternate code for same service may be available	Claim returned to provider
63. This OT code only billed on partial hospitalization claims (v1.0–v13.3)[a]	Claim returned to provider
64. AT service not payable outside the partial hospitalization program (v1.0–v13.3)[a]	Line item rejection
65. Revenue code not recognized by Medicare	Line item rejection
66. Code requires manual pricing	Claim suspension
67. Service provided prior to FDA approval	Line item denial
68. Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval	Line item denial
69. Service provided outside approval period	Line item denial
70. CA modifier requires patient discharge status indicating expired or transferred	Claim returned to provider
71. Claim lacks required device code (v6.1–v15.3 only)[a]	Claim returned to provider
72. Service not billable to the Medicare Administrative Contractor	Claim returned to provider
73. Incorrect billing of blood and blood products	Claim returned to provider
74. Units greater than one for bilateral procedure billed with modifier 50	Claim returned to provider

Edit	Edit disposition
75. Incorrect billing of modifier FB or FC (v.8.0–v15.3 only)[a]	Claim returned to provider
76. Trauma response critical care code without revenue code 068x and CPT 99291	Line item rejection
77. Claim lacks allowed procedure code (v6.1–v15.3 only)[a]	Claim returned to provider
78. Claim lacks required radiolabeled product (v9.0–v14.3)[a]	Claim returned to provider
79. Incorrect billing of revenue code with HCPCS code	Claim returned to provider
80. Mental health code not approved for partial hospitalization	Claim returned to provider
81. Mental health service not payable outside the partial hospitalization program	Claim returned to provider
82. Charge exceeds token charge ($1.00)	Claim returned to provider
83. Service provided on or after effective date of NCD non-coverage	Line item denial
84. Claim lacks required primary code	Claim returned to provider
85. Claim lacks required device code or required procedure code (v.13.0–v.14.3)[a]	Claim returned to provider
86. Manifestation code not allowed as principal diagnosis	Claim returned to provider
87. Skin substitute application procedure without appropriate skin substitute product code	Claim returned to provider
88. FQHC payment code not reported for FQHC claim	Claim returned to provider
89. FQHC claim lacks required qualifying visit code	Claim returned to provider
90. Incorrect revenue code reported for FQHC payment code	Claim returned to provider
91. Item or service not covered under FQHC PPS or for RHC	Line item rejection
92. Device-intensive procedure reported without device code	Claim returned to provider
93. Corneal tissue processing reported without cornea transplant procedure	Line item rejection
94. Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)	Claim returned to provider
95. 7-day-spanning partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care (v17.2 only-RTP, v18.3-present, LIR)	Line item rejection (Informational Only, no impact to payment)
96. Partial hospitalization interim claim From and Through dates must span more than 4 days (v17.2 only)	Claim returned to provider
97. Partial hospitalization services are required to be billed weekly (v17.2 only)	Claim returned to provider

Edit	Edit disposition
98. Claim with pass-through device lacks required procedure.	Claim returned to provider
99. Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	Claim returned to provider
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	Claim returned to provider
101. Item or service with modifier PN not allowed under PFS	Claim returned to provider
102. Modifier pairing not allowed on the same line	Claim returned to provider
103. Modifier reported prior to FDA approval date (v19.0 only)	Line item denial
104. Service not eligible for all-inclusive rate	Line item rejection
105. Claim reported with pass-through device prior to FDA approval for procedure	Line item denial
106. Add-on code reported without required primary procedure code	Line item denial
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	Line item denial
109. Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	Claim returned to provider
110. Service provided prior to initial marketing date	Line item rejection
111. Service cost is duplicative; included in cost of associated biological	Line item rejection
112. Information only service(s)	Line item rejection
113. Supplementary or additional code not allowed as principal diagnosis	Claim returned to provider
114. Item or service not allowed with modifier CS (v21.3-24.1 only)	Claim returned to provider
115. COVID-19 lab add-on code reported without required primary procedure (v22.0-24.1 only)	Line item denial
116. Opioid treatment program service not payable outside the opioid treatment program	Claim returned to provider
117. Token charge less than $1.01 billed by provider	Line item rejection
118. Invalid bill type	Claim returned to provider

Edit	Edit disposition
119. Invalid claim processing receipt date	Claim returned to provider
120. Incorrect reporting of modifier PT	Claim returned to provider
121. Non-covered service reported with inpatient only procedure where patient expired or transferred	Line item denial
122. 340B-acquired drug modifier(s) reported inappropriately	Line item rejection (Information only edit)
123. Modifier used after CMS termination date	Claim returned to provider
124. HCPCS reported after CMS termination date	Claim returned to provider
125. Incorrect billing of IMRT planning and delivery	Claim returned to provider
126. Incorrect reporting of telehealth modifier	Claim returned to provider
127. Service not allowed for Part B Inpatient claim	Line item rejection
128. Insufficient services on day of IOP	Line item rejection (Information only edit)
129. 7-day spanning IOP services require a minimum of 9 hours of service	Line item rejection (Information only edit)
130. Incorrect reporting of modifier on RHC IOP claim	Claim returned to provider
131. Insufficient services on day of PHP	Line item rejection (Information only edit)
132. Mental health code not approved for Intensive Outpatient Program	Claim returned to provider
133. Mental health service not payable outside the Intensive Outpatient program	Claim returned to provider
134. Service provided outside designated approval period	Line item rejection
135. Claim Day lacks required device code	Claim returned to provider
136. Reserved	Suspend

Edit	**Edit disposition**
137. Reserved	Suspend
138. Reserved	Suspend
139. Reserved	Suspend
140. Reserved	Suspend
141. Reserved	Suspend
142. Reserved	Suspend
143. Reserved	Suspend
144. Reserved	Suspend
145. Reserved	Suspend
146. Reserved	Suspend
147. Reserved	Suspend
148. Reserved	Suspend
149. Reserved	Suspend
150. Reserved	Suspend
151. Reserved	Suspend
152. Reserved	Suspend
153. Reserved	Suspend
154. Reserved	Suspend
155. Reserved	Suspend

Edit	Edit disposition
156. Reserved	Suspend
157. Reserved	Suspend
158. Reserved	Suspend
159. Reserved	Suspend
160. Reserved	Suspend
161. Reserved	Suspend
162. Reserved	Suspend
163. Reserved	Suspend
164. Reserved	Suspend
165. Reserved	Suspend
166. Reserved	Suspend
167. Reserved	Suspend
168. Reserved	Suspend
169. Reserved	Suspend
170. Reserved	Suspend
171. Reserved	Suspend
172. Reserved	Suspend
173. Reserved	Suspend
174. Reserved	Suspend

Edit	**Edit disposition**
175. Reserved	Suspend
176. Reserved	Suspend
177. Reserved	Suspend
178. Reserved	Suspend
179. Reserved	Suspend
180. Reserved	Suspend
181. Reserved	Suspend
182. Reserved	Suspend
183. Reserved	Suspend
184. Reserved	Suspend
185. Reserved	Suspend
186. Reserved	Suspend
187. Reserved	Suspend
188. Reserved	Suspend
189. Reserved	Suspend
190. IOP Primary service not reported for IOP day	Claim returned to provider
191. PHP Primary service not reported for PHP day	Claim returned to provider
192. Reserved	Suspend
193. Reserved	Suspend

Edit	**Edit disposition**
194. Reserved	Suspend
195. Reserved	Suspend
196. Reserved	Suspend
197. Reserved	Suspend
198. Reserved	Suspend
199. Reserved	Suspend

a. Edits are active only on claims that are more than 7 years old that are processed with previously archived software.

Chapter 3: OPPS program edits

This chapter contains information on the condition(s) which, when present, will generate an OPPS edit in the Integrated Outpatient Code Editor (IOCE) program.

At the end of this chapter is a section that contains additional information about certain cases where the logic in arriving at an edit or APC is not particularly obvious. For these details see "Special logic information" on page 78.

The following table summarizes when edits are generated and also includes other relevant information. Refer to chapter 2 (page 33) for edit dispositions and overall claim disposition information.

Edit summary for OPPS

Table 15. Edit summary

Edit	Generated when ...
1. Invalid diagnosis code	The principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid. Effective with v22.2, edit 1 is bypassed if a claim with a From-Through date spanning the quarter boundary (e.g., 09/29/-10/01) reports a diagnosis code that is valid in at least one quarter. If the diagnosis code is not valid in either of the quarters edit 1 is applied.
2. Diagnosis and age conflict	The diagnosis code includes an age range, and the age is outside that range.
3. Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim (v1.0–v25.1 only).
4. Medicare secondary payer alert[a]	The procedure code has a MSP alert warning indicator. This edit applies to v1.0 and v1.1 only, and is not applicable for reason for visit diagnosis.
5. External cause of morbidity code cannot be used as principal diagnosis	The principal diagnosis code is in the range V00-Y99.
6. Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.

Edit	Generated when ...
7. Procedure and age conflict	The age of the patient does not fall within the age range(s) designated for the procedure code reported. Note: Ages are based on published CMS/AMA information. This is an information only edit that sets the Line Item Denial Rejection flag = 3.
8. Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure coded on the record. This edit is bypassed if condition code 45 is present on the claim (v1.0–v25.1 only).
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	The procedure code is flagged as Non-covered for reasons other than statute exclusion or Revenue code is 099x with SI of E1 and is submitted without a HCPCS code. This edit is bypassed when code G0428 is present with E1. See edit 50 for non-covered statutory exclusions editing.
10. Service submitted for denial	The claim submitted has condition code 21 present. **Note**: Prior to the implementation of v22.0, edit 10 terminated processing early and returned Claim Processed Flag value 3 (Claim could not be processed (edit 10 condition code 21 is present)), and Return Code 20 (Claim was not processed, condition code 21 exists). Effective with v22.0, edit 10 no longer terminates processing but instead just returns the edit and all other edits if present on the claim.
11. Service submitted for MAC review (condition code 20)	The claim has a condition code 20.
12. Questionable covered service	The procedure code has a Questionable covered service flag.
13. Separate payment for services is not provided by Medicare	The claim is OPPS and the bill type is 12x, 13x, 14x, or 76x and the HCPCS code has status indicator E2.
14. Code indicates a site of service not included in OPPS[a]	The procedure code has a Not included in OPPS indicator. This edit applies to v1.0–v6.3 only.

Edit	Generated when ...
15. Service unit out of range for procedure (inactive)[a]	The maximum units allowed is greater than zero and The sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure and Modifier 91 is not present or modifier 91 is present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. Units for all line items with the same HCPCS code on the same day are added together when applying this edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS code is on a list of codes that are exempt, the unit edits are not applied.
16. Multiple bilateral procedures without modifier 50[a]	The same bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant procedure lines for dates of service prior to 10/01/05 only (v1.0–v6.2).
17. Inappropriate specification of bilateral procedure	The same inherent bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant bilateral procedure lines, except when modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code. Exception: For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17. For CAHs (085x), a professional service revenue code (096x, 097x, 098x) must be present on at least one of the multiple occurrences of the same inherently bilateral code to bypass editing.

Edit	Generated when ...
18. Inpatient procedure	A line has a C status indicator and is not on the 'separate procedure' list or A line has a C status indicator and is on the 'separate procedure' list, but there are no type T lines on the same day. All other line items on the same day as the line with a C status indicator are denied (line item denial/rejection flag = 1, APC return buffer) and edit 49 is assigned on all line items. This is the only edit that can cause one or more days of a multiple day claim to be denied, or single day claim with all lines denied.
19. Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present (*deleted, combined with edit 20 retroactive to earliest included version*)[a]	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The procedure is identified as part of another procedure on the claim coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
21. Medical visit on the same day as a type T or S procedure without modifier 25	One or more type T or S procedures occur on the same day as a medical visit line item with SI of V, without modifier 25.
22. Invalid modifier	The modifier is not in the list of valid modifier entries and the revenue code is not 540.
23. Invalid date	The service date and/or the from and through dates are invalid (or blank). Or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. Edits 23 and 24 for from/through dates, are IOCE program errors that are applicable to each bill type. **Note**: Exception: Home Health adjustment claims (032G) do not have edit 23 applied to any line items that report a service date outside the claim From-Through dates. **Note**: If edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates and processing continues.

Edit	Generated when ...
24. Date out of OCE range	The From/Through date falls outside the date range of any version of the program. Presence of this edit condition terminates processing for the claim. Edits 23 and 24 for from /through dates, are IOCE program errors that are applicable to each bill type
25. Invalid age	The age field is blank, non-numeric or outside the range of 0-124 years.
26. Invalid sex	The sex field is blank, non-numeric or outside the range of 0-2. This edit is bypassed if condition code 45 is present on the claim.
27. Only incidental services reported	All line items are incidental (SI= N) or all lines on the claim are a combination of the following conditions: ▪ Lines that are Packaged (SI= N) ▪ Invalid HCPCS Lines (Edit 6) ▪ Invalid Revenue Code Lines (Edit 41)
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare' indicator.
29. PHP/IOP service for non-applicable diagnosis	The principal diagnosis is not identified as applicable for the PHP or IOP program. See Data_DX10 for applicable diagnoses.
30. Insufficient services on day of partial hospitalization	If less than 3 PHP services are reported for any one day, the day is denied, and the lines return edit 30. See Partial Hospitalization Processing logic for more information. This edit applies to v1.0 – 24.3 only.
31. Partial hospitalization on same day as ECT or type T procedure[a]	Electroconvulsive therapy or a significant procedure (status indicator T) occurs on the same day as partial hospitalization, and APC 00033 (partial hospitalization) is assigned to a mental health service on the same day. This edit applies to v1.0–v6.3 only.
32. Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days[a]	A claim suspended for medical review (edit 30) does not span more than three days. This edit applies to v1.0–v9.3 only.
33. Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services[a]	A claim suspended for medical review (edit 30) spans more than three days. However, partial hospitalization services were not provided on at least 57% (4/7) of the days. This edit applies to v1.0–v9.3 only.

Edit	Generated when ...
34. Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria[a]	A claim suspended for medical review (edit 30) spans more than three days and partial hospitalization services were provided on at least 57% (4/7) of the days. However, on the days when partial hospitalization services were provided, less than 75% of the days met the partial hospitalization day of service criteria (i.e., edit 30 occurred on the line item). This edit applies to v1.0–v9.3 only.
35. Only Mental Health education and training services provided	Only education and training services are present without other mental health service; the claim fails mental health status. Effective with v21.2, edit 35 logic is revised retroactively to be returned if education and training services are the only service(s) reported on the claim. **Note**: Edit 27 is suppressed from being returned if conditions for edit 35 are present.
36. Extensive mental health services provided on day of type T procedure[a]	Electroconvulsive therapy or a non mental health type T procedure APC is present on the same day as extensive mental health service. This edit applies to v1.0–v6.3 only.
37. Terminated bilateral procedure or terminated procedure with units greater than one	A modifier 52 or 73 is present, as well as: a) an independent or conditional bilateral procedure with modifier 50 or b) a procedure with units greater than 1.
38. Inconsistency between implanted device or administered substance and implantation or associated procedure	The status indicator is H, U, or APC 987-997 (Implant) is present, but no type S, T, or non-implant type X procedures are present on the claim (v1.0-15.3 only). There is a code with status indicator H or U present, but no type S, T, or J1 procedures are present on the same claim.
39. Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (*deleted, combined with edit 40 retroactive to earliest included version*)[a]	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.

Edit	Generated when ...
41. Invalid revenue code	The revenue code is not in the list of valid revenue codes or the revenue code is reported prior to/exceeding its NUBC effective date. Effective with the July 1, 2021 (v22.2) release, revenue codes are validated based on the claims processing receipt date, as revenue codes are considered a non-medical code set and should be validated not based on claim From-through dates but per the date in which CMS received the claim.
42. Multiple medical visits on same day with same revenue code without condition code G0	Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other.
43. Transfusion or blood product exchange without specification of blood product	A blood transfusion or exchange is coded but no blood product is coded.
44. Observation revenue code on line item with non-observation HCPCS code	A 762 (observation) revenue code is used with a HCPCS other than G0378 or G0379.
45. Inpatient separate procedures not paid	On the same day, all lines with status indicator C are on the 'separate procedure' list, and there is at least one type T or J1 line.
46. Partial hospitalization condition code 41 not approved for type of bill	Bill type 043x is present with condition code 41. Prior to January 1, 2024, edit 46 returned for bill types 012x or 014x when condition code 41 was reported. Edit 46 terminates processing only for those bill types where no other edits are applied.
47. Service is not separately payable	The claim consists entirely of a combination of lines that: a) are denied or rejected or b) have a status indicator N Edit 47 is assigned to all lines with status indicator N, or that change from Q to N, that are not already denied or rejected and have no other service on the claim.
48. Revenue center requires HCPCS	The HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed if the revenue code is flagged as "Bypass_E48" in the Data_Revenue table.
49. Service on same day as inpatient procedure	A service is reported on the same day of an inpatient only procedure (SI= C) that is denied with edit 18.

Edit	Generated when ...
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	The HCPCS reported is on 'statutory exclusion' list or the revenue code center reported is on the "statutory exclusion" list with status indicator E1 and submitted without a HCPCS code.
51. Observation code G0378 not allowed to be reported more than once per claim	HCPCS code G0378 is reported more than once on a 13x or 85x claim/bill type. The edit is applicable to the subsequent lines of G0378 only. Edit 51 is bypassed if the subsequent G0378 line(s) has a line item action flag of 2, 3, or 4.
52. Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions[a]	The observation period is less than 8 hours or There is no diagnosis of CHF, chest pain or asthma or There is a T procedure (except 90780) on the same or previous day. This edit applies to v3.0–v6.3 only.
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.
54. Multiple codes for the same service[a]	Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035. This edit applies to v3.0–v4.1 only.
55. Non-reportable for site of service	The procedures reported are non-reportable for the site of service indicated.
56. E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1[a]	There is no E/M visit the day of or the day preceding the observation and The date of observation is not 12/31/yyyy or 01/01/yyyy. This edit applies to v4.0–v6.3 only.
57. E/M condition not met for observation and line item date for code G0378 is 1/1	There is no specified E/M or critical care visit the day of or the day preceding the observation and The date of observation is 01/01/yyyy.
58. G0379 only allowed with G0378	Code G0379 is present without code G0378 for the same line item date.
59. Clinical trial requires diagnosis code V707 as other than primary diagnosis (*deleted, retroactive to the earliest included version*)[a]	Code G0292, G0293 or G0294 is present and Diagnosis code V707 is not present as admit or secondary diagnosis.

Edit	Generated when ...
60. Use of modifier CA with more than one procedure not allowed	Modifier CA is present on more than one line or Modifier CA is submitted on a line with multiple units.
61. Service can only be billed to the DMERC	The procedure code has a 'DMERC billable only' flag indicator set and SI=Y.
62. Code not recognized by OPPS; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare for OPPS' indicator. Services with a status indicator of B always return edit 62. **Note**: Edit 62 is bypassed if the bill type is 022x or 023x with or without condition code 07.
63. This OT code only billed on partial hospitalization claims[a]	Occupational therapy services are present and the bill type is 12x or 13x without condition code 41. This edit applies to v1.0–v13.3 only.
64. AT service not payable outside the partial hospitalization program[a]	Activity therapy services are present and the bill type is 12x or 13x without condition code 41. This edit applies to v1.0–v13.3 only.
65. Revenue code not recognized by Medicare	The revenue code is flagged as "Not_ Recognized" by Medicare in the Data_Revenue table.
66. Code requires manual pricing	The HCPCS code is an unclassified drug code.
67. Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.
68. Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval	The line item date of service of a code is prior to the code activation date as determined by National Coverage Determination (NCD) or approval of a Demonstration.
69. Service provided outside approval period	The service was provided outside the period approved by CMS.
70. CA modifier requires patient discharge status indicating expired or transferred	CA modifier requires patient discharge status indicating expired or transferred.
71. Claim lacks required device code[a]	A specified procedure is submitted on a claim without the code(s) for the required device(s). (This edit is bypassed if the procedure is terminated - modifier 52, 73, or 74.) This edit applies to v6.1–v15.3 only.

Edit	Generated when ...
72. Service not billable to the Medicare Administrative Contractor	A code has a status indicator M. This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x. This edit is also bypassed on FQHC and RHC bill types if the code reported is flagged as "BYPASS E72 FQHC RHC." **Note**: The status indicator for the HCPCS code is changed from M to A.
73. Incorrect billing of blood and blood products	Blood product claims lack two identical lines (of HCPCS code, units, and modifier BL), one line with revenue code 38x and the other line with revenue code 39x.
74. Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same line. If bill type is 085x and revenue code is 096x, 097x, or 098x, the units are summed if multiple lines of the same HCPCS and same revenue code on the same day, if some or all the lines have modifier 50. Note: Exclude any lines that have any other modifier, other than 50, present.
75. Incorrect billing of modifier FB or FC[a]	Modifier FB or FC is present and SI is not S, T, or V. This edit applies to v8.0–v15.3 only.
76. Trauma response critical care code without revenue code 068x and CPT 99291	Trauma response critical care code is present without revenue code 068x and CPT code 99291 on the same date of service.
77. Claim lacks allowed procedure code[a]	A specified device is submitted on a claim without a code for an allowed procedure, and the bill type is not 12x. This edit applies to v6.1–v15.3 only.
78. Claim lacks required radiolabeled product[a]	A specified nuclear medicine procedure is submitted on a claim without the code for a required radiopharmaceutical. This edit applies to v9.0–v14.3 only.
79. Incorrect billing of revenue code with HCPCS code	The revenue code is 0381 with a HCPCS code other than packed red cells or the revenue code is 0382 with a HCPCS code other than whole blood.
80. Mental health code not approved for partial hospitalization	Mental health HCPCS codes that are not approved for partial hospitalization program submitted on bill type 076x. Effective January 1, 2024 bill type 076x must include CC 41 to identify PHP processing.
81. Mental health service not payable outside the partial hospitalization program	Mental health HCPCS codes that are not payable outside the partial hospital program submitted on bill type 013x.

Edit	Generated when ...
82. Charge exceeds token charge ($1.00)	Code C9898 is billed with charges greater than $1.00.
83. Service provided on or after effective date of NCD non-coverage	The line item date of service of a code is after the date of non-coverage determination.
84. Claim lacks required primary code	A specified add-on code is submitted without its required primary procedure on the same date of service. PHP add-on codes apply edit 84 until version 18.1. For v15.3 – v16.0 only, FQHC claims reporting psychotherapy add-on codes without a primary service are edited with 84.
85. Claim lacks required device code or required procedure code[a]	Code C9732 and C1840 not submitted together on the same day. (Code for insertion of ocular telescopic lens submitted without the code for the lens, or vice versa). This edit applies to v13.0–v14.3 only.
86. Manifestation code not allowed as principal diagnosis	A diagnosis code considered to be a manifestation code from the Medicare Code Editor (MCE) manifestation diagnosis list is reported as the principal diagnosis code on a hospice (81x, 82x) or home health (032x) bill type.
87. Skin substitute application procedure without appropriate skin substitute product code	A List A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service.
88. FQHC payment code not reported for FQHC claim	FQHC payment code not reported for a FQHC claim (bill type 077x without condition code 65). Note: If the bill type is 0770 (No payment claim), edit 88 is not applicable. **Note**: Edit 88 is bypassed on FQHC PPS claims that do not report the FQHC payment code for the following: Telehealth originating site services, Chronic Care Management and the Opioid Use Disorder (OUD) Demonstration Model; also edit 88 is bypassed for FQHC when only FQHC non-covered services are present with edit 91.

Edit	Generated when ...
89. FQHC claim lacks required qualifying visit code	FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS. **Note**: Edit 89 is bypassed on FQHC PPS claims that report the FQHC payment code and not the qualifying visit for the following: Telehealth originating site services, Chronic Care Management and the Opioid Use Disorder (OUD) Demonstration Model; also edit 89 is bypassed for FQHC when only FQHC non-covered services are present with edit 91.
90. Incorrect revenue code reported for FQHC payment code	FQHC payment code not reported with revenue code 519, 52X or 900.
91. Item or service not covered under FQHC PPS or for RHC	A service considered to be non-covered under FQHC PPS or for RHC is reported.
92. Device-intensive procedure reported without device code	A device-intensive procedure is reported without a device code.
93. Corneal tissue processing reported without cornea transplant procedure	Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date.
94. Biosimilar HCPCS reported without biosimilar modifier	A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier. This edit applies to v17.0–v19.0 only.
95. 7-day-spanning partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care	A PHP claim contains weekly PH services that total less than 20 hours per 7-day span. This edit applies to v17.2 only-RTP, and v18.3-present, LIR. This is an information only edit that sets the Line Item Denial Rejection flag = 3.
96. Partial hospitalization interim claim from and through dates must span more than 4 days	An interim PHP claim (bill type 763 or 133 with condition code 41) From and Through date spans less than 5 days. This edit applies to v17.2 only.
97. Partial hospitalization services are required to be billed weekly	A PHP claim From and Through date spans more than 7 days. This edit applies to v17.2 only.
98. Claim with pass-through device lacks required procedure	A pass-through device is present without an associated, required procedure.
99. Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V.

Edit	Generated when ...
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services.
101. Item or service with modifier PN not allowed under PFS	Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603.
102. Modifier pairing not allowed on the same line	A line item is reported with a pair of modifiers that have conflicting meaning and should not be reported together. Please reference the data files for a report named Modifier Pairs, which contains an up to date list of modifiers not allowed to be reported on the same line.
103. Modifier reported prior to FDA approval date	A modifier is reported prior to the mid-quarter activation date. This edit applies to v19.0 only.
104. Service not eligible for all-inclusive rate	RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.
105. Claim reported with pass-through device prior to FDA approval for procedure	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.
106. Add-on code reported without required primary procedure code	A claim is submitted with a Type I add-on code(s) without the applicable defined primary procedure(s). The edit is returned on the add-on code line(s) when conditions of the edit are not met. **Note**: Effective v.24.0 (1/1/23), for 013x and 013x w/CC41 bill types, Remote Mental Health (RMH) add-on codes, are subject to this edit if reported without the primary code. For 013x only, Software as a Service (SAAS) add-on codes, are subject to this edit if reported without the primary code.
107. Add-on code reported without required contractor-defined primary procedure code	A claim is submitted with a Type II add-on code(s) reported with a professional services revenue code (096x, 097x or 098x), to allow for contractors to review and define the primary procedure on the claim. See Add-on Code Edit Processing for more information.

Edit	Generated when ...
108. Add-on code reported without required primary procedure or required contractor-defined primary procedure code	A claim is submitted with a Type III add-on code(s) without a defined primary(s) or contractor defined primary(s) procedure. This edit is returned on the add-on code line(s) when conditions are not met.
109. Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	A PHP/IOP claim is submitted with a Code First diagnosis without a mental health diagnosis in the first secondary diagnosis position. Note: Edit 29 is suppressed from being returned if a code first diagnosis is present in the pdx position.
110. Service provided prior to initial marketing date	The line item date of service of a code is prior to the initial marketing date for which it can be reported.
111. Service cost is duplicative; included in cost of associated biological	The reported line item is considered duplicative as the routine costs of all steps in creating a biological are bundled into the covered benefit, the biological. Any procedure identified as being “bundled into biological,” and reported as a line item are rejected. Additionally, this edit is returned if revenue codes 870-873 are submitted as line items with blank HCPCS.
112. Information only service(s)	The reported line item is a non-covered service as it is for informational reporting purposes only. Any HCPCS identified as being an information only service is assigned a non-covered status indicator and is line item rejected and has no impact on payment.
113. Supplementary or additional code not allowed as principal diagnosis	The principal diagnosis code reported is considered supplementary or an additional code and cannot be used as the principal diagnoses. The unacceptable principal diagnosis list is defined by the Medicare Code Editor (MCE), but there are some exclusions to the MCE list due to current OPPS coding requirements and guidelines. Any diagnosis code flagged as being an exclusion to the Unacceptable Principal Diagnosis list does not return edit 113.
114. Item or service not allowed with modifier CS	Modifier CS is reported on an item or service that is not on the coinsurance waiver eligible list. Modifier CS should only be reported on items that are identified by CMS as being eligible for a coinsurance waiver. Refer to the DATA_HCPCS table and column for named coinsurance_waiver_eligible for the list of services that are appropriate to report with modifier CS. (v21.3-24.1 only)

Edit	Generated when ...
115. COVID-19 lab add-on code reported without required primary procedure	HCPCS U0005 is reported on a claim without one of its primary procedures U0003 or U0004 on the same date of service. (v22.0-24.1 only) **Note**: U0005 may be considered a Type I add-on code but it has been given a separately distinct function than regular addon code edit 106. This add-on code is only subject to edit 115 in the IOCE.
116. Opioid treatment program service not payable outside the opioid treatment program	Opioid Treatment Program HCPCS codes are reported on a bill type that is not approved for an Opioid Treatment Program provider. Opioid Treatment Program HCPCS codes should only be reported on claims with bill types 87x, 13x with condition code 89, or 85x with condition code 89x.
117. Token charge less than $1.01 billed by provider	A drug HCPCS with final SI= K or G is reported with charges that are less than $1.01 and at least $0.01. The edit is not applied if a line item action flag of 2, 3, or 4 is present on the drug line(s).
118. Invalid bill type	A claim is submitted with a bill type that is not programmed to process in the IOCE. The presence of this edit terminates the processing of the claim, claim processed flag value 1 and return code 18 are provided. Edit 118 is not specified in the Edits by bill type table as this edit can only be applied to bill types that are not programmed in the IOCE.
119. Invalid claim processing receipt date	The claims processing receipt date is invalid (malformed) or the date falls outside the date range of any version of the IOCE program. This edit is an IOCE program error and is applicable to being returned on all programmed bill types. The claim processed flag value 1 and return code 29 are provided if edit 119 is applied.
120. Incorrect reporting of modifier PT	A single day claim or a single date of service on a multiple day claim is submitted with modifier PT present and no Colorectal procedure is reported for the same service date. This edit is returned at the line level. Refer to the DATA_HCPCS table and the column named Colorectal, for a list of procedures that are to be reported in the presence of modifier PT. This edit is also returned for Non-OPPS bill type 085x (Critical Access Hospitals). Note: A line item action flag of 1 overrides this edit when input by the MAC.

Edit	Generated when ...
121. Non-covered service reported with inpatient only procedure where patient expired or transferred	Non-covered services, identified with status indicators B, E1, E2, C or M, should not be paid separately when reported on a claim with an inpatient-only procedure and modifier CA.
122. 340B-acquired drug modifier(s) reported inappropriately	Pass-through drug and biological (SI=G) incorrectly reported with 340B program modifier.
123. Modifier used after CMS termination date	The reported claim is submitted with a HCPCS and appended with a modifier designated as not reportable after the CMS determined termination date for the modifier (Example modifier(s) includes: CS). **Note**: A line item action flag of 1 overrides this edit when input by the MAC.
124. HCPCS reported after CMS termination date	The reported claim is submitted with a HCPCS on a date of service after the CMS determined termination date. Refer to the DATA_HCPCS table and the column named "CMS_Mid-Quarter_Termination" for a list of codes applicable. **Note**: A line item action flag of 1 overrides this edit when input by the MAC.
125. Incorrect billing of IMRT planning and delivery	A code is present that should not be reported on the same claim as 77301 (Intensity Modulated Radiotherapy Plan). Refer to the Map_IMRT table for list of applicable codes. Note: The applicable codes are not separately reportable on the same claim since they are already included in the APC payment or should not be reported for verification of the treatment field during a course of IMRT.
126. Incorrect reporting of telehealth modifier	A code not flagged as "Telehealth" is present with modifiers 95, GT or GQ. Refer to the Telehealth column in Data_HCPCS for allowable Telehealth service codes as designated by CMS.

Edit	Generated when ...
127. Service not allowed for Part B Inpatient claim	The revenue code reported is not on the allowable list for the Part B Inpatient claim, bill type 12x. **Note**: Edit 127 is bypassed when there is an allowable HCPCS present without a Part B Inpatient billable revenue code. Additionally, this edit is bypassed when condition code W2 is present. For a list of allowable revenue codes, see the Part B Billable Inpatient Revenue list in Data_Revenue. For a list of allowable HCPCS codes, see the Part B Billable Inpatient HCPCS list in Data_HCPCS.
128. Insufficient services on day of IOP	Less than 3 IOP services are reported for the day. This is an information only edit that sets the Line Item Denial Rejection flag = 3.
129. 7-day spanning IOP services require a minimum of 9 hours of service	An IOP claim contains weekly IOP services that total less than 9 hours per 7-day span, as evidenced in the IOP plan of care. This is an information only edit that sets the Line Item Denial Rejection flag = 3.
130. Incorrect reporting of modifier on RHC IOP claim	A modifier (for example, CG) is billed with revenue code 0905 on a RHC IOP claim (bill type 071x with condition code 92), and the HCPCS code is not an IOP Primary service.
131. Insufficient services on day of PHP	Less than 3 PHP services are reported for any one day. This is an information only edit that sets the Line Item Denial Rejection flag = 3.
132. Mental health code not approved for Intensive Outpatient Program	Mental health HCPCS codes that are not approved for Intensive Outpatient Program submitted on bill type 076x with condition code 92.
133. Mental health service not payable outside the Intensive Outpatient program	Mental health HCPCS codes that are not payable outside the Intensive Outpatient program submitted on bill type 013x.
134. Service provided outside designated approval period	The service reported was provided outside of the period approved by CMS.
135. Claim Day lacks required device code	A specified procedure is submitted on a claim without the code for the required device on the same date of service. This edit is bypassed if the procedure is terminated and reported with modifier 52, 73, or 74. See Map-Device_Procedure table for applicable procedures and devices.
136. Reserved	Line level reserved edit

Edit	Generated when ...
137. Reserved	Line level reserved edit
138. Reserved	Line level reserved edit
139. Reserved	Line level reserved edit
140. Reserved	Line level reserved edit
141. Reserved	Line level reserved edit
142. Reserved	Line level reserved edit
143. Reserved	Line level reserved edit
144. Reserved	Line level reserved edit
145. Reserved	Line level reserved edit
146. Reserved	Line level reserved edit
147. Reserved	Line level reserved edit
148. Reserved	Line level reserved edit
149. Reserved	Line level reserved edit
150. Reserved	Line level reserved edit
151. Reserved	Line level reserved edit
152. Reserved	Line level reserved edit
153. Reserved	Line level reserved edit
154. Reserved	Line level reserved edit
155. Reserved	Line level reserved edit
156. Reserved	Line level reserved edit
157. Reserved	Line level reserved edit

Edit	Generated when ...
158. Reserved	Line level reserved edit
159. Reserved	Line level reserved edit
160. Reserved	Line level reserved edit
161. Reserved	Line level reserved edit
162. Reserved	Line level reserved edit
163. Reserved	Line level reserved edit
164. Reserved	Line level reserved edit
165. Reserved	Line level reserved edit
166. Reserved	Line level reserved edit
167. Reserved	Line level reserved edit
168. Reserved	Line level reserved edit
169. Reserved	Line level reserved edit
170. Reserved	Line level reserved edit
171. Reserved	Line level reserved edit
172. Reserved	Line level reserved edit
173. Reserved	Line level reserved edit
174. Reserved	Line level reserved edit
175. Reserved	Line level reserved edit
176. Reserved	Line level reserved edit
177. Reserved	Line level reserved edit
178. Reserved	Line level reserved edit

Edit	Generated when ...
179. Reserved	Line level reserved edit
180. Reserved	Line level reserved edit
181. Reserved	Line level reserved edit
182. Reserved	Line level reserved edit
183. Reserved	Line level reserved edit
184. Reserved	Line level reserved edit
185. Reserved	Line level reserved edit
186. Reserved	Line level reserved edit
187. Reserved	Line level reserved edit
188. Reserved	Line level reserved edit
189. Reserved	Line level reserved edit
190. IOP Primary service not reported for IOP day	An IOP service is reported without an IOP Primary service on the same day of an IOP claim. See IOP_Primary in the Data_HCPCS for applicable codes.
191. PHP Primary service not reported for PHP day	A PHP service is reported without a PHP Primary service on the same day of a PHP claim. See PH_Primary in the Data_HCPCS for applicable codes.
192. Reserved	Claim level reserved edit
193. Reserved	Claim level reserved edit
194. Reserved	Claim level reserved edit
195. Reserved	Claim level reserved edit
196. Reserved	Claim level reserved edit
197. Reserved	Claim level reserved edit

Edit	Generated when ...
198. Reserved	Claim level reserved edit
199. Reserved	Claim level reserved edit

a. Edits are active only on claims that are more than 7 years old that are processed with previously archived software.

Edits by bill type for OPPS

The bill type is a reference to the UB-04 form locator field 4, which provides information about the type of facility that is reported for claim submission to Medicare. Each Bill Type in the following table is programmed to apply the specified edits if the OPPS flag is set to 1 indicating OPPS processing. If the APC Return Buffer is "Yes," this indicates the Type of Bill if reported has APC payment applied. If the APC Return Buffer is "No," this indicates this Type of Bill does not have APC payment applied. This table contains edit values for applicable bill types that are within the 28 prior quarters (7 years) for each release.

Table 16. Edits by bill type for OPPS

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
12x	Hospital Inpatient (Medicare Part B Only)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 35, 37, 38, 40, 41, 43, 45, 47, 48, 49, 50, 53, 57, 58, 60, 61, 62, 65, 66, 67, 68, 69, 70, 72, 73, 74, 76, 79, 82, 83, 87, 92, 93, 94, 98, 99, 100, 102, 103, 105, 106*, 110, 111, 112, 113, 114, 115, 116, 117, 119, 120, 121, 122, 123, 124, 125, 127, 134, 135	Yes
12x with condition code 41	Hospital Inpatient with Partial Hospitalization (Medicare Part B Only)	23, 24, 118, 119	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
13x	Hospital Outpatient	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 35, 37, 38, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 57, 58, 60, 61, 62, 65, 66, 67, 68, 69, 70, 72, 73, 74, 76, 79, 81, 82, 83, 87, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105, 106*, 110, 111, 112, 113, 114, 115, 116, 117, 119, 120, 121, 122, 123, 124, 125, 133, 134, 135	Yes
13x with condition code 41	Hospital Outpatient with Partial Hospitalization	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 35, 37, 38, 40, 41, 43, 45, 47, 48, 49, 50, 58, 61, 62, 65, 66, 67, 68, 69, 72, 74, 80, 83, 84, 92, 94, 95, 99, 101, 102, 103, 106*, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 122, 123, 124, 131, 134, 135, 191	Yes
13x with condition code 89	Hospital Outpatient with Opioid Treatment Program	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 27, 40, 41, 47, 50, 53, 61, 65, 67, 68, 69, 72, 83, 110, 112, 113, 114, 115, 117, 119, 122, 123, 124, 134	Yes
013x with condition code 92	Hospital Outpatient with Intensive Outpatient Program services	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 20, 22, 23, 24, 25, 26, 27, 28, 29, 34, 35, 37, 38, 40, 41, 43, 45, 47, 48, 49, 50, 58, 61, 62, 65, 66, 67, 68, 69, 72, 74, 83, 92, 94, 99, 101, 102, 103, 106*, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 122, 123, 124, 128, 129, 134, 135, 190	Yes
14x	Hospital – Laboratory services Provided to Non-Patients	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 20, 22, 23, 24, 25, 26, 27, 28, 37, 40, 41, 47, 48, 50, 53, 55, 61, 62, 65, 67, 68, 69, 72, 74, 83, 94, 102, 103, 110, 112, 113, 115, 116, 119, 123, 124, 134	Yes
14x with condition code 41	Hospital – Laboratory services Provided to Non-Patients with Partial Hospitalization	23, 24, 118, 119	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
22x 23x	Skilled Nursing Inpatient (Medicare Part B Only) Skilled Nursing – Outpatient	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 28, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
32x	Home Health Services under a plan of treatment	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 65, 67, 68, 69, 72, 83, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
34x	Home Health Services not under a plan of treatment with APC covered services on claim (i.e., Vaccine Administration, Antigens, Splints, Casts, or v18.0 NPWT)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 28, 38, 40, 41, 43, 45, 47, 48, 50, 53, 55, 65, 67, 68, 69, 72, 83, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	Yes
34x	Home Health Services not under a plan of treatment with no APC covered services on claim	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 43, 48, 50, 53, 55, 62, 65, 67, 68, 69, 72, 74, 83, 94, 110, 111, 112, 113, 114, 115, 116, 119, 122, 123, 124, 134	No
43x	Religious Non-Medical Health Care Institutions – Outpatient Services	10, 23, 24, 25, 26, 41, 55, 65, 119	No
71x	Clinic – Rural Health (RHC)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 22, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 91, 94, 102, 104, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
071x with condition code 92	Clinic – Rural Health (RHC) with Intensive Outpatient Program services	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 22, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 91, 94, 102, 104, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 130, 134, 190	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
72x	Clinic – Hospital or Independent Renal Dialysis Center (ESRD)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
74x	Clinic – Outpatient Rehabilitation Facility (ORF)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
75x	Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
076x with condition code 41	Clinic- Community Mental Health Center (CMHC)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 18, 20, 22, 23, 24, 25, 26, 27, 29, 30, 40, 41, 43, 45, 47, 48, 49, 50, 53, 55, 61, 65, 67, 68, 69, 72, 80, 83, 84, 94, 95, 99, 101, 102, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 122, 123, 124, 131, 134, 191	Yes
076x with condition code 92	Clinic- Community Mental Health Center (CMHC) with Intensive Outpatient Program services	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 18, 20, 22, 23, 24, 25, 26, 27, 29, 40, 41, 43, 45, 47, 48, 49, 50, 53, 55, 61, 65, 67, 68, 69, 72, 82, 83, 84, 94, 99, 101, 102, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 122, 123, 124, 128, 129, 132, 134, 190	Yes
77x	Clinic – Federally Qualified Health Center (FQHC) (v15.3 – Current FQHC-PPS)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 22, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 88, 89, 90, 91, 94, 102, 106, 107, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
077x with condition code 92	Clinic – Federally Qualified Health Center (FQHC) with Intensive Outpatient Program Services	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 22, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 88, 89, 90, 91, 94, 102, 106, 107, 110, 111, 112, 113, 116, 119, 123, 124, 128, 134, 190	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
077x	Clinic – Federally Qualified Health Center (FQHC) (Logic prior to v15.3 or condition code 65 reported for payment not under the FQHC-PPS, **Discontinued 10/1/2020**)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 69, 72, 94, 106, 107, 110, 112, 113, 114, 115, 119	No
81x 82x	Hospice (Non-Hospital Based) Hospice (Hospital Based)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 50, 53, 55, 65, 67, 68, 69, 72, 83, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
87x	Freestanding Non-Residential Opioid Treatment Program	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 112, 113, 114, 115, 119, 123, 124, 134	No
22x, 23x, 32x, 72x, 74x, 75x, 81x, 82x, with condition code 7, and Antigen, Splints, or Cast	Treatment of non-terminal condition for Hospice patient with APC covered services on claim (i.e., Antigens, Splints, or Casts)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 43, 47, 50, 53, 55, 62, 65, 67, 68, 69, 72, 74, 83, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 119, 122, 123, 124, 134	Yes

Notes:

* Edit 106 involves an update to specific bill types, from the standard Add-on and Drug Admin Add-on logic to include:

- Software As a service add-on logic (E106)- Edited at the Claim Level: Effective January 1, 2023 (v24.0), Software as a service add-on codes are subject to edit 106 if the primary procedure is not present on the claim.
- Remote Mental Health add-on logic (E106)- Edited at the Day level: Effective January 1, 2023 (v24.0), Remote Mental Health add-on codes, are subject to edit 106 when reported without a primary Remote Mental Health code on the same date of service.

Special logic information

This section describes special conditions that apply to the IOCE software program logic for OPPS.

Medical visit processing

Medical visits and procedure processing on the same day

Under some circumstances, medical visits on the same date as a procedure result in additional payments. When modifier 25 is reported with a code that is assigned a status indicator V, it is identifying that the service reported is a medical visit that takes place on the same date that a procedure code with status indicator S or T is performed, but that is significant and separately identifiable from the procedure. However, if any medical visit code with SI of V that occurs on a day with a type “T” or “S” procedure does not have a modifier of 25, then edit 21 applies and the claim is returned to the provider.

Multiple medical visit conditions

If there are multiple E&M codes on the same day, on the same claim, the rules associated with multiple medical visits are shown in the following table.

Table 17. Multiple medical visit conditions

E&M code	Revenue center	Condition code	Action	Edit
2 or more	Revenue center is different for each E&M code, and all E&M codes have units equal to 1	Not G0	Assign medical APC to each line item with E&M code	-
2 or more	Two or more E&M codes have the same revenue center **OR** One or more E&M codes with units greater than one had same revenue center	Not G0	Assign medical APC to each line item with E&M code and Return Claim to Provider	42

E&M code	Revenue center	Condition code	Action	Edit
2 or more	Two or more E&M codes have the same revenue center **OR** one or more E&M codes with units greater than one had same revenue center	G0*	Assign medical APC to each line item with E&M code	-

The condition code G0 specifies that multiple medical visits occurred on the same day with the same revenue center, and that these visits were distinct and constituted independent visits (e.g., two visits to the ER for chest pain, one in the morning and one in the afternoon, and/or two visits to the ER, one in the morning for a fractured arm and one later in the day for chest pain).

Note: For codes with SI of V that are also on the Inherent Bilateral list, condition code 'G0' takes precedence over the bilateral edit to allow multiple medical visits on the same day.

Medical visit processing and COVID-19 related services

Effective July 1, 2023 (v24.2), the logic for modifier CS and edit 114 is deactivated. See Public Health Emergency (PHE) Processing (page 26) for more information.

Effective 03/18/2020 (v21.2), OPPS claims (bill type 13x w/o CC 41) with (E&M) visit code(s) reported with modifier CS apply a payment adjustment flag (PAF) of 9, if the SI is V or J2. Critical Care visit code 99291 and HOPD specimen collection code C9803 reported with modifier CS and SI= S, are also applicable for a PAF assignment of 9. In the circumstance the visit line with modifier CS is packaged (SI= N), the payment adjustment flag is not set to 9. The reporting of modifier CS indicates that the line(s) is a COVID-19 visit with testing-related services, deductible and coinsurance is not applicable for the visit. Additionally, modifier CS should only be reported when the item or service is identified by CMS as being eligible for a coinsurance and deductible waiver. If Modifier CS is reported on items or services not eligible for a coinsurance and deductible waiver, edit 114 is returned (RTP). (Refer to the DATA_HCPCS table within the data files for services flagged as coinsurance_deductible_waiver_eligible. Refer to the Observation Processing under C-APCs (page 106) as this logic also applies to Comprehensive Observation C-APCs (SI= J2).

Inpatient procedure processing

Inpatient-only procedures

Services designated as inpatient-only are only paid by Medicare when the services are furnished in the inpatient hospital setting. These types of services are typically, but not always, surgical services which require an inpatient level of care due to (1) the complexity and nature of the

procedure, (2) the underlying physical condition of patients requiring the service, or (3) the need for at least 24 hours of postoperative recovery time and monitoring before the patient can be safely discharged. Inpatient-only procedures are recognized by SI = C. When a claim is reported with inpatient-only procedure(s), the IOCE denies the line(s) with edit 18. If there are no SI= T procedure lines in addition to the inpatient-only procedure on the same day or there are no SI=J1 procedure lines for any of the claim days reported, the IOCE not only denies the SI =C line(s) with edit 18, but all other line items on the same day are edited with edit 49.

Refer to the Inpatient Procedure processing under Comprehensive APCs section for CAPC processing.

Separate inpatient procedures

There are inpatient-only procedures that are defined by CPT© as separate procedures. The designation of a procedure as a “Separate procedure” refers to the procedure being identified as an essential component of a total service or procedure, according to the CPT© guidelines. Inpatient-only procedures on the ‘separate procedure’ list, when reported with other services that are SI= T or J1, are line-item rejected with edit 45. Note that the order of the logic for edits 18 and 49 execute prior to the separate procedure logic (edit 45), when these edits are present, the IOCE does not assign edit 45 on the same day.

Additionally, if there are no SI= T or J1 procedures reported in addition to the Inpatient-only separate procedure on the same day, the IOCE not only denies the SI = C line with edit 18, but also all other line items on the same day, with edit 49. Note that when inpatient only procedures are reported that have the “separate procedure” designation in Data_HCPCS, and there are no procedures with SI of T or J1 present for the same date of service, they are also line-item denied with edit 18.

For conditional APC processing with Inpatient only procedures, see Other Identified Logic Processing for Conditional APCs.

Part B hospital inpatient processing

Hospitals are to bill Part B inpatient services on a 012x bill type (both OPPS and non-OPPS), which is a bill type that is processed by the IOCE. Typically, a hospital bills for Part B inpatient services when the hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient services rather than hospital inpatient services, and the hospital has already discharged the beneficiary from the hospital. The hospital submits an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the hospital treated the beneficiary as a hospital outpatient, rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

There are certain services allowable for Hospital Part B claims processing which can be identified by either HCPCS or revenue codes. These services can include, but are not limited to, preventive services, covered drugs, and/or other diagnostic services. For a full list of allowable HCPCS services, see the Part B Billable Inpatient HCPCS list in Data_HCPCS. For a list of the allowed revenue codes, see the Part B Billable Inpatient Revenue list in the Data_Revenue table.

Effective July 1, 2023 (v24.3), in the instance that a revenue code is reported on a Hospital Part B Inpatient claim that is not on the Part B Billable Inpatient list, the IOCE returns edit 127 (LIR). However if a HCPCS is present from the Part B Billable Inpatient list, without a Part B Inpatient allowable revenue code, the IOCE bypasses edit 127. Note: In the presence of condition code W2 (indicating a rebilling of a Reasonable and Necessary Part A Hospital Inpatient Denials), the IOCE bypasses edit 127.

Computation of discounting fraction

There are nine different discount formulas that can be applied to a line item:

D = Discounting Fraction (Currently 0.5)

U = Number of Units

T = Terminated Procedure Discount (Currently 0.5)

1. 1.0
2. (1.0 + D(U-1))/U
3. T/U
4. (1 + D)/U
5. D
6. TD/U (Discontinued 1/1/2008, v9.0)
7. D(1 + D)/U (Discontinued 1/1/2008, v9.0)
8. 2.0
9. 2D

Note: Formula six and seven are discontinued and replaced with formula 3 and 9.

Type "T" multiple and terminated procedure discounting

Line items with a status indicator of "T" are subject to multiple-procedure discounting unless modifiers 76, 77, 78 and/or 79 are present. The "T" line item with the highest payment amount is not multiple procedure discounted, and all other "T" line items are multiple procedure discounted. All line items that do not have a status indicator of "T" are ignored in determining the multiple procedure discount. A modifier of 52 or 73 indicates that a procedure was terminated prior to anesthesia. A terminated type "T" procedure is also discounted although not necessarily at the same level as the discount for multiple type "T" procedures. Terminated bilateral procedures or terminated procedures with units greater than one should not occur, and have the discounting factor set so as to result in the equivalent of a single procedure. Claims submitted with terminated bilateral procedures or terminated procedure with units greater than one are returned to the provider (edit 37).

Bilateral procedures are identified from the "bilateral" field in the physician fee schedule. Bilateral procedures have the following values in the "bilateral" field:

1. Conditional bilateral (i.e. procedure is considered bilateral if the modifier 50 is present)
2. Inherent bilateral (i.e. procedure in and of itself is bilateral)
3. Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures))

Inherent bilateral procedures are treated as non-bilateral procedures since the bilateralism of the procedure is encompassed in the code. For bilateral procedures the type "T" procedure discounting rules take precedence over the discounting specified in the physician fee schedule. In the instance that the same inherent bilateral procedure code is reported more than once, on the same service date, all relevant bilateral procedure lines are line-item rejected with edit 17. Note: When modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code, edit 17 is not returned. Additionally, for codes with an SI of V that are also on the Inherent Bilateral list, when condition code G0 is reported, it takes precedence over the bilateral edit; and these claims do not receive edit 17. For bilateral procedure processing logic specific to Critical Access Hospitals, see Bilateral Procedure processing for Critical Access Hospitals.

All line items for which the line item denial or rejection indicator is 1 and the line item action flag is zero, or the line item action flag is 2, 3 or 4, are ignored in determining the discount; packaged line items (the packaging flag is not zero or 3) are also ignored in determining the discount.

Note: Surgical procedures (SI= S or T and in CPT© code range 10000-69999) reported with charges less than $1.01 but greater than $0.00 where the packaging flag is 0 have the packaging flag reset to 3 when there are other surgical procedures on the claim with charges greater than $1.00.

The discounting process utilizes an APC payment amount file. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type "T" procedures.

There may be some procedure codes that have a SI value assigned that differs from the APC SI (for example, HCPCS SI = T, but APC SI= S). In these circumstances, the discounting formula is assigned based on the HCPCS SI; the APC with the highest payment rate (if multiple 'T' procedures are present) although having a different SI, is used to determine the discounted amount for the multiple procedures that may be present.

To determine which APC has the highest payment amount, the terminated procedure discount (T) and any applicable offset, is applied prior to selecting the type T procedure with the highest payment amount. If both offset and terminated procedure discount apply, the offset is applied first, before the terminated procedure discount. Note that if a procedure has terminated modifier 73 (or 52), the procedure should be discounted, regardless of whether it was repeated (modifier 76). Even if the procedure was repeated but terminated early, the terminated discount should be calculated.

If modifier 50 is present on an independent or conditional bilateral line that has a composite APC, or a separately paid STVX/T-packaged procedure, or a comprehensive APC, the modifier is ignored in assigning the discount formula.

Non-type T procedure discounting

All line items with SI other than "T" are subject to terminated procedure discounting when modifier 52 or 73 is present.

For Discount Formulas applied to non-type T procedures: If not terminated, non-type T Conditional bilateral procedures with modifier 50 are assigned discount formula eight; non-type T Independent bilateral procedures with modifier 50 are also assigned to formula eight (*8).

Conditional APC processing

Processing procedures with status indicators of Q1 and Q2

Effective January 1, 2017 (v18.0), conditional APC assignment and packaging discussed in this section for procedures with SI = Q1 or Q2 are executed across the claim if multiple service dates are present, and not by individual date of service. References noted as processed by day are to be considered for claims with From Dates prior to January 1, 2017. Procedure codes with SI of Q1 or Q2 are packaged when they appear with other specified services on the same day or claim; however, they may be assigned to a payable SI and APC and paid separately if there are no other specified services on the same day or claim. Procedures with SI = Q1 are packaged in the presence of any payable procedure code with SI of S, T, or V. Procedures with SI = Q2 are packaged only in the presence of payable codes with SI = T or effective with version 16.0, J1. The SI is changed from Q1 or Q2 to N for packaging if present with other payable services, or to the standard SI and APC specified for the code when separately payable. If there are multiple Q1 or Q2 procedures on a specific date or claim and no service with which the codes would be packaged on the same date or claim, the Q1/Q2 code assigned to the APC with the highest payment rate is paid and all other codes are packaged. If a procedure with SI = Q1 or Q2 has been previously packaged (SI = N) prior to the execution of the conditional APC processing logic, the packaged Q1 or Q2 is ignored from the selection as the service with the highest paying APC payment rate. Additionally, procedures with SI = Q1 or Q2 that are packaged with SI = N under conditional APC processing logic are not evaluated in any subsequent processing (e.g. composite or comprehensive APC processing).

There are several codes with SI = Q2 that may resolve to a final SI of J1 (comprehensive APC procedure) if they are present with no other payable procedures. In the event this occurs, the Q2 procedure is not subject to comprehensive APC procedure ranking or complexity adjustment, but all other comprehensive APC packaging and exclusion processing is applied.

In the execution of conditional APC processing logic, which occurs prior to the composite APC logic, procedure codes with SI of Q3 (composite candidates) that may be present with Q1 or Q2 procedures are evaluated as payable procedures using the standard SI associated with the Q3 procedure's standard APC.

If a Q1 or Q2 procedure is an independent or conditional bilateral code with modifier 50 and resolves to a standard SI and APC assignment (i.e. not packaged), the modifier is ignored in assigning the discount formula.

Procedures with SI = Q1 or Q2 that are denied or rejected are not included in any subsequent conditional packaging logic, and the default SI (Q1, Q2) is retained as the final SI. If codes with SI of Q1 or Q2 that are denied or rejected are present with other non-denied/rejected Q1 or Q2 codes, if no other payable procedure is present, the non-denied/rejected Q1 or Q2 codes are evaluated and processed for separate payment. There is an exception if Line Item Action Flag = 1 is assigned to the line; the denial or rejection is ignored, and the line is included in subsequent conditional packaging logic, from which the final SI is determined.

Service units are reduced to 1 for any line where an SI of Q1 or Q2 is changed to a separately payable SI and APC and Payment Adjustment Flag 11 is assigned. The reduction of units for procedures designated as sometimes therapy that may have default SI assignment of Q1 or Q2 does not occur if the reporting of the sometimes therapy service under a therapy plan of care results in final assignment of SI = A.

Sometimes therapy processing for wound care services

Certain wound care services considered “sometimes therapy” may be paid an APC rate or from the Physician Fee Schedule, depending on the circumstances under which the service was provided. The IOCE changes the status indicator to A and removes the APC assignment when sometimes therapy codes are appended with therapy modifiers (GP for physical therapy, GO for occupational therapy, or GN for speech language pathology) or therapy revenue codes (042x, 043x, 044x). If the SI is changed to A these services are excluded from being packaged in the presence of a comprehensive APC. (See Comprehensive APC processing (page 103).)

Critical care processing

Processing of certain ancillary services with SI of Q1 or Q3 that are reported with critical care code 99291 are packaged when reported on the same service date, or effective with version 18.0, on the same claim, as the critical care code. If procedure code 99291 is present with any of the specified ancillary procedure codes, the IOCE changes the SI of the ancillary procedure code from Q1 or Q3 to N for packaging. An exception applies if code 99291 is present and modifier 59, XE, XP, XS or XU are present on any line with the same date of service or on the same claim, the specified critical care ancillary codes are not packaged; the SI is changed to the standard SI and APC specified for the code. If 99291 is not present on the same date of service or the same claim, the SI for the ancillary procedures is changed to the standard SI and APC specified for the code when separately payable, or packaged under previous conditional APC processing logic for specified ancillary services with SI = Q1, if there are other payable procedures present.

If critical care code 99291 is present and the claim meets the criteria for assignment under the Comprehensive Observation APC (version 17.0), the exception for the presence of modifier 59, XE, XP, XS or XU does not occur; all ancillary, adjunctive services are packaged under the Comprehensive Observation APC.

Critical care-packaged ancillary service code 94762 is not subject to the modifier 59, XE, XP, XS, XU exception, and always packages when present with critical care code 99291. If reported in

the absence of 99291, 94762 (SI = Q3) is subject to packaging under comprehensive APC processing, otherwise it is assigned its standard APC and SI for separate payment.

Note: effective with version 18.3, critical care ancillary service code 36600 is no longer subject to the modifier exception.

Advance care planning

Effective January 1, 2016 (v17.0), Advance Care Planning services reported with procedure codes 99497 and 99498, that are also reported on the same date of service with the Medicare annual wellness visit (initial or subsequent), are paid under the Medicare Physician Fee Schedule (SI changed to A); otherwise, advance care planning is subject to conditional packaging. If advance care planning procedure 99497 is reported with no other payable OPPS service, it is assigned its standard SI and APC values; if reported with other OPPS payable services (SI = S, T, V, J1, J2, Q1, Q2, Q3), on the same claim, it is packaged (SI = N).

Note that procedure code 99498 is an add-on procedure code with standard SI = N. If 99498 is reported with the annual wellness visit but the primary code 99497 is not present, it continues to be packaged with SI = N. If 99498 is not reported with the annual wellness visit, it retains packaging status with SI = N.

Conditional processing for laboratory procedures

Effective January 1, 2016 (v17.0), laboratory codes with SI = Q4 are subject to conditional packaging criteria in determining the final SI assignment, i.e., paid under the clinical lab fee schedule (SI = A), or packaged (SI = N): If a laboratory code with an SI= Q4 results in a final SI assignment of A, it returns a PMF value of 2.

For claims with bill type 13x: if the laboratory code(s) with SI Q4 is reported with modifier L1 (Separately payable lab test) and is present with other payable OPPS services that have SI = J1, J2, S, T, V, Q1, Q2, or Q3 on the same claim, the SI is changed to A; otherwise the laboratory code(s) is packaged with SI= N. If there are only laboratory codes present, all laboratory codes with SI=Q4 are changed to SI=A.

Note: Modifier L1 is deactivated as of January 1, 2017 (v18.0), and the provision to change the SI to A if modifier L1 is present is discontinued. If laboratory codes with SI = Q4 are present with other payable OPPS procedures, the laboratory codes are packaged with SI = N.

- Effective January 1, 2017 (v18.0), special conditions apply to OPPS services that have a final SI of Q1, Q3, S, T, or V and a line item action flag of 2 or 3 present. If the payable OPPS service(s) has the line item action flag (2/3) present, the laboratory codes with SI = Q4, are processed for payment by having the SI changed from SI=Q4 to SI=A.
- For claims with bill type 12x without condition code W2, and for claims with bill type 14x: if a laboratory code(s) is present with SI Q4, the SI is changed to A. Laboratory services on claims with bill type 12x that do contain condition code W2 remain packaged (SI = N).

Note: Some laboratory codes (e.g. molecular pathology codes) are always assigned SI = A, and are not subject to the conditional packaging logic. There are also laboratory codes that are assigned SI = N and are not subject to conditional packaging logic; laboratory codes with SI = N are always packaged.

Other Identified Logic Processing for Conditional APCs

Inpatient Procedure Processing for Conditional APCs

Services that are designated as inpatient-only are not appropriate to be furnished in a hospital outpatient department and are typically, but are not limited to being, surgical services which require an inpatient level of care. Inpatient-only procedures are recognized by SI = C. When a claim contains only an inpatient-only service, the IOCE denies the line with edit 18. Additionally, when an inpatient only procedure is denied with edit 18, all other services reported on the same day are also denied, with edit 49.

- In the instance, a procedure with a native SI=Q1/Q2 is reported with an inpatient procedure, the inpatient procedure is line-item denied with edit 18 and the SI=Q1/Q2 line is denied with edit 49.
- Additionally, when a procedure with a native SI=Q3 is reported with an inpatient procedure, the inpatient procedure is line-item denied with edit 18 and the SI=Q3 line is denied with edit 49.

Inpatient-only procedures on the 'separate procedure' list, when reported with other services that are SI=T or J1, are line-item rejected with edit 45. Note that the processing order of the logic for edits 18 and 49 execute prior to the separate procedure logic (edit 45), when these edits are present, the IOCE does not assign edit 45 on the same day.

Note that although edits 18 and 49 take precedence during logic processing, there are instances in which other edits return for those same denied lines.

See Inpatient Procedure Processing for more information on standard Inpatient Procedure processing logic.

Comprehensive Observation Processing for Conditional APCs

Claims for observation services (SI = J2) meeting specified criteria are paid under a single Comprehensive Observation C-APC payment rate, to include all services submitted on the claim.

- Conditionally assigned procedure codes with SI = Q1 are packaged in the presence of any payable procedure code with SI= S, T, or V. Some conditional (SI=Q1) procedures can convert to a payable SI such as S, T, or V however, it depends on the order of logic processed for the claim. Once logic determines all requirements are met for a Comprehensive Observation claim, the final SI for the conditional APC line may be packaged instead of a payable SI such as S, T, or V.

- Conditionally assigned procedure codes with SI = Q2 are packaged only in the presence of payable codes with SI = T or effective with version 16.0, J1. When a conditional APC results in a final SI of T or J1, the observation visit is packaged into the SI=T line and the comprehensive APC is not assigned.

See Observation Processing under C-APCs for more information on standard Comprehensive Observation processing logic.

Section 603: Community Mental Health Center outpatient claims reporting Modifier PN

For CMHC PHP or IOP claims, bill type 076x with condition code 41 (PHP) or 92 (IOP), when a conditionally assigned procedure code is reported with modifier PN and results in a final SI=P, edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.

See Non-Excepted Items or Services in Off-Campus Provider-Based Hospitals (Section 603) for more information on standard processing logic.

Composite APC processing

Certain codes may be grouped together for reimbursement as a "composite" APC when they occur together on the same claim with the same date of service (SI = Q3). Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When the composite criteria for a group are met, the primary code is assigned the composite APC and status indicator for payment; non-primary codes, and additional primary codes from the same composite group, are assigned status indicator N and packaged into the composite APC. Special composite adjustment flags identify each composite and all the packaged codes on the claim that are related to that composite. Composite adjustment flags are not assigned for composite-packaged lines that are included on a claim containing a comprehensive APC. Multiple composites, from different composite groups, may be assigned to a claim for the same date. Terminated codes (modifier 52 or 73) are not included in the composite criteria. If the composite criteria are not met, each code is assigned an individual SI/APC for standard OPPS processing. Some composites may have additional or different assignment criteria. Lines that are denied or rejected are ignored in the composite criteria.

Partial hospitalization program processing for outpatient hospitals and CMHCs v25.0-Current

For PHP claims processing prior to January 1, 2024 (v25.0) please refer to the Partial Hospitalization and CMHC Processing section.

A partial hospitalization program (PHP) is a daily outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness or substance use disorder. Partial hospitalizations are paid on a per diem basis according

to the number of services reported. In order to assign the partial hospitalization APC (PHP APC), certain criteria for the amount of services provided and types of services provided must be met.

Requirements for PHP composite APC assignment

Effective January 1, 2024 (v25.0), partial hospitalization program (PHP) reimbursement is paid by a level I or II per diem PHP APC dependent on the provider type (hospital-based PHP program (13x w/ CC41) or a CMHC program (76x W/CC41), condition codes, bill types, diagnosis and HCPCS codes.

PHP claims submitted without a mental health diagnosis reported as the principal diagnosis are returned to the provider (edit 29), except in the instance of a code first diagnosis condition present. Effective October 1, 2018 (v19.3), PHP claims submitting a claim with a code first diagnosis in the principal diagnosis position without a mental health diagnosis in the first secondary diagnosis position, are returned to the provider (edit 109). Please reference the DATA_DX10 table within the data files for diagnoses flagged as CODE_FIRST and/or MENTAL_HEALTH.

To obtain the Level I PHP APC, a service identified as a primary PHP (PH_PRIMARY) must be reported on each day that a PHP service is reported. If at least one PHP Primary service is not reported on a day in which PHP services have been reported, the IOCE returns the claim to the provider with edit 191. Note: If a PHP primary service is reported without a PHP service, edit 191 is not returned. (Please reference the DATA_HCPCS table within the data files for the PH_PRIMARY list as well as the list for PH_SERVICE for applicable codes.)

To obtain the Level II PHP APC, a minimum of four PHP services must be reported for the day, one of which must be from the primary PHP list (edit 191). When the criteria for a PHP day is met, the IOCE assigns the first line-item containing the HCPCS code from the PH_PRIMARY list as the PHP composite APC line, with a final SI = P, a payment indicator of 8, a discounting factor of 1, a line-item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a unique composite adjustment flag (CAF) value. All other partial hospitalization services on the same day are packaged, SI is changed to N. A composite adjustment flag identifies the PHP APC and all the packaged PHP services on the day; a different composite adjustment flag is assigned for each PHP day on the claim. Additionally, payment adjustment flag value of 11 is assigned to the PHP payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

Although the minimum requirement is one primary PHP service to obtain at least a Level I PHP APC, line-item informational rejection edit 131 is assigned to applicable line-items by the IOCE if the total amount of services for the day are less than three for a PHP day. Note that certain PHP services that are add-on codes are not included in the count of number of services for the day. (Please reference the DATA_HCPCS table within the data files for list of PH_ADDON services.)

Additionally, there are services identified as reportable for the PHP or IOP program that do not count towards the PHP or IOP composite APC for the day. When such services are reported on PHP or IOP claims, these lines are packaged (SI=N). See the PHP_IOP_Reportable list in the Data HCPCS table for applicable codes.

PHP and mental health composite processing

Hospital-based PHP claims (13x w/CC41)

Effective January 1, 2023, Daily mental health (DMH) services are allowed to be reported on a hospital-based PHP claim (13x w/ CC41) along with PHP services. In the instance that DMH services are also reported when a Partial Hospitalization composite is met and a PHP APC is obtained, the IOCE assigns the first DMH service line item to the DMH composite APC (DMH APC) with payment method flag = 1. Other DMH services reported on the same day are packaged (SI= N) into the DMH APC. (Note: The DMH APC is assigned even if the DMH composite cap threshold has not been exceeded when the PHP composite APC has been assigned for the day). The IOCE assigns a unique CAF to the DMH services, different from the PHP APC CAF, to identify the line with the DMH APC and any other DMH packaged services. This further indicates to the OPPS Pricer program that there is no additional payment for the DMH composite lines on the same date of service.

In the instance that MH services are reported and there is no PHP APC assigned, and the sum of payments for those DMH services exceed the Daily Mental Health composite cap (single level PHP hospital-based APC payment rate), the IOCE assigns the DMH APC, as a payable APC, to the first mental health service line, and all other DMH services for that day are packaged; SI is changed to N. A CAF is assigned by the IOCE to identify the DMH APC and all other packaged MH services on the day related to the DMH composite.

The processing of Remote Mental Health (RMH) services is also allowable on hospital-based PHP claims. These services are provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder and furnished to beneficiaries in their homes by clinical staff of the hospital using communications technology. Although RMH services are not recognized or counted as partial hospitalization services, they are available to those in a partial hospitalization program. When RMH services are reported on a PHP claim (13x w/ CC41) that meets the requirements to obtain a PHP APC, RMH services are packaged (SI= N) into the DMH composite APC with any other DMH services provided on the same day. Note: If RMH services are reported in the presence of a PHP APC and no DMH services are present, the RMH service(s) package into the DMH APC. The IOCE assigns the first qualifying (not an add-on code) RMH service to the DMH APC, with a payment method flag = 1 and all other RMH services reported on the same date of service are packaged (SI= N). Additionally, a unique CAF is assigned to the RMH services, different from the PHP APC CAF, to identify the line with the DMH APC and any other RMH packaged services. See the REMOTE_MENTAL_HEALTH column in Data_HCPCS for applicable codes. Note: If a RMH add-on code is reported without a primary code on the same date of service, the line is line-item denied with edit 106.

When RMH services are reported on a PHP claim with no PHP APC, but a DMH APC is present, these services package into the DMH APC. If requirements are not met to obtain either the PHP APC or the DMH APC, (when no PHP APC is present), DMH and RMH lines are separately paid following standard APC payment rules. Additionally, lines with an SI= C or lines that are denied or rejected are ignored in PHP and DMH processing.

Note: There are services that are identified as both PHP (PH_Primary or PH_Service in the DATA_HCPCS table) and DMH (Daily_Mental_Health in the Data_HCPCS table). In the instance

that PHP service lines are denied for the day with one or more of those service lines identified as also DMH, the denied line(s) are not processed within the DMH logic.

Community mental health center claims (076x w/ CC 41)

For Community Mental Health Center PHP claims (076x w/ CC 41), partial hospitalization program (PHP) reimbursement is paid by a level I or II per diem PHP APC rate dependent upon meeting the reporting requirements for each applicable PHP day (condition code (41), mental health diagnosis and use of HCPCS codes to report PHP services).

To obtain the Level I PHP APC, a service identified as a primary PHP (PH_PRIMARY) must be reported on each day that a PHP service is reported. If at least one PHP Primary service is not reported on a day in which PHP services have been reported, the IOCE returns the claim to the provider with edit 191. Note: If a PHP primary service is reported without a PHP service, edit 191 is not returned. (Please reference the DATA_HCPCS table within the data files for the PH_PRIMARY list as well as the list for PH_SERVICE for applicable codes.)

To obtain the Level II PHP APC, a minimum of four PHP services must be reported for the day, one of which must be from the primary PHP list (edit 191). When the criteria for a PHP day is met, the IOCE assigns the first line-item containing the HCPCS code from the PH_PRIMARY list to the applicable PHP APC with a final SI = P, a payment indicator of 8, a discounting factor of 1, a line-item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a unique composite adjustment flag (CAF) value.

Although the minimum requirement is one primary PHP service to obtain at least a Level I PHP APC, line-item informational rejection edit 131 is assigned to applicable line-items by the IOCE if the total amount of services for the day are less than three for a PHP day. Note that certain PHP services that are add-on codes are not included in the count of number of services for the day. (Please reference the DATA_HCPCS table within the data files for list of PH_ADDON services.)

Note that CMHCs do not allow daily mental health processing on PHP claims. If daily mental health services that are not approved for the partial hospitalization program are submitted on a CMHC PHP claim, the claim is returned to the provider (edit 80).

Additionally, Community Mental Health Centers (CMHCs), are not permitted to report remote mental health (RMH) services. In the instance that remote mental health services are reported on a CMHC claim, the claim is returned to the provider (edit 55). See the REMOTE_MENTAL_HEALTH column in Data_HCPCS for applicable codes.

See CMHC PHP outpatient claims with bill type 076x with condition code 41(PHP) or 92 (IOP) Reporting Modifier PN for logic processing with modifier PN.

7-day spanning PHP and interim claims processing

Effective October 1, 2017 (v18.3), the IOCE returns edit 95 for informational purposes only, if a PHP claim contains weekly services with less than 20 hours of PHP services per week. Hours of service for PHP services that result in packaging (SI = N) due to PHP APC processing are included in the total count of hours per week; however, certain PHP services that are add-on codes are not included towards the weekly count of hours. If the PHP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional

amount and the service units are utilized in the calculation of total hours per week. If conditions are present for edit 95, an informational only line item denial or rejection flag value of 3 is returned, indicating that although the conditions for edit 95 exist, payment is not impacted, and the line item rejection disposition flag in the claim return buffer is not set. The IOCE continues to process lines with edit 95 for payment by the OPPS Pricer.

Note that the IOCE does not apply edit 95 on the admission week submitted on an admission PHP claim (0761 w/CC 41, 0762 w/CC 41, 0131 w/CC 41, or 0132 w/CC 41); instead, if the admission week has less than 20 hours of PHP services, Payer condition code MP is provided. Note: The Admission Week is determined as being the first 7 days on the claim, based on the claim's From Date and not the particular day of the week (Sunday-Saturday). The IOCE also does not apply edit 95 on the discharge week when submitted on a PHP discharge claim (0761 w/CC 41, 0764 w/CC 41, 0131 w/CC 41, or 0134 w/CC 41); instead, Payer condition code MQ is provided if the discharge week contains less than 20 hours of PHP services. Effective July 1, 2019 (v20.2), the discharge week is identified as the last full (7 days) week on the claim and is never edited with 95 nor any partial days that follow; instead, MQ is returned if the last full week contains less than 20 hours of PHP services.

Additionally, the IOCE returns Payer Value Code and Value Code Amount QW on Interim PHP claims that have a partial last week present. The last 5 values of the Value Code Amount provided with QW represents the count of days and hours in which PHP services are provided for the partial week (first portion of week). For example, if the last week on an interim PHP claim is not 7 days but instead only 3 days, and in those 3 days 15 ½ hours of PHP services are provided, the last 6 values in the Value Code Amount is 00000031550. Note that the partial week represented by the QW output is not edited with 95. The IOCE receives the next claim with Value Code QA and the associated value code amount from the QW output which was on the previous claim (first portion). Note that the Shared System Maintainer (SSM) may only supply this information on input. The IOCE then combines the partial week information from the previous claim and the claim being processed into one full week (7 days), if the full week does not contain up to 20 hours of PHP services, the lines on the second portion used in calculating the full week are edited with 95 and Payer Value Code MV is output. The output of MV requires the SSM to adjust the claim containing the first portion of the partial week, as the partial weeks after combining is not 20 hours. The SSM submits condition code MW on input for the PHP adjustment claim, indicating that the IOCE needs to edit the partial (last) week present on the claim. The IOCE edits with 95 on the line items associated with the partial week and outputs QW with the value code amount applicable.

Table 18. Payer Value Codes for Partial Hospitalization

Value Code	Description	Note	Dates Effective
QW	Partial week present on interim PHP claim	Provided on output from the IOCE. The value code amount following Payer Value Code QW, zero-fill the first 5 values, the next 6 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 00000020850. 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.	July 1, 2019- to present
QA	Offset for combining partial PHP week on interim PHP claim	Provided on input to the IOCE. Value Code QA is provided on input and the value code amount provided should zero-fill the first 5 values, the next 6 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 00000020850.	July 1, 2019- to present

Table 19. Payer Condition Codes for Partial Hospitalization

Condition Code	Description	Note	Dates Effective
MP	PHP claim contains initial admit week	Provided on output from the IOCE. Payer-defined condition code MP is returned when the PHP claim represents the initial admit week. Note: Edit 95 is not returned on an initial admit week or a final discharge week of a PHP claim.	October 1, 2017- to present
MQ	PHP claim contains final discharge week	Provided on output from the IOCE. Payer-defined condition code MQ is returned when the PHP claim represents the final discharge week.	October 1, 2017- to present

Table 20. Partial Hospitalization and Daily Mental Health APC Table

APC	Dates Effective	Description
05851	1/1/2016-12/31/2016	Level 1 Partial Hospitalization (3 services) for CMHCs
05852	1/1/2016-12/31/2016	Level 2 Partial Hospitalization (4 or more services) for CMHCs
05853	1/1/2017-12/31/2023	Partial Hospitalization (3 or more services) for CMHCs
05853	1/1/2024-present	Partial Hospitalization (up to 3 services) for CMHCs
05854	1/1/2024-present	Partial Hospitalization (4 or more services) for CMHCs
05861	1/1/2016-12/31/2016	Level 1 Partial Hospitalization (3 services) for Hospital-based PHPs
05862	1/1/2016-12/31/2016	Level 2 Partial Hospitalization (4 or more services) for Hospital-based PHPs
05863	1/1/2017-12/31/2023	Partial Hospitalization (3 or more services) for Hospital-based PHPs
05863	1/1/2024-present	Partial Hospitalization (up to 3 services) for Hospital-based PHPs
05864	1/1/2024-present	Partial Hospitalization (4 or more services) for Hospital-based PHPs
08010	1/1/2016-present	Mental Health Services Composite

Note: APCs that are no longer effective are italicized.

Partial Hospitalization and CMHC Processing: Prior to v.25.0

For processing PHP claims with DMH services, or PHP claims after January 1, 2024 (v25.0), refer to the Partial Hospitalization Program Processing for Outpatient Hospitals v25.0-Current section.

Prior to v18.0, different PHP APCs, Level I and Level II, are assigned for hospital-based and Community Mental Health Center (CMHC) partial hospitalization programs according to the number of services provided. In obtaining the level II PHP APC a minimum of 4 or more services is provided, with at least one of those services being from the PH_PRIMARY list. To obtain the level I PH APC a minimum of 3 or more services is provided, with at least one of those services also being from the PHP Primary list. As mentioned above, the line item that obtains the PH APC

is the first reported Primary PHP HCPCS reported (SI=P), and all other services on the claim are packaged with an SI of N.

Note: Edits 95, 96 and 97 are deactivated with the October 2016 (v17.3) release, retroactively to 7/1/2016.

Effective January 1, 2017 (v18.0), partial hospitalization program (PHP) reimbursement is paid a single level per diem PHP APC dependent on the provider type (hospital-based PHP program (13x w/ CC41) or a CMHC program (76x)), condition codes, bill types and HCPCS codes. To obtain the PHP APC a minimum of three or more PHP services must be reported per day, one of which must be from the PH_PRIMARY list. (Please reference the DATA_HCPCS table within the data files for the PH_PRIMARY list as well as the list for PH_SERVICE(s).) The first line item containing the HCPCS code from the PH_PRIMARY list is assigned the PHP APC and the final SI = P. All other partial hospitalization services on the same day are packaged, SI is changed to N. A composite adjustment flag identifies the PHP APC and all the packaged PHP services on the day; a different composite adjustment flag is assigned for each PHP day on the claim. Effective 4/1/2015 through the current version, the payment adjustment flag value of 11 is assigned to the PHP payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

Effective October 1, 2017 (v18.3), edit 95 is reactivated for informational purposes only, with no impact on payment.

If less than the minimum amount (number and type) of services required for PHP are reported for any day, the PHP day is denied, i.e., all PHP services on the day are denied and no PHP APC is assigned (edit 30). Note: Edit 30 is discontinued effective 1/1/2024.

Any non-PHP services on the same day are processed per the usual OPPS rules. Lines that are denied or rejected are ignored in PHP processing. If mental health services that are not approved for partial hospitalization are submitted on a PHP claim (013x TOB with condition code 41 or TOB 076x), the claim is returned to the provider (edit 80) prior to January 1, 2023 (v24.0).

Effective January 1, 2023 (v24.0), the IOCE allows daily mental health (DMH) services to be reported on a PHP claim (13x w/ CC41) along with PHP services, edit 80 is no longer returned for hospital-based claims. If there is an inpatient only procedure (SI = C) on the same claim as PHP or Daily Mental Health services, no Partial Hospitalization or Daily Mental Health processing logic is performed. See PHP and Mental Health Composite Processing for additional processing information.

CMHC partial hospitalization processing through v24.3

Effective January 1, 2017 (v18.0), CMHC providers may be subject to outlier payment limitations. If condition code 66 (Provider does not wish outlier payment) is present for a CMHC claim with bill type 076x, payment method flag value of 6 is provided on each OPPS payable line (OPPS paid lines are those that would have previously had payment method flag 0). If condition code MY (Outlier cap bypass) is passed to the IOCE by the MAC, with or without condition code 66, payment method flag value of 9 is returned and the outlier payment limitation is bypassed.

Effective October 1, 2018 (v19.3), PHP claims submitting a claim with a code first diagnosis in the principal diagnosis position without a mental health diagnosis in the first secondary diagnosis position, return edit 109. Please reference the DATA_DX10 table within the data files for diagnoses flagged as CODE_FIRST and/or MENTAL_HEALTH. PHP claims submitted without a mental health diagnosis reported as the principal diagnosis are RTP (edit 29), except in the instance of a code first diagnosis condition present.

Effective January 1, 2023 (v24.0), although hospital-based PHP claims (TOB 13x w/ CC41) allow daily mental health processing, Community Mental Health Centers (TOB 076x) do not. If daily mental health services that are not approved for the partial hospitalization program are submitted on a CMHC PHP claim, the claim is returned to the provider (edit 80).

Remote Mental Health (RMH) services are non-PHP services provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder and furnished to beneficiaries in their homes by clinical staff of the hospital using communications technology. Although these services are not recognized or counted as partial hospitalization services, they are available to those in a partial hospitalization program and are allowable for reporting on PHP claims (013x w/ CC 41). Note: Community Mental Health Centers (CMHCs), which are sole providers of services for PHP by statute, are not permitted to bill Medicare for remote mental health services furnished by clinical staff of the CMHC in an individual's home. In the instance that remote mental health services are reported on a CMHC claim (076x), the claim is returned to the provider (edit 55). See the REMOTE_MENTAL_HEALTH column in Data_HCPCS for applicable codes.

Daily mental health processing: v18.0 - Current

Effective January 1, 2024 (v25.0), reimbursement for a day of outpatient mental health services in a non-PH (bill types 012x or 013x) program is capped at the amount of the level II hospital-based partial hospital per diem rate. On a non-PH claim, the IOCE totals the payments for all the designated DMH services with the same date of service; if the sum of the payments for the individual MH services exceeds the partial hospitalization single level hospital-based per-diem (PHP APC) payment rate, the IOCE assigns a special "Mental Health Service" composite payment APC (DMH APC) to one of the line items that represent DMH services. Refer to the Partial Hospitalization and Daily Mental APC table for the applicable APC(s).

Note: The payment rate for the Mental Health Services composite APC is the same as that for the level II hospital-based partial hospitalization APC.

Effective 4/1/2015 (v16.1), payment adjustment flag value 11 is assigned to the Mental Health payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing. All other MH services for that day are packaged; SI changed from Q3 to N. A composite adjustment flag (CAF) identifies the Mental Health Service composite APC and all the packaged MH services on the day that are related to that composite. Additionally, lines that are denied or rejected are ignored in the Daily Mental Health logic processing.

Discontinued effective January 1, 2024: Effective January 1, 2017 (v18.0), the comparison for summing the payment of the individual MH services to the level II partial hospital-based per

diem APC payment rate is changed to compare the sum to the single level PHP hospital-based per diem APC payment rate. This cap was performed due to limiting the costs associated with administering a partial hospitalization program representing the most resource intensive of all outpatient mental health treatment.

Daily mental health education and training

The use of code G0177 (Education and Training) is allowed on MH claims that are not billed as Partial Hospitalization. If Education and Training is the only service reported for the day, the claim is returned to the provider with edit 35. Note: For a multi-day claim, if Education and Training is the only service reported on a single date of service, even though other dates of the claim have other services reported, the IOCE still returns the claim to the provider with edit 35.

Daily mental health and remote mental health processing: v24.0- Current

Effective 1/1/2023 (v24.0) Remote Mental Health (RMH) services reported on Daily Mental Health claims are permitted, and count towards the daily mental health service cap. If the cap is met, and the DMH APC is assigned, these services are packaged in addition to all other DMH services. However, if the cap is not met and there is no DMH APC, RMH services follow standard APC processing. Note: If a RMH add-on code is reported without a primary code on the same date of service, the line is denied with edit 106.

Services not eligible for reporting on mental health claims

There are some mental health services which are specific to partial hospitalization and are not payable outside of a PH program; if any of these codes are submitted on a 013x bill type, the claim is returned to the provider (edit 81).

Additionally, effective January 1, 2024 (v25.0), there are some mental health services which are specific to the intensive outpatient program and are not payable outside of an IOP approved facility; if any of these codes are submitted on a 013x bill type, the claim is returned to the provider (edit 133).

Intensive outpatient program processing for outpatient hospitals v25.0- Current

An Intensive Outpatient Program (IOP) is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to conditions such as depression, schizophrenia, and substance use disorders. IOP is considered to be less intensive than PHP.

Effective January 1, 2024, Intensive Outpatient Program (IOP) services can be provided by hospital outpatient departments, Critical Access Hospitals (CAHs), Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and Opioid Treatment Programs (OTPs).

Intensive outpatient programs are identified by means of the bill type, condition code(s), revenue code(s) and HCPCS code(s) which specify the individual services that represent an intensive outpatient program. Hospital-based Intensive outpatient programs are reported with condition code 92 to identify claims in which services were provided under an IOP care plan. IOP claims should not report both condition codes, CC 92 (IOP) and CC 41 (PHP); in the event both condition codes are reported, the claim processes as IOP.

Requirements for IOP composite APC assignment for hospital-based and CMHC claims

IOP services are allowed only for mental health disorder diagnoses. The principal diagnosis (pdx) for an IOP claim must be designated as Mental Health. When an IOP claim is submitted without a mental health diagnosis as the pdx, the claim is returned to the provider with edit 29. Additionally, there are some diagnosis codes designated as Code First, which indicates that when those codes are reported as the pdx, they require a mental health diagnosis to be reported in the first secondary dx position. When an IOP claim is submitted with a Code First diagnosis without a mental health diagnosis in the first secondary diagnosis position, the claim is returned to the provider with edit 109. Refer to the Data_DX10 table within the data files for diagnoses flagged as CODE_FIRST and/or MENTAL_HEALTH. See also, the Non-Mental Health Diagnosis and Code First Editing for PHP/IOP claims section for additional information.

IOPs are paid on a per diem basis according to the number of services reported per IOP day. To obtain the level I IOP APC, at least one service identified as a primary service from the IOP Primary list must be provided. Refer to the IOP primary list in the Data_HCPCS table for applicable codes. To obtain the level II IOP APC, a minimum of 4 or more services must be provided, with at least one of those services identified as a primary service from the IOP Primary list. If an IOP service is reported without at least one IOP Primary service for the day on an IOP claim, the IOCE returns the claim to the provider with edit 190.

Additionally, although the minimum requirement is one primary IOP service to obtain an IOP APC, informational edit 128 is assigned by the IOCE for each IOP line present for the day if the total amount of services for the day are less than three. Refer to the IOP Services list in the Data_HCPCS table for applicable codes. Note that there are services identified as reportable for the IOP or PHP program that do not count towards the IOP or PHP composite APC for the day. When such services are reported on IOP or PHP claims, these lines are packaged (SI=N). See the PHP_IOP_Reportable list in the Data HCPCS table for applicable codes. The IOP_Addon list in Data_HCPCS identifies services, that are already standardly packaged and reportable for IOP claims, these services also do not count towards the IOP composite APC and if reported without the presence of an IOP primary return edit 190.

Note: If there is an inpatient only procedure (SI = C) on the same day as IOP or Daily Mental Health services, no Intensive Outpatient Therapy or Daily Mental Health processing logic is performed.

Requirements differ for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Opioid Treatment Programs (OTPs), and Critical Access Hospitals (CAHs) IOP claims processing. Refer to applicable sections for detailed information.

IOP and mental health composite processing

When the IOP composite criteria is met and an IOP APC is obtained, the first line item containing the HCPCS code from the IOP_PRIMARY list is assigned the IOP APC and a final SI = P. All other IOP services on the same day are packaged, the SI is changed to N. A composite adjustment flag (CAF) is assigned by the IOCE to identify the IOP APC and all the packaged IOP services on the day.

Note: A different composite adjustment flag is assigned for each IOP day on the claim.) Additionally, the payment adjustment flag value of 11 is assigned to the IOP payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing.

In the instance that DMH services are also reported in the presence of an IOP APC, the IOCE assigns the first DMH service line item to the DMH composite APC (DMH APC) with a payment method flag = 1, and all other DMH services package (SI= N) into the DMH APC. (Note: The DMH APC is assigned even if the DMH composite cap threshold has not been exceeded when the IOP composite APC has been assigned for the day). The IOCE assigns a unique CAF to the DMH services, different from the IOP APC CAF, to identify the line with the DMH APC and any other DMH packaged services. This further indicates to the OPPS Pricer program that there is no additional payment for the DMH composite lines on the same date of service.

The processing of Remote Mental Health (RMH) services is also allowable on IOP claims. These services are provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder and furnished to beneficiaries in their homes by clinical staff of the hospital using communications technology. Although RMH services are not recognized or counted as partial hospitalization services, they are available to those in an intensive outpatient program. When RMH services are reported on an IOP claim that meets the requirements to obtain an IOP APC, RMH services are packaged (SI= N) into the DMH composite APC with any other DMH services provided on the same day. Note: If RMH services are reported in the presence of an IOP APC and no DMH services are present, the RMH service(s) package into the DMH APC. The IOCE assigns the first qualifying (not an add-on code) RMH service to the DMH APC, with a payment method flag = 1 and all other RMH services reported on the same date of service are packaged (SI= N). Additionally, a unique CAF is assigned to the RMH services, different from the IOP APC CAF, to identify the line with the DMH APC and any other RMH packaged services. See the REMOTE_MENTAL_HEALTH column in Data_HCPCS for applicable codes.

Note: If a RMH add-on code is reported without a primary code on the same date of service, the line is line-item denied with edit 106.

7-day spanning IOP and interim claims processing

For weekly IOP claim processing, IOP claims spanning seven days, IOP claims require a weekly claim submission of at least 9 hours of IOP services per week. If less than 9 hours of IOP services are submitted for a weekly claim, the IOCE rejects applicable lines by assigning edit 129 for informational purposes only. Edit 129 is not returned on an initial admit week or a final discharge week of an IOP claim. Refer to the IOP_Duration column for applicable codes in Data_HCPCS.

Hours of service for IOP services that result in packaging (SI = N) due to IOP APC processing are included in the total count of hours per week; however, there are certain IOP services that are add-on codes and are not included towards the weekly count of hours. Refer to IOP_Addon column in the Data_HCPCS table for applicable codes. If the IOP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week. If conditions are present for edit 129, an informational only line-item denial or rejection flag value of 3 is returned, indicating that although the conditions for edit 129 exist, payment is not impacted, and the line-item rejection disposition flag in the claim return buffer is not set. The IOCE continues to process lines with edit 129 for payment by the OPPS Pricer.

Note that the Admission Week is determined as being the first 7 days on the claim, based on the claim's From Date and not the particular day of the week (Sunday-Saturday). The IOCE does not apply edit 129 on the admission week submitted on an admission IOP claim instead, if the admission week has less than 9 hours of IOP services, payer condition code MP is provided.

The discharge week is identified as the last full (7 days) week on the claim and the IOCE does not apply edit 129 on the discharge week when submitted on an IOP discharge claim.

The IOCE returns Payer Value Code and Value Code Amount QW on Interim IOP claims that have a partial last week present. The last 5 values of the Value Code Amount provided with QW represents the count of days and hours in which IOP services are provided for the partial week (first portion of week). Note that the partial week represented by the QW output is not edited with edit 129. The IOCE receives the next claim with Value Code QA and the associated value code amount from the QW output which was on the previous claim (first portion).

Note that the Shared System Maintainer (SSM) may only supply this information on input. The IOCE then combines the partial week information from the previous claim and the claim being processed into one full week (7 days). If the full week does not contain up to 9 hours of IOP services, the lines on the second portion used in calculating the full week are edited with edit 129 and Payer Value Code MV is output. The output of MV requires the SSM to adjust the claim containing the first portion of the partial week, as the partial weeks after combining is not 9 hours.

The SSM submits condition code MW on input for the PHP/IOP adjustment claim, indicating that the IOCE needs to edit the partial (last) week present on the claim. The IOCE edits with 129 on the line-items associated with the partial week and outputs QW with the value code amount applicable.

Table 21. Payer Value and Condition Codes for IOP

Code	Description	Dates Effective
Value Code: QW	Partial week present on interim PHP/IOP claim. Provided on output from the IOCE.	January 1, 2024 - to present
Value Code: QA	Offset for combining partial PHP/IOP week on interim PHP/IOP claim. Provided on input to the IOCE.	January 1, 2024 - to present

Code	Description	Dates Effective
Condition Code: MP	PHP/IOP claim contains initial admit week Provided on output from the IOCE. Payer-defined condition code MP is returned when the PHP/IOP claim represents the initial admit week. Note: Edit 129 is not returned on an initial admit week or a final discharge week of a IOP claim.	January 1, 2024 - to present
Condition Code: MQ	PHP/IOP claim contains final discharge week Provided on output from the IOCE. Payer-defined condition code MQ is returned when the PHP/IOP claim represents the final discharge week.	January 1, 2024 - to present

Intensive outpatient program processing for community mental health centers: v25.0-Current

Effective January 1, 2024 (v25.0) CMHCs report CC 92 when reporting IOP services. In the event, 076x is reported without a condition code, edit 118 returns the claim to the provider for definitive reporting.

CMHCs must follow IOP diagnosis and HCPCS reporting requirements in order to qualify for an IOP APC; that is, there must be a mental health principal diagnosis code and at least one primary IOP service present to obtain a level I IOP APC. If at least one IOP Primary is not present for the day on an IOP claim, the IOCE returns the claim to the provider with edit 190. To obtain the level II IOP APC, a minimum of 4 or more services must be provided, with at least one of those services identified as a primary service from the IOP Primary list. Note: If less than 3 IOP services are reported for the day, including the IOP primary service, the IOCE assigns information only edit 128.

If condition code 66 (Provider does not wish outlier payment) is present for a CMHC claim with bill type 076x and CC 92 or 41, payment method flag value of 6 is provided on each OPPS payable line (OPPS paid lines are those that would have previously had payment method flag 0).

If condition code MY (Outlier cap bypass) is passed to the IOCE by the MAC, with or without condition code 66, payment method flag value of 9 is returned and the outlier payment limitation is bypassed.

Mental health services that are not approved for IOP and are submitted on an IOP claim for CMHCs are returned to the provider with edit 132. Refer to MH_not_IOP in the Data_HCPCS for applicable codes.

Additionally, remote mental health services are not allowed to be reported on a CMHC claim, in the instance RMH services are reported for a CMHC, the claim is returned to the provider (edit 55). See the REMOTE_MENTAL_HEALTH column in Data_HCPCS for applicable codes.

Table 22. Intensive Outpatient Program APC Table

APC	Dates Effective	Description
05851	1/1/2024 - Present	Intensive Outpatient (3 services) for CMHCs
05852	1/1/2024 - Present	Intensive Outpatient (4 or more services) for CMHCs
05861	1/1/2024 - Present	Intensive Outpatient (3 services) for Hospital-based IOPs
05862	1/1/2024 - Present	Intensive Outpatient (4 or more services) for Hospital-based IOPs
08010	1/1/2016 - Present	Mental Health Services Composite

LDR prostate brachytherapy composite APC processing and assignment criteria

Note: The LDR composite APC is effective only for versions 9.0 – 18.3; LDR claims with From Dates on or after 1/1/2018 (v19.0) are included in the comprehensive APC processing logic.

- If a "prime" code is present with at least one non-prime code from the same composite on the same date of service, assign the composite APC and related status indicator to the prime code; assign status indicator N to the non-primary code(s) present.
- Assign units of service = 1 to the line with the composite APC.
- Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
- If there is more than one prime code present, assign the composite APC to the prime code with the lowest numerical value and assign status indicator N to the additional prime code(s) on the same day.
- Assign the indicated composite adjustment flag to the composite and all component codes present.
- If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.
- Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.
- Procedures that are packaged (SI changed to ‘N’ in an earlier processing step) are not included in the composite assignment logic.

- Effective 1/1/2017 (v18.0), prime code 55875 may be subject to comprehensive APC processing when reported without non-prime code 77778.

Multiple imaging composite assignment rules & criteria

For hospital outpatient bill types, when multiple imaging procedures are performed during a single date of service, using the same imaging modality, the services are assigned to a Multiple Imaging composite APC. These services are paid with one composite APC payment each time a hospital bill type, bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

Multiple imaging composite APCs are assigned for three 'families' of imaging procedures – ultrasound, computed tomography and computed tomographic angiography (CT/CTA), and magnetic resonance imaging and magnetic resonance angiography (MRI/MRA).

Note that when a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

- Within two of the imaging families (i.e., CT/CTA and MRI/MRA), imaging composite APCs are further assigned based on procedures performed with contrast and procedures performed without contrast. There is currently a total of five multiple imaging composite APCs (08004, 08005, 08006, 08007, and 08008). For a list of procedures eligible for the composite assignment, refer to the MAP_COMPOSITE table within the data files.
- If multiple imaging procedures from the same family are performed on the same DOS, a multiple imaging composite APC is assigned to the first eligible code encountered; all other eligible imaging procedures from the same family on the same day are packaged (the status indicator is changed to N).
- Multiple lines or multiple units of the same imaging procedure count to assign the composite APC; independent or conditional bilateral imaging procedures with modifier 50 count as 2 units.
- If multiple imaging procedures within the CT/CTA family, or the MRI/MRA family are performed with contrast and without contrast during the same session (same DOS), the 'with contrast' composite APC is assigned.
- Imaging procedures that are terminated (modifier 52 or 73 present), are not included in the multiple imaging composite assignment logic; standard imaging APC is assigned to the line(s) with modifier 52 or 73 (SI changed from Q3 to separately payable SI and APC).
- Imaging procedures that are packaged (SI changed from Q# to N in an earlier processing step) are not included in the multiple imaging composite assignment logic.
- If the imaging composite APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.

- Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, the OCE re-assigns units of service = 1 and returns a payment adjustment flag = 11.
- Effective 1/1/2016 (v17.0), certain CT scan codes performed on equipment not meeting NEMA standards are reported with modifier CT. If multiple CT scan codes reported with modifier CT are present, and contribute to the assignment of a composite APC, the first eligible line assigned to the composite APC receives payment adjustment flag 14, whether or not modifier CT is reported on the line. All other CT scan codes reported with modifier CT that are included for composite APC assignment are packaged (SI = N), and do not have payment adjustment flag 14 assigned.
- Lines that are candidates for composite APC assignment that are present on a comprehensive APC claim do not have the composite adjustment flag applied; composite candidates are packaged with SI = N under comprehensive APCs.
- Special consideration is given to code 75635, which is a current composite candidate under ultrasound with SI = Q2 which makes it eligible for conditional APC processing. If 75635 is present, consideration of separate payment under conditional APC processing is evaluated prior to composite candidate consideration. If composite conditions are not present, then 75635 is processed for separate payment or packaging under conditional APC processing.

Note that in the instance imaging composite services are reported for non-hospital outpatient bill types, the status indicator and payment indicator are returned on output, but no payment APC is provided.

Comprehensive APC processing

Effective 1/1/2015 (v16.0), certain high cost procedures which have an SI=J1 are paid an all-inclusive rate to include all services submitted on the claim, except, for services excluded by statute. All allowed, adjunctive services submitted on the claim are packaged into the "comprehensive" APC payment rate (i.e., the status indicator is changed to N). Multiple comprehensive procedures, if present on the claim in specified combinations, may be assigned to a higher-paying comprehensive APC representing a complexity adjustment. Services that are excluded from the all-inclusive payment retain their standard APC and SI for standard processing.

Effective v17.0, if SRS planning and preparation codes are present on the same claim with the SRS C-APC, the planning and preparation codes are excluded from the C-APC packaging logic.

General comprehensive APC assignment rules and criteria: V16.0- Current

- Comprehensive APC processing is performed only for OPPS claims with bill type 13x, or claims with bill type 12x with condition code W2.
- Comprehensive APCs are assigned using the following hierarchy:
  - Inpatient-Only Patient Expired (SI = J1)
  - High-Cost Procedures (SI = J1)

  - Comprehensive Observation (SI = J2)

- If there are multiple comprehensive APC procedures existing on the same claim from the different categories listed above, the comprehensive APC procedures are packaged (SI = N) according to the hierarchy of services present; the procedure or service highest in the hierarchy is assigned the comprehensive APC for the claim. Additional processing conditions for each of the different categories is listed separately below.
- Multiple service units reported on a comprehensive APC line are reduced to one for processing payment based on a single comprehensive APC payment rate; payment adjustment flag 11 is assigned.
- Services that are excluded from comprehensive APC packaging include; ambulance, brachytherapy (SI=U), mammography, physical therapy, speech-language pathology, occupational therapy services, pass-through drugs, biologicals and devices (SI= G or H), preventive care including influenza, Hepatitis B, COVID-19 and pneumococcal vaccines (SI=L), self-administered drugs (SADs), corneal tissue acquisition, certain CRNA services, monoclonal antibody administration for COVID-19, services assigned to New Technology APCs (1491-1599 and 1901-1908) with SI = S or T and FDA-authorized or approved drugs and biologicals (including blood products (i.e. packed red cells or whole blood) reported with the appropriate revenue code) that are authorized or approved to treat or prevent COVID-19.

  Effective January 1, 2023 (v24.0), drugs reported using C9399 (Unclassified drugs or biologicals) with SI = A, are excluded from packaging under comprehensive APC processing. Edit 66 continues to apply at the line level.
- Certain wound care services identified as “sometimes therapy” when appended with a therapy modifier (GP for physical therapy, GO for occupational therapy, or GN for speech language pathology) or a therapy revenue code (042x, 043x, 044x), change the SI of the service to A, and are excluded from comprehensive APC packaging.
- Procedures that are not allowed on OPPS claims (SI = B, C, E, E1, E2 or M) are edited as usual and retain the standard SI, with the exception of procedure codes representing DME services with SI = Y (Billable only to DMERC); DME codes with SI = Y are packaged into the comprehensive APC payment; edit 61 is not returned.
- Comprehensive APC claims containing lines that may be composite APC candidates do not have the composite adjustment flag applied.

Comprehensive APC assignment for high-cost procedures: v16.0 - current

- If a single comprehensive procedure (SI = J1) is present on a claim, assign the standard comprehensive APC for all-inclusive claim payment.
- If multiple comprehensive APC procedures are present, select the highest ranked comprehensive procedure for standard comprehensive APC assignment.
- Once the highest ranked comprehensive procedure is determined, if there are multiple comprehensive procedures present with SI = J1 or there are qualifying add-on procedure codes present (SI = N), determine if there are any pairings that may qualify for a complexity adjustment. Multiple occurrences or service units of the same comprehensive procedure, or

the reporting of modifier 50, may qualify for complexity adjustment. If there is a qualifying pair present associated with the highest ranked comprehensive procedure, assign the complexity-adjusted comprehensive APC.

- If the highest ranked comprehensive procedure has service units greater than one, reduce the service units to one and assign payment adjustment flag 11.
- If a comprehensive APC procedure is terminated by the reporting of modifier 52, 73 or 74, no complexity adjustment is performed for the claim; the standard comprehensive APC is assigned to the comprehensive procedure with the highest rank. Usual terminated procedure discounting is applied if modifiers 52 or 73 are reported (modifier 74 does not apply the terminated procedure discount).
- If the comprehensive APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.
- Effective 1/1/2016 (v17.0), when SRS (stereotactic radiosurgery) planning and preparation codes are reported on the same claim as the comprehensive APC for SRS (APC 5627), the planning and preparation codes are excluded from packaging; the standard SI and APC, or the composite APC and SI (if criteria is met for multiple CT scan imaging procedures) are assigned. If the SRS planning and preparation codes are reported on a claim with any other comprehensive APC procedure, the codes are packaged under the comprehensive APC packaging criteria.
- Effective 1/1/2016 (v17.0), if conditions are present for pass-through device offset, a single device offset is provided for comprehensive APC claims only if the comprehensive APC procedure is paired with the pass-through device. Otherwise, no device offset is provided for device offset conditions that may be present for procedures that are packaged (SI = N) as a result of comprehensive APC processing.
- Effective 1/1/2019 (v20.0), procedure codes assigned to New Technology APC's are excluded from packaging under comprehensive APC processing logic for J1 or J2 services; standard SI and APC are assigned. Note: Procedure codes assigned to New Technology APC's which have a standard SI = T, prevent a J2 comprehensive observation APC from being assigned, due to standard Observation C-APC assignment criteria.

Inpatient procedure processing under comprehensive APCs

Services that are designated as inpatient-only are not appropriate to be furnished in a hospital outpatient department. These types of services are typically, but are not limited to being, surgical services which require an inpatient level of care due to the complexity and nature of the procedure, the underlying physical condition of patients requiring the service, or the need for at least 24 hours of postoperative recovery time and monitoring before the patient can be safely discharged. Inpatient-only procedures are recognized by SI = C. When a claim is reported and the only service is inpatient only, the IOCE denies the line with edit 18. Additionally, when an inpatient only procedure is denied with edit 18, all other services reported on the same day are also denied, with edit 49.

Effective January 1, 2016 (v17.0), if an inpatient-only procedure is present with modifier CA for a patient who expires or transfers to another hospital (patient status code is 2, 5, 20, 62, 63, 65,

66, 82, 85, 90, 91, 93 or 94), the inpatient procedure is assigned under a comprehensive APC (SI = J1), and all other services reported on the claim are packaged (SI= N), except for those items excluded under comprehensive APC processing. Excluded items with non-covered SI = B, E, C or M return line item denial edit 121 (Non-covered service reported with an inpatient only procedure in which the patient expired or transferred) in addition to the payment indicator 3 and payment method flag 1.

If modifier CA is reported for an inpatient-only procedure and the discharge status does not indicate the patient expired or transferred, the claim is returned to the provider (edit 70). Additional comprehensive APC procedures (SI = J1 or J2) reported on the same claim as the inpatient-only procedure where the patient expired or transferred are packaged (SI = N). If multiple lines, or one line with multiple units, have SI = C and modifier CA, generate edit 60 for all lines with SI = C and modifier CA.

Note: When the specific edit criteria are met, inpatient-only procedure lines that result in being assigned to the Inpatient-Only Expired Comprehensive APC (SI = J1), that may or may not be reported with modifier CA, also generate edits 60 and/or 70.

Inpatient-only procedures that are on the s procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T, or effective 1/1/2015, if reported on a claim with a comprehensive APC procedure (SI = J1). The line(s) with the inpatient-separate procedure is rejected (edit 45) and the claim is processed per usual OPPS rules.

Effective January 1, 2018 if procedure code 01402 (Anesthesia for TKA) is reported on the same day as procedure code 27447 (Total Knee Arthroplasty) the SI of 01402 changes from C to N and will always package. If code 01402 is reported with any other procedure without 27447 reported on the same claim, the SI remains its standard SI = C and processes as usual.

Observation processing under C-APCs

Effective January 1, 2016 (v17.0), claims for observation services (SI = J2) meeting specified criteria are paid under a single Comprehensive Observation C-APC payment rate, to include all services submitted on the claim. The same exception criteria for excluded services under high cost procedure comprehensive APCs (SI = J1) apply to the Comprehensive Observation APC, and all allowed adjunctive services submitted on the claim with the Comprehensive Observation APC are packaged (SI is changed to N). If multiple visits are present for qualified Comprehensive Observation C-APC assignment, the visit code with the highest standard APC payment rate is assigned the Comprehensive Observation APC; all other visits are packaged.

Effective July 1, 2023 (v23.2), the logic for edit 114 is deactivated.

Effective 03/18/2020 (v21.2), OPPS claims (bill type 13x w/o CC 41) with E&M visit code(s) reported with modifier CS that meet the criteria for Observation C-APC assignment (SI = J2) or are assigned standard SI=V, return a payment adjustment flag of 9. Critical care code 99291 reported with modifier CS with an SI = S instead of SI=J2, is also applicable for a PAF assignment of 9. If the final status indicator for a visit line(s) with modifier CS is packaged (SI= N), the payment adjustment flag is not set to 9. The reporting of modifier CS indicates that the line(s) is a COVID-19 visit with testing-related services, deductible and coinsurance is not applicable for

the visit. Additionally, modifier CS should only be reported when the item or service is identified by CMS as being eligible for a coinsurance and deductible waiver. If Modifier CS is reported on items or services not eligible for a coinsurance and deductible waiver, edit 114 is returned (RTP). (Refer to the DATA_HCPCS table within the data files for services flagged as coinsurance_deductible_waiver_eligible. Refer also to the Medical Visit Processing and COVID-19 Testing-Related Services (page 79) as this logic is applicable to the medical visit processing logic.

Comprehensive observation APC assignment criteria

- The claim does not contain a comprehensive APC procedure with SI = J1.
- There is no procedure with SI = T present for the claim. If a procedure with SI = T is present, no comprehensive observation APC is assigned. If a procedure with SI = T and line item action flag 2, 3, or 4 is present, the line is ignored from processing and is not considered in comprehensive observation logic. If a new technology APC with SI = S is present on a Comprehensive Observation APC claim, it is excluded from packaging and assigned its standard APC.
- HCPCS G0378 is reported once with 8 or more service units. If a period of observation spans more than 1 calendar day, all the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins. If subsequent lines of G0378 are reported, edit 51 is applied (RTP) and the units associated with the subsequent G0378 line are not evaluated for C-APC assignment. Note: If a LIAF of 2, 3, or 4 is present, the line is ignored from processing and edit 51 is not applied.
- There is a visit code present from the following list on the same day or one day before HCPCS G0378: Type A/Type B emergency department visits, critical care, outpatient clinic visit, or HCPCS G0379 for direct referral is present on the same day as G0378.
- If multiple visit codes with SI = J2 are present, the visit code with the highest standard APC payment rate is chosen as the comprehensive observation APC; all other visit codes are packaged (SI = N).
- If the claim does not meet the conditions for comprehensive observation APC assignment, the visit code(s) is/are assigned their standard APC and SI.
- If HCPCS G0379 is present and criteria is not met for comprehensive observation APC, and there are other visit codes present (SI = J2 resulting in standard APC and SI = V), G0379 is packaged. Additional reporting (subsequent occurrences) of HCPCS G0379 are packaged (SI = N).

Packaged/incidental service processing

Packaged services are items and services that are deemed essential components of another service covered by the OPPS. No separate payment is made for packaged services, because the cost of these items and services are included in the APC payment for the service of which they are inherently linked to. Examples of these services include routine supplies, anesthesia, recovery room use, and some drugs. The services listed are most often considered to be an

integral part of a surgical procedure, so payment for these items are typically packaged into the APC payment for the surgical procedure.

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services are not made since payment is included in the APC.

Packaging types

Unconditionally packaged services are not paid separately because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are assigned status indicator N.

STV-packaged services for which separate payment is made only if there is no service with status indicator S, T, or V reported on the same claim. If a claim includes a service that is assigned status indicator S, T, or V reported on the same claim as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator Q1. See Type “T” Multiple and Terminated Procedure Discounting: for additional logic details and information.

T-packaged services for which separate payment is made only if there is no service with status indicator T reported on the same claim. T-packaged services are assigned status indicator Q2. See Processing Procedures with Status Indicators of Q1 and Q2 for additional logic details and information.

A service that is assigned to a composite APC and mapped to a composite APC are assigned status indicator Q3. See Composite APC Processing for additional logic details and information.

Laboratory service codes with SI = Q4 designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” See Conditional Processing for Laboratory Procedures for additional logic details and information.

Hospital Part B services paid through a comprehensive APC (SI = J1) are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service. See Comprehensive APC Processing for detailed logic.

Comprehensive Observation Services: SI = J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. Payment for all adjunctive services reported on the same claim as a SI = J2 service is packaged into payment for the SI = J2 service when certain conditions are met. See Observation Processing under C-APCs for detailed logic.

Device-intensive procedure editing and processing

Certain procedure codes that require the use of devices are identified as device intensive procedures. Any applicable codes for devices that are used to perform the procedures must also be reported.

Effective 1/1/2015 (v16.0), since the submission of a device-intensive procedure also requires that a device be submitted on the same claim/day, when any device-intensive procedure is submitted without a code for a device on the same claim with the same date of service, the claim is returned to the provider (edit 92). Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not edited for a missing device code. Effective 1/1/2019 (v20.3), certain device-intensive procedures codes are applicable for bypassing edit 92 if an insertion of a device is not completed (e.g., revision only). For the edit to be bypassed a device procedure on the "BYPASS_E92_MODIFIER" list is reported with modifier CG. For a list of applicable device procedures, reference the corresponding bypass column in the DATA_HCPCS table in the quarterly data files.

Effective 1/1/2016 (v17.0), if there is a terminated device-intensive procedure from a specified list reported with modifier 73, the device portion cost of the procedure APC is output by the IOCE with a Payer Value Code of QQ. The device portion amount is used by the OPPS Pricer program to reduce the APC payment rate prior to application of the terminated procedure discount. A unique payment adjustment flag value of 16 identifies the device-intensive procedure reported with modifier 73. In the event there are multiple terminated device-intensive procedures present with modifier 73, the device portion amounts are summed, and the total device portion is provided; the payment adjustment flag of 16 is assigned for each terminated procedure. Terminated procedure lines present with modifier 73 that may be packaged (SI = N) do not contribute to the device portion amount, and a payment adjustment flag is not returned.

Note: Effective January 1, 2017 (v18.0), the device portion cost for the terminated procedure offset is determined at the individual HCPCS code level, regardless of the APC assignment.

Some implanted devices and some administered substances (SI = H, U), require an implantation or other associated procedure (SI = S, T or J1) to be billed on the same claim. If an associated procedure is not present, the claim is returned to the provider (edit 38).

Effective January 1, 2024, for certain device procedures, when they are reported without their required device code on the same day, the IOCE returns the claim to the provider with edit 135. Note: Device procedures associated with this edit are not applicable or may no longer be applicable to edit 92 (meaning the bypass for modifier CG does not apply). Additionally, if the device procedure is terminated early (modifier 52, 73, 74), and the required device HCPCS is not present, edit 135 is bypassed and the terminated device offset is still calculated. See the Map_Device_Procedure table for specified device procedures and required devices.

Device credit conditional processing

Effective 1/1/2016 (v17.0), if conditions exist for full or partial device credit for a device intensive APC represented by the presence of Condition Code 49, 50 or 53, the device credit amount is output by the IOCE with Payer Value Code QU, which is used by the OPPS Pricer program to reduce the device intensive APC payment rate by the device credit amount. A unique payment adjustment flag value of 17 identifies the device intensive procedure for which the device credit applies. In the event there are multiple device intensive APCs present for device credit, the credits are summed and the total is provided in the Value Code Amount field; the payment adjustment flag of 17 is assigned for each device intensive procedure associated with

the device credit. Device intensive procedures that are packaged (SI = N) do not contribute to the device credit amount, and a payment adjustment flag is not returned. If the device intensive procedure is a comprehensive APC procedure and is also eligible for complexity-adjusted APC assignment under comprehensive APCs, the device credit amount for the complexity-adjusted comprehensive APC is provided.

Note: Effective January 1, 2017 (v18.0), the full or partial device credit amount is determined at the individual HCPCS code level, regardless of the APC assignment.

Pass-through device processing

Claims with pass-through device HCPCS codes (SI = H) furnished with certain device-intensive procedures require a payment offset to the APC payment rate for the procedure. Effective January 1, 2016 (v17.0), the IOCE shall identify the offset condition for the pass-through device HCPCS and associated device-intensive procedure by providing a unique claim level Payer Value Code (QN), with Value Code amount representing the payment offset in the claim return buffer. A payment adjustment flag is returned to identify the pass-through device HCPCS line(s) associated with the payment offset(s); multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through device HCPCS lines present that are associated with the same device-intensive procedure, and the total amount is summed and output with Value Code QN. An additional claim level Payer Value Code (QO) and payment adjustment flag value may be returned if there is an additional condition present for a separate device offset on the same claim (Payment adjustment flag values of 12 and 13 identify the pass-through devices which require offsets). Claims with pass-through devices reported without the associated device-intensive procedure are returned to the provider (edit 98).

Effective April 1, 2018 (v19.1), certain procedure and pass-through device pairings may have a mid-quarter activation date associated with FDA approval. Claims reporting pass-through devices prior to the mid-quarter activation date are line item denied (edit 105). The edit will be returned on the line containing the pass-through device.

Note: Effective January 1, 2017 (v18.0), the pass-through device offset amounts are determined at the HCPCS code level, regardless of the APC assignment.

If there is a comprehensive APC procedure present (SI = J1) and there are conditions present on the claim for pass-through device payment offset, if there is a pass-through device associated (paired) with the primary comprehensive APC procedure, then a single device offset condition is identified for the claim (Payer Value Code QN only with corresponding offset amount). Conditions that may be present for pass-through device offset on a claim with a comprehensive APC that result in packaging of the device intensive procedure (SI = N) paired with the pass-through device do not produce a pass-through device payment offset.

An exception is made for claims containing the comprehensive APC for an inpatient-only procedure reported with modifier CA for a patient who expires that also contain conditions for pass-through device payment offset; the pass-through device payment offset is provided.

Drug administration

When multiple occurrences of any APC that represents drug administration are assigned in a single day, modifier 59 is required on the code(s) to permit payment for multiple units of that APC, up to a specified maximum; additional units above the maximum are packaged. If modifier 59 is not used, only one occurrence of any drug administration APC is allowed, and any additional units are packaged (v6.0–v7.3 only).

Blood and blood storage processing

In order for Medicare to correctly allocate payment for blood processing and storage, providers are required to submit two lines with different revenue codes for the same service when blood products are billed. One line is required with revenue code 39X and an identical line (same HCPCS, modifier and units) with revenue code 38X. Modifier BL, special acquisition of blood and blood products, is required to be present on each line for the specified revenue codes or the claim is returned the provider (edit 73). Revenue code 381 is reserved for billing packed red cells and revenue code 382 is reserved for billing whole blood; if packed red cells and whole blood are not reported correctly, the claim is returned to the provider (edit 79). If both lines match (same HCPCS, modifier BL and units) edit 73 is not applicable and payment adjustment flag values 5 and 6 are applied (5 to revenue code 38x and 6 to revenue code 39x).

Note: Payment Adjustment Flag values are not assigned to packaged blood lines.

Effective 1/1/2015, packed red cells reported with revenue code 381 and whole blood reported with revenue code 382 that appear on a claim with a comprehensive APC procedure (SI = J1) are excluded from packaging; the standard SI is retained.

Nuclear medicine procedure processing

Please reference a previous specifications document to review Nuclear medicine procedure processing, which is now out of scope of the current IOCE version.

Managed care processing

OPPS claims for Managed Care beneficiaries, as identified by the MAC (Payer only condition code MA – Managed Care enrollee), are not subject to line level deductible. Payment adjustment flag 4 is applied to all line items except for those that are packaged (SI = N) with line item charges = $0.00 or the line item is subject to a payment adjustment flag of 9 or 10.

Preventive services and deductible/coinsurance waiver processing

Deductible and coinsurance is waived for certain preventive services (see the Data_HCPCS table within the data files for services flagged for Deductible_na, deductible_coins_na, or coins_na). A

payment adjustment flag (PAF) value of 4, 9, 10 or 25 is applied to services to specify that either the deductible and coinsurance is not applicable (PAF 9), the deductible is not applicable (PAF 4), or that the coinsurance is not applicable (PAF 10), and effective for January 1, 2022 (v23.0), a deductible is not applicable and there is a reduction in coinsurance when modifier PT is reported on applicable procedure (PAF 25, see below). The payment adjustment flag value 9 is assigned over values 25, 10 and 4, in instances where more than one of these payment adjustment flag values are applicable. In conditions where both payment adjustment flag values 10 and 4 are applicable, a value of 10 is assigned. Services that are packaged with SI= N and line item charges = $0.00 do not have coinsurance or deductible waived. Additionally, any services submitted with modifier Q3 (Live kidney donor surgery and related services) are waived for deductible and coinsurance (PAF 9).

For claims submitted prior to January 1, 2022, the deductible is waived for colorectal cancer screening services that become diagnostic or therapeutic, and for any other OPPS surgical procedures (SI = J1, T, or Q1, Q2, Q3 that resolve to J1 or T) present for the same service date. The presence of HCPCS modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) is used to identify when there is a diagnostic or therapeutic procedure or service reported, that was converted from a colorectal cancer screening. If modifier PT is present for either a single day claim or a single date of service on a multiple day claim, there must also be a Colorectal procedure present for the same service date. In the instance that modifier PT is present and there is no Colorectal procedure reported for the same service date, edit 120 (RTP) is returned at the line level. (See the Data_HCPCS table, within the data files, for procedures identified as Colorectal). The IOCE sets the PAF to 4 on the Colorectal procedure and the OPPS payable procedure line(s) except when any other PAF is already applied to the same line. Additionally, if a line reporting modifier PT is packaged (SI = N) with charges = $0.00, PAF 4 is not returned. Note: For Critical Access Hospital Non-OPPS claims with bill type 085x, the logic for setting the PAF is not applicable however, editing for the correct reporting of modifier PT does apply.

Effective January 1, 2022 (v23.0), Section 122 of the Consolidated Appropriations Act (CAA) includes not only a waiver of the deductible, but also requires a gradual reduction to the beneficiary coinsurance payment to be implemented over the next eight years for colorectal cancer screening services that are converted to diagnostic procedures or services. To accommodate the OPPS Pricer in providing the deductible waiver and gradual reduction in coinsurance, the IOCE no longer sets the PAF to 4, the IOCE now returns PAF 25 (Deductible not applicable and coinsurance reduced) on the Colorectal procedure and the OPPS payable procedure line(s) except when any other PAF is already applied to the same line, or when a line reporting modifier PT is packaged (SI= N) with charges = $0.00, PAF 25 is not returned.

For bypassing the deductible and/or coinsurance on Part B claims with payer only condition codes and modifiers, see Payer Only Bypass of Coinsurance and/or Deductible.

SDOH risk assessment, community health integration services, and principal illness navigation services

Social determinants of health (SDOH) are defined as economic and social conditions that influence the health of people and communities. To identify a patient's social determinants of health needs, a social determinants of health risk assessment is performed. The SDOH Risk Assessment is separately payable with no beneficiary cost sharing when furnished as part of the same visit with the same date of service as the Medicare annual wellness visit (AWV) (initial or subsequent). Additionally, for a Hospital Outpatient bill type (013x), the coinsurance and deductible are waived in the instance that the SDOH risk assessment is performed on the same date as the AWV, the IOCE assigns PAF= 9 to the SDOH risk assessment line.

See FQHC PPS – SDOH Risk Assessment Processing for SDOH Risk Assessment claims processing for FQHCs.

Community Health Integration (CHI) services characterize the work of coordinating care for people with health-related social barriers as recognized by SDOH. CHI services address the particular SDOH needs that present a barrier to patient care. Codes for these services involve coordination among healthcare practitioners, social services, and caregivers, and include health education around patient self-advocacy skills, healthcare access and navigation, and facilitating behavioral change. These codes are allowed for processing and are separately payable on hospital bill types (including PHP and IOP claims), however they are not separately payable for PHP or IOP claims for CMHCs (076x). (There is no defined logic in the IOCE for these services, however when these services are reported for CMHCs, the status indicator(s) and payment indicator(s) are returned on output, but no payment APC is provided.)

Principal Illness Navigation (PIN) services were designed to help people who are diagnosed with a serious, high-risk disease identify and connect with appropriate clinical and supportive resources, through the support of an individual such as a patient navigator or peer specialist. PIN services are permitted to be reported for Hospital Outpatient bill types on the same day as partial hospitalization (PHP) or on the same day as the Intensive Outpatient Program (IOP). For relevant bill types, PIN services are packaged (SI=N) with no additional payment. See applicable services in the PHP_IOP_Reportable column of the Data_HCPCS table.

OTP Processing- Intensive Outpatient Program

Since IOPs can also be furnished in an OTP, OTPs are permitted to report HCPCS code G0137 (Intensive outpatient services; minimum of nine services over a 7-contiguous day period). For OTPs, only the IOP HCPCS code is reported, condition code 92 is not required. Other requirements for the reporting of a primary IOP service or specified use of revenue codes for IOP are also not required.

Opioid treatment program processing

Opioid Use Disorder (OUD) treatment services are items and services that are furnished by an OTP for the treatment of opioid use disorder, including FDA approved opioid agonist and

antagonist medications, dispensing and administration of such medications, substance use counseling, individual and group therapy, toxicology testing, and other items and services that are determined are appropriate.

Effective January 1, 2021 (v22.0), Opioid Treatment Program (OTP) services are payable under Medicare Part B for claims reporting bill type 087x (Freestanding Non-Residential Opioid Treatment Program). Hospital provider-based claims reporting bill type 013x or 085x (CAH) if submitted with condition code 89 are also approved for reporting Opioid Treatment Program services. The presence of condition code 89 indicates that the claim is for Opioid Treatment Program services provided by a licensed Opioid Treatment Program provider. It is expected that only approved OTP provider types are to report Opioid Treatment Program HCPCS (see Data_HCPCS for a list of HCPCS). If Opioid Treatment Program HCPCS are inappropriately billed on bill types not approved for reporting OTP services, edit 116 is applied.

Intensive outpatient program for OTPs

Since IOPs can also be furnished in an OTP, OTPs are permitted to report HCPCS code G0137 (Intensive outpatient services; minimum of nine services over a 7-contiguous day period). For OTPs, only the IOP HCPCS code is reported, condition code 92 is not required. Other requirements for the reporting of a primary IOP service or specified use of revenue codes for IOP are also not required.

Opioid use disorder model processing

Effective April 1, 2021 (v22.1), office-based Opioid Use Disorder (OUD) treatment HCPCS (see Data_HCPCS for list of HCPCS) that are reported on claims with Condition Code M5 indicating the claim is included in the CMS Value in Opioid Use Disorder Treatment model under applicable OPPS bill types (013x, 013x w/CC 41, 013x w/CC 89 and 076x), set the Payment Adjustment Flag to 9 to ensure that no coinsurance or deductible is applied. If the OUD office-based HCPCS are packaged, PAF 9 is not applied.

Special processing for drugs and biologicals

Effective April 1, 2016 (v17.1), claims containing specified pass-through drugs or biologicals furnished with an associated procedure require pass-through payment offset. If conditions exist for pass-through drug or biological payment offset, the IOCE shall provide a unique Payer Value Code with Value Code amount representing the amount of the payment offset. A payment adjustment flag will be assigned to the pass-through drug or biological to identify which line(s) is associated with the corresponding Payer Value Code and Value Code amount; PAF 18, identify the first pass-through drug or biological, while PAFs 19 and 20 identify the second and third pass-through drug or biologicals. Multiple iterations of the same payment adjustment flag value may be returned in the event there are multiple pass-through drugs or biologicals present that are associated with the same offset condition. Claims that may contain multiple conditions eligible for pass-through drug or biological offset return additional Payer Value Codes.

Conditions that may be present for pass-through drug or biological payment offset on a claim with a comprehensive APC that result in packaging of the associated procedure (SI = N) paired with the pass-through drug or biological continue to produce a pass-through drug or biological payment offset. Specific pass-through drugs and biologicals that are not reported with an associated procedure for APC payment offset do not have coinsurance applied. Each PT drug present must be paired with an associated procedure (APC) in order to complete processing (edit 98).

There are four categories of pass-through drug and biological conditions eligible for payment offset: radiopharmaceuticals, skin substitute products, contrast agents and stress agents. Conditions for payment offset for pass-through radiopharmaceuticals reported with an associated nuclear medicine procedure are considered across the claim; otherwise conditions for payment offset for other pass-through drug and biological categories reported with an associated procedure are performed for the same service date.

Effective October 1, 2016 (v17.3), claims containing drugs and biological HCPCS codes with pass-through status (SI =G) or non-pass-through status (SI = K) that are reported without an OPPS payable procedure (SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V) are returned to the provider (edit 99). There are exceptions for blood clotting factor HCPCS which may be self-administered, and certain biologic response modifier HCPCS, which do not require that an OPPS procedure is present. Additionally, payment for pass-through and non-pass-through drugs is no longer determined by the OPPS Pricer; the IOCE assigns payment indicator value of 2 for pass-through and non-pass-through drug HCPCS codes, representing drugs HCPCS priced by fee schedule (e.g. ASP drug file), although the final payment APC is provided.

Effective July 1, 2021 (v22.2), drug HCPCS with final SI= G or K that are reported with charges less than $1.01 and at least $0.01 are line item rejected (edit 117), unless a LIAF of 2, 3, or 4 is present.

Note: Token charges are greater than $0.00 and less than $1.01.

Effective January 1, 2018 (v19.0), any service that is identified as a method used in manufacturing a drug or biological are not paid separately; these services are bundled into the total cost of the drug or biological. Claims submitted using these bundled services (HCPCS) are line item rejected with edit 111, indicating that the service cost is duplicative. If the service identified as being bundled into the cost of the biological has a SI=B, edit 62 is not returned and instead edit 111 is applied. Additionally, if revenue code 870, 871, 872, or 873 (cell/gene therapy) are reported with blank HCPCS, edit 111 is returned (LIR) to identify that the charges associated with the revenue center are bundled into the cost of a drug or biological.

The 340B Drug Pricing Program is a federal program that requires drug manufacturers to provide outpatient drugs to eligible healthcare centers, clinics, and hospitals at a reduced price. Each separately payable, non-pass through (SI=K) 340B-acquired drug should be billed with the appropriate 340B modifier. When a drug or biological is acquired with 340B drug pricing program discount, modifiers TB or JG are applied to the applicable line(s). These modifiers should be appended to separately payable non-pass through OPPS drugs that are acquired through the 340B program and do not need to be reported with pass through drugs that have SI=G. Effective April 1, 2022 (v23.1), if modifier “JG” is reported with a pass-through drug and biological line (SI=G), edit 122 is returned as an information only edit that has no impact to payment.

Skin substitute editing and processing

Effective 1/1/2014 (v15.0), the submission of certain skin substitute application procedures require the reporting of a skin substitute product for the same day. Certain skin substitute application procedures and skin substitute products are divided into two lists based on high or low cost. Claims containing a high cost skin substitute application procedure without any of the high cost skin substitute product codes, and conversely any low cost skin substitute application procedure without a low cost skin substitute product code for the same day, are returned to the provider (edit 87). (See the DATA_HCPCS table within the data files for skin substitute products flagged as either high or low cost.)

Effective 10/1/2015 (v16.3), if a skin substitute product code is present with line item action flag value of 2 representing an external line item denial, the line is not ignored by the IOCE for the purposes of applying edit 87. If the denied skin substitute product is on the list of skin substitute products and the skin substitute application procedure is also present, edit 87 is not returned.

Biosimilar HCPCS processing

Effective January 1, 2016 (v17.0), OPPS and non-OPPS claims containing biosimilar HCPCS codes without a corresponding modifier representing the biosimilar manufacturer, are returned to the provider (edit 94).

Effective July 1, 2017, certain modifiers used for biosimilar HCPCS reporting may have a mid-quarter activation date associated with the FDA approval. Claims reporting these specific modifiers prior to the mid-quarter activation date are line item denied (edit 103).

Note: Edits 94 and 103 are discontinued effective April 1/2018 (v19.1). These edits are returned on claims submitted within their respective effective dates.

HSCT and donor acquisition services processing

Effective January 1, 2017 (v18.0), claims containing HSCT (hematopoietic stem cell transplantation) allogenic transplantation procedure 38240 require the reporting of a separate line representing donor acquisition costs with revenue code 815. If the separate line with revenue code 815 is not present, the claim is returned to the provider (edit 100).

Radiological processing

CT scan equipment not meeting NEMA standards

Effective January 1, 2016 (v17.0), if modifier CT is reported for certain imaging codes for CT scans performed on equipment not meeting NEMA standards, a payment adjustment flag value of 14 is passed to the OPPS Pricer indicating the line is subject to payment reduction. Codes from the specified list that are reported with modifier CT and are packaged (SI = N) due to multiple

imaging composite APC assignment or comprehensive APC assignment, do not receive payment adjustment. The first code assigned to a multiple imaging composite APC receives the payment adjustment flag if there are CT scan codes reported with modifier CT that are constituents of the composite APC (i.e., the composite APC line may or may not have modifier CT reported).

Note: Modifier CT should not be reported on the same hcpcs line with X-ray Modifiers FX or FY as they are modifier conflicts, edit 102 is returned to the provider.

Film x-ray HCPCS processing

Effective January 1, 2017 (v18.0), if modifier FX (x-ray taken using film) is reported with a film x-ray HCPCS code, a payment adjustment flag value of 21 is passed to the OPPS Pricer program indicating the line is subject to payment reduction. If the film x-ray reported with modifier FX is packaged (SI = N), no payment adjustment flag is assigned. If a film x-ray HCPCS code is reported with modifier FX and is also on the coinsurance deductible n/a procedure list, payment adjustment flag 23 is returned to pricer indicating that the line is subject to a payment reduction as well as the coinsurance/ deductible being not applicable.

Computed radiography technology HCPCS processing

Effective January 1, 2018 (v19.0), if modifier FY (X-ray using computed radiography technology/cassette-based imaging) is reported with an x-ray HCPCS code using computed radiography technology, a payment adjustment flag value of 22 is passed to the OPPS Pricer program indicating the line is subject to payment reduction. If the computed radiography x-ray reported with modifier FY is packaged (SI = N), no payment adjustment flag is assigned. If an x-ray HCPCS code is reported with modifier FY and is also on the coinsurance deductible n/a procedure list, payment adjustment flag 24 is returned to pricer indicating that the line is subject to a payment reduction as well as the coinsurance/ deductible being not applicable.

Note: Effective January 1, 2018 (v19.0), edit 102 is returned if modifiers FX and FY are reported together on the same line as they are identified as a modifier pairing conflicts. To review the list of modifier conflicts subject to edit 102, please reference the MAP_MODIFIER_CONFLICT and table within the data files.

Intensity-modulated radiotherapy (IMRT) planning

Intensity Modulated Radiotherapy (IMRT) is a computer-based method of planning for and delivery of radiation to solid tumors. IMRT planning and delivery uses an approach for obtaining the dose distributions needed to irradiate complex targets positioned near, or invaginated by, sensitive normal tissues, thus improving the therapeutic ratios. Effective 1/1/2017, payment for the services identified by CPT codes 77014, 77295, 77306, 77307, 77316, 77317, 77318, 77321, 77331, and 77370 are included in the APC payment for CPT code 77301 (IMRT planning). These codes are not to be reported on the same claim as CPT code 77301 when provided prior to or as part of the development of the IMRT plan. In addition, CPT codes 77280, 77285 and 77290 (simulation-aided field settings) are not to be reported for verification of the treatment field

during a course of IMRT. In the instance that the above listed codes are reported on the same claim as 77301, the claim is returned to the provider (edit 125).

Radiation oncology model (ROM) processing Logic

This section is reserved for the ROM processing logic for which implementation has been postponed.

Hospice processing logic

Effective 10/1/2014, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis on hospice claims. Hospice claims submitted with a manifestation code as principal diagnosis are returned to the provider with (edit 86).

Per the Medicare Claims Processing Manual, any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider using institutional claims for non-hospice Medicare payment. On institutional claims, these services are coded with condition code 07 “Treatment of Non-terminal Condition for Hospice.” If condition code 07 is submitted on a claim bill type 22x, 23x, 32x, 72x, 74x, 75x, 81x, or 82x (OPPS= 1) with an antigen, splint, or cast service, these services are paid by APC under OPPS. Please refer to the Edits by Bill Type Table (OPPS) to reference the editing that is performed if condition code 07 is present on an applicable bill type with antigen, splint or cast.

In order to allow the MAC to process and pay for certain physician services on Hospice claims (bill types 081x or 082x), any HCPCS code with status indicator M that is submitted with revenue code 0657, has the status indicator changed from M to A; the claim is not returned to the provider with edit 72. Note that services reported for hospice patients that are not antigens, splints, or casts are not payable under OPPS and payment method flag 2 is applied.

Home health processing logic

Home health claims (32x) are episode-based with dates of service that can span a maximum of 30 days (January 1, 2020) or 60 days (Claims prior to January 1, 2020). Prior to v22.2, to allow for home health claims to be processed through the IOCE, diagnosis codes reported on a claim with dates of service that span the annual October diagnosis update and the previous quarter, bypass edit 1. Effective with v22.2, all claims (including 32x) that have From and Through dates that span any quarterly boundary (e.g., 09/29-10/29) bypass edit 1 if the diagnosis reported is valid in at least one of the two quarters. If the diagnosis code reported is not valid in either of the two quarters, edit 1 is applied.

Effective 1/1/2015, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis for home health claims submitted

with bill type 32x. Home Health claims submitted with a manifestation code as principal diagnosis are returned to the provider with (edit 86).

Vaccine administration, antigens, splints, and casts are paid under OPPS for hospitals. When these services are provided to patients by HHAs not under an HHA plan of care or under the Home Health PPS (34x), these services are paid under OPPS. Effective January 1, 2017 (v18.0), Negative Pressure Wound Therapy (NPWT), reported with procedure codes 97607 or 97608, are separately payable OPPS services for HHAs when submitted on claims with bill type 34x, Home Health PPS and not under a HHA plan of care. If the NPWT codes are reported as a therapy service (therapy modifier and/or therapy revenue code present for the line), the codes are not processed as "sometimes therapy" and changed to SI=A by the IOCE; the standard SI and APC are retained for payment purposes.

Effective with the July 2018 release (v19.2), HHA claims (bill type 32x) are subject to procedure based edits 6 (Invalid Procedure) and 22 (Invalid Modifier); except in the instance of reporting a HIPPS code with revenue code 0023. Effective with the April 2019 release (v20.1), HHA's (32x) submitting claims with dates of service that span the annual (January) release and the previous quarter do not return edit 6 if the service provided is effective for the reported line item date of service.

Effective with the April 2021 release (v22.1), HHA claims (bill type 32x) reporting a HIPPS code with revenue code 0023 do not have edit 23 applied if the line item date of service is outside the claim From Date and Through Date.

Effective with the October 2021 release (v22.3). home health adjustment claims (bill type 032G) do not have edit 23 applied to any line items that report a service date outside the claim From-Through date.

Home health claims processing not under a home health plan of care

Vaccine administration, antigens, splints, and casts are paid under OPPS for hospitals. When these services are provided to patients by HHAs not under an HHA plan of care or under the Home Health PPS (034x), these services are paid under OPPS.

Discontinued effective January 1, 2024 (v25.0): Effective January 1, 2017 (v18.0), Negative Pressure Wound Therapy (NPWT), reported with procedure codes 97607 or 97608, are separately payable OPPS services for HHAs when submitted on claims with bill type 034x, not under the Home Health PPS and not under a HHA plan of care. If the NPWT codes are reported as a therapy service (therapy modifier and/or therapy revenue code present for the line), the codes are not processed as "sometimes therapy" and changed to SI=A by the IOCE; the standard SI and APC are retained for payment purposes. For the specified lists of services mentioned above please refer to the DATA_HCPCS table within the data files.

Non-excepted items or services in off-campus provider-based hospitals

Effective January 1, 2017 (v18.0), certain items and services, when provided in an off-campus provider-based hospital outpatient department, may be considered non-excepted under Section

603 of the Bipartisan Budget Act of 2015. Non-excepted services are reported with modifier PN (Non-excepted off-campus svc), and are subject to special processing in the IOCE for determination of whether or not payment is to be made or reduced under an alternative method (i.e. Physician Fee Schedule (PFS)). Claims containing certain services that are not allowable with modifier PN are returned to the provider (edit 101). Claims that are reported with two of the following modifiers (PO, PN, or ER) on the same line item are returned to the provider, (edit 102).

Criteria for non-excepted services reported with modifier PN

- Special processing occurs only for hospital outpatient claims with bill type 13x with and without condition code 41, and bill type 76x (effective January 1, 2024, 076x must be reported with either CC 41 or 92 to identify if the claim is for Partial Hospitalization or the Intensive Outpatient Program).
- Non-excepted processing logic occurs after all other IOCE processing.
- Services reported with modifier PN are identified using the Payment Method Flag for determination of payment method or reduction by the OPPS Pricer (PMF 7 or PMF 8).

Hospital outpatient claims with bill type 13x without condition code 41 reporting modifier PN

- Emergency department visits and critical care encounters that have standard assignment under SI = V or S (critical care) are not allowed with modifier PN. Edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.
- Payment Method Flag Value 7 is applied for the following:
  - Services with SI = F, H, L, R and U that are excepted under Section 603
  - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T and V that have Payment Adjustment Flag Value 4, 9, 10, or 25 assigned (preventive services)
  - Certain HCPCS codes for radiation treatment with SI = B when reported with modifier PN have the SI changed to S and are assigned a special APC.

    Note there are other HCPCS codes identified that when reported with modifier PN, remain SI = S and the PMF is set to 7. See the Override_Section_603 column in the Data_HCPCS table for applicable codes.
- Payment Method Flag Value 8 is applied for the following:
  - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T, and V, except for emergency department visits with SI = V and critical care encounters with SI = S.

    Note: HCPCS G0463 for clinic visit with SI = J2 (for comprehensive observation APC) or standard SI = V is always assigned Payment Method Flag 8; regardless of the payment adjustment flag value being 4, 9, or 10. HCPCS G0463 is not included in the list of emergency department visit codes or critical care encounters that are subject to edit 101.
  - Effective January 1, 2019, off-campus provider-based outpatient departments submitting clinic visit HCPCS code G0463 with modifier PO also have payment method

flag of 8 returned, to apply the physician fee schedule reduction in the OPPS Pricer. Note: Modifiers PO and PN cannot be submitted on the same hcpcs line item, edit 102 is returned to the provider.

- Services with SI = A, G, K and N have no impact; Payment Method Flag values 7 and 8 are not applicable.

Hospital outpatient claims with bill type 13x with condition code 41 (PHP) reporting modifier PN

- PHP services with SI = P, reported with modifier PN, have a change in APC assignment to a CMHC PHP APC, with Payment Method Flag 7 applied. Note the CMHC APC may be assigned as Level I or Level II depending upon the number of services reported for a PHP day. See Community Mental Health Center PHP claims (076x w/ CC 41) for additional information regarding the levels.

Note: Non-PHP services reported with modifier PN that may be present on a hospital PHP claim are subject to the logic listed above for claims with bill type 13x without condition code 41.

CMHC PHP outpatient claims with bill type 76x reporting modifier PN

- PHP services with SI = P are not allowed with modifier PN if these services are submitted with modifier PN; edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.
- IOP services with SI = P are not allowed with modifier PN if these services are submitted with modifier PN; edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.

Hospital outpatient (013x) claims with condition code 92 (IOP) Reporting Modifier PN:

Effective January 1, 2024, for intensive outpatient program (IOP) services, non-excepted off-campus provider-based departments of a hospital are required to report a “PN” modifier on each claim line for non-excepted items and services. The use of modifier PN triggers a payment rate under the Medicare Physician Fee Schedule. IOP services with SI = P, reported with modifier PN, have a change in APC assignment to a CMHC PHP APC, with Payment Method Flag 7 applied. Note the CMHC APC may be assigned as Level I or Level II depending upon the number of services reported for a PHP day. See Community Mental Health Center IOP claims (076x w/ CC 92) for additional information regarding the levels.

Hospital off-campus provider-based outpatient departments submitting claims with Modifier PO

- Effective January 1, 2015, modifier PO is added as a valid modifier to voluntarily report items or services furnished in an off-campus provider-based outpatient department of a hospital. Effective January 1, 2016, reporting modifier PO is required to be reported for items or services performed in a hospital off-campus provider-based outpatient department.

- Effective January 1, 2019, off-campus provider-based outpatient departments submitting clinic visit HCPCS code G0463 with modifier PO have payment method flag A returned, to apply a payment reduction in the OPPS Pricer. Note: Modifiers PO, PN, or ER cannot be submitted on the same HCPCS line item, edit 102 is returned to the provider.
- Effective January 1, 2024, for intensive outpatient program (IOP) services, excepted off-campus provider-based departments of a hospital must report existing modifier PO for all excepted items and services furnished.

FQHC processing under FQHC PPS

Effective for claims with From Dates on or after October 1, 2014, claims submitted through the IOCE with bill type 77x for Federally Qualified Health Centers (FQHC) are processed under FQHC PPS. Effective October 1, 2020, claims submitted through the IOCE for bill type 77x (FQHC) with condition code 65, which indicated the claim was not subject to FQHC PPS, are processed under the FQHC PPS. Processing occurs for each date of service if the claim contains multiple dates. FQHC claims are paid under a per encounter basis for qualified clinic visits. Any supporting ancillary services provided on the day of the FQHC visit are packaged into the encounter payment. If the FQHC claim contains multiple dates of service, each day is processed separately through the IOCE. Special output flag values are assigned during FQHC processing under the IOCE to facilitate identification of FQHC payment processing by the Pricer program.

Criteria for FQHC encounters/visit processing logic

FQHC encounters require the reporting of both a unique FQHC payment HCPCS code indicating the type of visit (New or established medical visit, new or established mental health visit, or Initial Preventive Physical Exam/Annual Wellness Visit), and a qualifying visit HCPCS related to the services performed. FQHC claims that do not contain a required FQHC payment HCPCS code are returned to the provider (edit 88). The FQHC HCPCS payment code must be reported with revenue code 519, 52x or 900. FQHC payment HCPCS codes reporting revenue codes other than those listed are returned to the provider (edit 90). FQHC claims that do not contain both the FQHC payment HCPCS code and a qualifying visit code are also returned to the provider (edit 89). The FQHC payment HCPCS code identifies the line where the Pricer program applies the FQHC encounter payment. (For a list of paired qualifying visit codes, reference the MAP_FQHC_VISIT table within the data files.)

Specific revenue code to FQHC payment code requirements are as follows:

- Medical visit codes require revenue code 52x or 519
- Mental health visit codes require revenue code 900 or 519

FQHC encounters for new patient visits or for the IPPE/AWV are identified by the IOCE for additional payment adjustment by the Pricer program. Only one FQHC payment code per day is identified for the new patient/IPPE/AWV payment adjustment.

Payable FQHC payment code lines are flagged with a Payment Indicator (PI) = 10, unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported,

PI= 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. If multiple visits are reported, only one new patient FQHC payment HCPCS is assigned PI=13 per day. Any additional FQHC payment codes present for the same day are assigned PI=10. Qualifying visit codes that accompany the FQHC payment code are flagged with PI=12 and are packaged with Packaging Flag = 5.

If a mental health visit is provided on the same day as a medical clinic visit, both visits are recognized for FQHC encounter payments, providing the claim meets the criteria for payment of each visit, i.e. FQHC payment HCPCS codes are present for each visit, qualifying visit HCPCS codes are present, and appropriate revenue codes are reported.

If there is an additional FQHC payment code for an established medical visit reported on the same day with modifier 59, this indicates that the visit is a subsequent, unrelated illness or injury provided on the same day as another FQHC visit. The subsequent visit may be eligible for FQHC encounter payment, provided the appropriate FQHC visit criteria are met for the established patient FQHC visit reported with modifier 59. Any additional FQHC visits reported on the same day, reported with or without modifier 59, are packaged.

A composite adjustment flag is assigned for lines reporting FQHC payment codes, identifying the type of FQHC visit(s) present for a date of service, whether for: 01) medical visit or IPPE/AWV, 02) mental health visit, or 03) a subsequent visit reported with modifier 59. The composite adjustment flag is used by the Pricer program to identify line item charges associated with each type of FQHC encounter. All FQHC payment codes are assigned a composite adjustment flag by the IOCE; the assignment of the composite adjustment flag has no bearing on whether or not the visit is eligible for separate FQHC encounter payment.

Services with SI = M are not billable to the MAC and are subject to edit 72. Effective 4/1/2018 (v19.1), there is a list of HCPCS codes with SI = M that are reportable for FQHC claims and therefore bypass edit 72 processing. For the list of HCPCS applicable to the edit 72 bypass condition, see the DATA_HCPCS table within the quarterly data files and reference the BYPASS_E72_FQHC_RHC column.

FQHC PPS – SDOH risk assessment processing

For general information about Social Determinants of Health Risk Assessment, see SDOH Risk Assessment, Community Health Integration Services, and Principal Illness Navigation Services.

FQHCs are eligible to furnish an SDOH Risk Assessment as an additional element of an AWV, if provided as an optional element of the AWV (no cost-sharing) in an FQHC or with a FQHC Qualifying Visit G-code (as part of an E/M) (with cost-sharing). With either, the SDOH does not receive separate payment; that is, it is packaged with the AWV or with the FQHC Qualifying Visit.

When an SDOH is furnished as an optional element of the AWV, only one visit is paid the lesser of charges or the FQHC PPS rate with the AWV adjustment for FQHCs. Since coinsurance is not applicable when furnished as part of the same visit and on the same date of service as the AWV, the IOCE assigns Packaging flag = 6.

Example: When SDOH (G0136) is billed as optional element of an AWV with FQHC payment code (G0468) and a qualifying visit code (G0438), FQHCs are paid the lesser of the charges or the PPS rate for the specific payment code, with an adjustment for AWV, and coinsurance is $0.

Additionally, For FQHCs, the SDOH Risk Assessment is not considered a qualifying visit. When the assessment is furnished in conjunction with a qualifying visit (E/M) on the same day in a FQHC, only the visit will be paid under the FQHC PPS and coinsurance will be applicable.

Example: When SDOH (G0136) is billed on the same day as an E/M visit with an FQHC payment code and a qualifying visit code, FQHCs are paid the lesser of the charges or the PPS rate for the specific payment code and coinsurance is applied, the IOCE assigns Packaging flag = 5.

Additional criteria for FQHC processing

Effective January 1, 2016 (v17.0), Grandfathered Tribal FQHC providers are identified by the presence of payer only condition code MG passed to the IOCE on a claim for FQHC PPS services. Claims submitted for Grandfathered Tribal FQHC providers have different encounter requirements than other FQHC PPS providers. Only one visit is payable per day; if multiple visits are present for the same day, the first medical visit (or first mental health visit if no medical visits are reported) is identified to OPPS Pricer for payment with a payment indicator (PI=14); all other visits are packaged.

FQHC PPS - Preventive services

Preventive services under the FQHC PPS shall be packaged into the FQHC encounter payment; however, line items reporting preventive services are subject to a waiver of coinsurance payment. The IOCE shall identify to the Pricer program the FQHC packaged preventive services by way of a specific packaging flag value 6 (FQHC packaged preventive or other reported service not subject to coinsurance payment).

Effective January 1, 2016, Advance Care Planning services reported with code 99497 are considered a preventive service under FQHC PPS when reported with an annual wellness visit (initial or subsequent). If advance care planning is reported with the annual wellness visit it is identified as a packaged preventive service. If advance care planning is reported without the annual wellness visit, it is treated as a qualifying visit code to satisfy the FQHC encounter requirements and is packaged as a qualifying visit code.

Influenza and pneumococcal vaccines and associated vaccine administration services continue to be paid under reasonable cost through the cost report and are not packaged into the FQHC encounter payment. If influenza and/or pneumococcal vaccine and vaccine administration is reported on the FQHC claim, the services are identified for the Pricer program as non-packaged services that are excluded from the FQHC encounter payment (PI=11).

FQHC PPS - Non-covered services

Items or services that are not covered under the FQHC are line item rejected PPS (DME, ambulance, laboratory, and other non-covered services). Non-covered lines are assigned Line Item Action Flag 5 and PI=3, and although SI is ignored under FQHC, all non-covered lines are assigned to SI=E1. If line items with non-covered charges are passed into the IOCE with Line Item Action Flag 5 previously assigned, these lines are not line item rejected.

Note: All line items submitted on a claim with bill type 0770 (No payment claim) are submitted to the IOCE with Line Item Action Flag 5 assigned; edit 91 is not returned for claims with bill type 0770, nor is any other FQHC editing performed.

FQHC non-covered items or services include durable medical equipment submitted with revenue code 29X, ambulance services submitted with revenue code 54X, laboratory services paid under the Clinical Lab Fee Schedule (excluding venipuncture, 36415, which is packaged), hospital-based care, group services and non-face-to-face services.

Effective October 1, 2015 (v16.3), claims containing only FQHC non-covered services reported without a FQHC payment code and qualifying visit code are not returned to the provider.

FQHC PPS – Chronic care management services

Effective 1/1/2016 (v17.0), Chronic Care Management (CCM) services are not packaged under FQHC PPS. If Chronic Care Management is reported, PI = 2 is assigned, indicating that it is paid under the Medicare Physician Fee Schedule. CCM services reported without a FQHC payment code or qualifying visit code bypass edits 88 and 89.

FQHC PPS – telehealth services

Telehealth services (HCPCS Q3014 and G2025) are paid by the Medicare physician fee schedule and are not packaged into the FQHC encounter payment. If applicable FQHC telehealth services are reported on an FQHC claim, the service is processed through the IOCE and identified as a non-packaged service for the Pricer program in order to be processed for fee schedule payment (packaging flag = 0). Effective July 1, 2015 (v16.2), applicable FQHC Telehealth services reported without an FQHC payment code and qualifying visit code are not returned to the provider (edit 88 and edit 89).

FQHC PPS - COVID-19 services

Effective July 1, 2023 (v23.2), the logic for edit 114 is deactivated.

Effective March 18, 2020 (v21.2), FQHC claims with a HCPCS line item(s) reported with modifier CS return payment method flag (PMF) value C. A PMF of C indicates that payment is made by the FQHC PPS and coinsurance is not applicable as the item is a COVID-19 testing-related service. Additionally, modifier CS should only be reported when the item or service is identified by CMS as being eligible for a coinsurance and deductible waiver. If Modifier CS is reported on items or services not eligible for a coinsurance and deductible waiver, edit 114 is returned (RTP). (Refer to the DATA_HCPCS table within the data files for services flagged as coinsurance_deductible_waiver_eligible. Note: FQHC claims do not have deductible applied.

FQHC PPS – Opioid use disorder treatment demonstration

Effective April 1, 2021 (v22.1), Opioid use disorder (OUD) treatment demonstration code G2172 is paid by the Medicare physician fee schedule (payment indicator = 2) and is not packaged into

the FQHC encounter payment (packaging flag =0). OUD treatment demonstration code G2172 if reported without an FQHC payment code or qualifying visit code bypasses edits 88 and 89.

Note: If office-based OUD treatment codes are reported with OUD treatment demonstration code, G2172, without an FQHC payment code or qualifying visit code, edits 88 and 89 are not bypassed.

Effective April 1, 2021, office-based Opioid Use Disorder treatment services (see Data_HCPCS, Opioid Use Disorder Model HCPCS) reported on claims containing condition code M5 (indicating reporting under the Value in Opioid Treatment Demonstration model) set the packaging flag to 6 (FQHC packaged preventive or other reported service not subject to coinsurance payment) in order for the Pricer to not calculate coinsurance payment for these HCPCS.

Intensive Outpatient Program (IOP) processing for FQHCs

For Outpatient Hospital IOP claims processing, see Intensive Outpatient Program Processing for Outpatient Hospitals v25.0- Current

Effective January 1, 2024, FQHCs (bill type 077x) must report condition code 92 when providing intensive outpatient program (IOP) services. For IOP services lines to count towards receiving the IOP composite, they must be reported with revenue code 0905.

At least one primary IOP service is required to receive the IOP encounter payment however, if there are less than 3 IOP services, including the IOP primary, reported for the IOP visit the IOCE assigns information only edit 128. The line-item receiving payment for the IOP encounter is assigned payment indicator = 15 with composite adjustment flag = 4. All other IOP services reported for the same day are packaged with payment indicator = 12 and packaging flag = 5. In the event at least one IOP Primary is not present on a day in which IOP services are reported the same day for an IOP claim, the IOCE returns the claim to the provider with edit 190. Refer to the IOP primary list in the Data_HCPCS table for applicable codes.

Note that for an FQHC IOP encounter, the reporting of either a FQHC payment HCPCS code (indicating the type of visit) or a qualifying visit HCPCS (related to the services performed) is not required. However, for an IOP encounter, in the instance an FQHC qualifying visit code, not included in the IOP composite as an IOP service, is reported without an accompanying FQHC payment HCPCS code, the IOCE returns the claim to the provider with edit 88. Additionally, if a unique FQHC payment code is reported without an accompanying FQHC qualifying visit code, standard FQHC processing criteria applies and the IOCE returns the claim to the provider with edit 89. The FQHC HCPCS payment code must be reported with revenue code 0519, 052x or 0900. FQHC payment HCPCS codes reporting revenue codes other than those listed are returned to the provider with edit 90. See Criteria for FQHC Encounters/ Visit Processing Logic for additional information regarding standard FQHC processing logic.

All line-items submitted on a claim with bill type 0770 (non-payment/zero claim; a claim with only non-covered charges) are not subject to IOP processing. Additionally, as noted in the FQHC PPS – Non-Covered Services section, lines with Line-Item Action Flag 5 assigned; edit 91 is not returned for claims with bill type 0770, nor is any other FQHC editing performed.

Note: There are some services that overlap between the FQHC Non-covered list and services that are reportable for IOP list, these services bypass edit 91 (Item or service not covered under FQHC PPS) when the criteria for an IOP encounter is met for the day.

FQHC IOP and mental health visit processing

On a day in which there is an IOP encounter, and a mental health visit is provided, only one payment is made at the IOP rate, the mental health visit is packaged into the IOP visit for the same day. Note: Mental health services should continue to be reported with revenue code 0900.

For multi-day claims, if a mental health visit is reported on a separate day from the IOP encounter, standard FQHC logic applies for that separate day, a qualifying visit and FQHC payment code with the proper revenue code(s) must be present to avoid RTP edits 88, 89 and/or 90. When these reporting requirements are met, the mental health visit is paid for the day and the payable FQHC payment code lines are flagged with a Payment Indicator (PI) = 10, unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported, PI= 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. Qualifying visit codes that accompany the FQHC payment code are flagged with PI=12 and are packaged with Packaging Flag =5.

FQHC IOP and medical visit processing

On a day in which there IOP services are furnished as part of a medical visit, FQHC standard processing logic still applies to ensure the reporting requirements are met but one payment is made for the medical visit under the FQHC PPS, and one payment is made for IOP encounter at the IOP rate.

Additionally, FQHCs can provide Principal Illness Navigation (PIN) services as part of the IOP benefit. When PIN services are reported for FQHC IOP claims, they are packaged (PI=12 and are packaged with Packaging Flag =5). See applicable services in the PHP_IOP_Reportable column of the Data_HCPCS table.

FQHC IOP processing for Medicare Advantage (MA) organizations

FQHCs that contract with MA organizations, identified with revenue code 0519, receive a wrap-around payment from Medicare to cover the difference when IOP services are reported. To receive the wrap-around payment, FQHCS that contract with MA organizations must report condition code 92, follow the IOP HCPCS code reporting requirements, and report revenue code 0519 for the IOP service line receiving wrap-around payment. When the requirements are met for the IOP service to receive wrap-around payment, the IOCE assigns payment indicator = 16, in addition to CAF = 4.

Note: In the event, a primary IOP service is reported with revenue code 0905 in addition to an IOP primary service reported with revenue code 0519 on the same day, the primary IOP with revenue code 0905 is assigned as the payable IOP visit line for the day.

FPHC IOP processing for Grandfathered tribal FQHC claims

Grandfathered Tribal FQHCs, identified with condition code MG, continue to be paid their PPS rate, not the IOP rate. When payer only condition code 'MG' is present on the claim and the criteria is met for an IOP day (CC 92, IOP primary and revenue code 905 or 519 (MA claims), only one visit is payable per day and the IOCE continues to assign payment indicator = 14 to the applicable visit line, all other visits are packaged.

Rural health clinic visit processing

Rural Health Clinics (RHCs) are healthcare clinics that provide primary outpatient care and preventive services in rural areas of the United States.

Effective 4/1/2016 (v17.1), the non-covered services list for FQHC is applied to RHC (Rural Health Clinic) claims with bill type 071x. Program logic associated with the execution of edit 91 is included for RHC claims, however, the Line Item Action Flag value of 5 is not returned (Note: RHC claims are not subject to any additional FQHC PPS logic).

Services with SI = M are not billable to the MAC and are subject to edit 72. Effective 4/1/2018 (v19.1), there is a list of HCPCS codes with SI = M that are reportable for RHC claims and therefore bypass edit 72 processing. For the list of HCPCS applicable to the edit 72 bypass condition, see the DATA_HCPCS table within the quarterly data files and reference the BYPASS_E72_FQHC_RHC column.

Effective 4/1/2018 (v19.1), certain services deemed incorrectly reported with modifier CG (Policy criteria applied) for RHC claims are line item rejected (edit 104) as not being included in the RHC all-inclusive rate. Effective April 1, 2021, the list of codes incorrectly reporting modifier CG includes office-based Opioid Use Disorder HCPCS.

RHC - Intensive outpatient program processing for RHCs

Effective January 1, 2024, to identify RHCs providing intensive outpatient program (IOP) services, claims must be reported with condition code 92. In addition to condition code 92, IOP services performed must also be reported with revenue code 0905. At least one primary IOP service is required to constitute an IOP visit. In the instance a IOP service is reported on a day without at least one IOP Primary service on the same day, the IOCE returns the claim to the provider with edit 190. See IOP_Primary in the Data_HCPCS for applicable services.

RHCs must also report the CG modifier on the line for payment, along with the charges, for coinsurance to be calculated. In the event that the CG modifier is reported with a service not designated as an IOP primary service, the IOCE returns the claim to the provider with edit 130.

Note that there are some services reportable for an IOP day that would otherwise be applicable to the non-covered services list (edit 91) when reported during standard RHC claims processing. In the instance non-covered services are reported for RHC IOP claims, edit 91 is bypassed.

Religious Nonmedical Health Care Institutions (RNHCI) (043x)

Religious nonmedical health care institutions (RNHCI) provide care and services to people who do not accept conventional medical care because of their religious beliefs. Medicare may cover items and services in religious nonmedical health care institutions (RNHCIs) under special conditions such as inpatient hospital or skilled nursing facility (SNF) care.

In the event that this bill type is reported with condition code 41, the claim is returned to the provider with edit 46.

Chapter 4: Non-OPPS program output

This chapter describes Integrated Outpatient Code Editor (IOCE) program output for non-OPPS claims, including edit information, status indicators, and payment indicators. For a list of Input data elements see "Program input" on page 14.

Versions and date ranges

The following table lists the versions contained in this release of IOCE software for non-OPPS hospital claims processing. The date entered in the program as Date of Service From determines the version used for processing.

Table 23. Program versions

IOCE version	Effective date range
25.1.0	04/01/2024–03/31/2034[a]
25.0.x	01/01/2024–03/31/2024
24.3.x	10/01/2023–12/31/2023
24.2.x	07/01/2023–06/30/2023
24.1.x	04/01/2023–06/30/2023
24.0.x	01/01/2023–03/31/2023
23.3.x	10/01/2022–12/31/2022
23.2.x	07/01/2022–09/30/2022
23.1.x	04/01/2022–06/30/2022
23.0.x	01/01/2022–03/31/2022
22.3.x	10/01/2021–12/31/2021
22.2.x	07/01/2021–09/30/2021
22.1.x	04/01/2021–06/30/2021
22.0.x	01/01/2021–03/31/2021
21.3.x	10/01/2020–12/31/2020
21.2.x	07/01/2020–09/30/2020
21.1.x	04/01/2020–06/30/2020
21.0.x	01/01/2020–03/31/2020
20.3.x	10/01/2019–12/31/2019

IOCE version	Effective date range
20.2.x	07/01/2019–09/30/2019
20.1.x	04/01/2019–06/30/2019
20.0.x	01/01/2019–03/31/2019
19.3.x	10/01/2018–12/31/2018
19.2.x	07/01/2018–09/30/2018
19.1.x	04/01/2018–06/30/2018
19.0.x	01/01/2018–03/31/2018
18.3.x	10/01/2017–12/31/2017
18.2.x	07/01/2017–09/30/2017

a. The ending date of the current version will be modified to the actual ending date with the next release.

Line item information

The program processes input data and generates the following information for each line item on the claim:

- Healthcare Common Procedure Coding System (HCPCS) procedure code
- Service units
- Charge

Dispositions

Each edit is associated with a disposition. For example, there can be a rejection of the line item itself or a rejection of the entire claim. In addition to edit dispositions, the program assigns an overall disposition to the claim. Edit and claim dispositions are discussed in the sections that follow.

Edit disposition

A disposition is assigned based on the presence of any edits on a line. The meaning of each edit disposition is described in the following table. It is possible for a claim to have one or more edits in all dispositions.

Edit disposition definitions

Table 24. Edit disposition definitions

Disposition	Definition
Claim rejection	The provider can correct and resubmit the claim but cannot appeal the rejection.
Claim denial	The provider cannot resubmit the claim but can appeal the denial.
Claim returned to provider (RTP)	The provider can resubmit the claim once the problems are corrected.
Claim suspension	The claim is not returned to the provider, but it is not processed for payment until the Medicare Administrative Contractor (MAC) makes a determination or obtains further information.
Line item rejection	The claim can be processed for payment with some line items rejected for payment (i.e., the line item can be corrected and resubmitted but cannot be appealed).
Line item denial	There are one or more edits that cause one or more individual line items to be denied. The claim can be processed for payment with some line items denied for payment (i.e., the line item cannot be resubmitted but can be appealed).

The Edit disposition summary contains a complete list of program edits and edit dispositions.

Claim disposition

Since a claim can have several edit dispositions assigned to line items, the claim is assigned an overall disposition. Claim disposition values are shown in the following table.

Table 25. List of claim dispositions

Value	Description
0	No edits are present on the claim.
1	The only edits present are for line item denial or rejection.
2	Claim is for multiple days with one or more days denied or rejected.

Value	Description
3	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only post-payment edits.
4	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with only pre-payment edits.
5	Claim is denied, rejected, suspended or returned to provider, or single day claim with all line items denied or rejected, with both post- and pre-payment edits.

Payment information

Non-OPPS payment is not directed by the IOCE.

Edit disposition summary

The following table lists the edits currently applied to non-OPPS hospital outpatient claims. Note that edits are not numbered sequentially; IOCE edits that are not currently applied to non-OPPS hospital claims are not listed. For information on what conditions will generate an edit, as well as relevant important comments for specific edits, see "Non-OPPS program edits" on page 139

Table 26. Edit disposition summary

Edit	Edit disposition
1. Invalid diagnosis code	Claim returned to provider
2. Diagnosis and age conflict	Claim returned to provider
3. Diagnosis and sex conflict (v1.0–v25.1 only)	Claim returned to provider
5. External cause of morbidity code cannot be used as principal diagnosis	Claim returned to provider
6. Invalid procedure code	Claim returned to provider
7. Procedure and age conflict	Line item rejection (Informational Only, no impact to payment)
8. Procedure and sex conflict (v1.0–v25.1 only)	Claim returned to provider

Edit	Edit disposition
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	Line item denial
10. Service submitted for denial	Claim denial
11. Service submitted for FI/MAC review (condition code 20)	Claim suspension
12. Questionable covered service	Claim suspension
13. Separate payment for services is not provided by Medicare	Line item rejection
15. Service unit out of range for procedure[a]	Claim returned to provider
17. Inappropriate specification of bilateral procedure	Line item rejection
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
22. Invalid modifier	Claim returned to provider
23. Invalid date	Claim returned to provider
24. Date out of OCE range	Claim suspension
25. Invalid age	Claim returned to provider
26. Invalid sex	Claim returned to provider
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	Line item rejection
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection
41. Invalid revenue code	Claim returned to provider
44. Observation revenue code on line item with non-observation HCPCS code	Claim returned to provider
46. Partial hospitalization condition code 41 not approved for type of bill	Claim returned to provider
48. Revenue center requires HCPCS	Claim returned to provider
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	Claim returned to provider
51. Observation code G0378 not allowed to be reported more than once per claim	Claim returned to provider
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Line item rejection
54. Multiple codes for the same service[a]	Claim returned to provider
55. Non-reportable for site of service	Claim returned to provider
61. Service can only be billed to the DMERC	Claim returned to provider

Edit	Edit disposition
62. Code not recognized by OPPS; alternate code for same service may be available	Claim returned to provider
65. Revenue code not recognized by Medicare	Line item rejection
67. Service provided prior to FDA approval	Line item denial
68. Service provided prior to date of National Coverage Determination (NCD) approval	Line item denial
69. Service provided outside approval period	Line item denial
72. Service not billable to the Medicare Administrative Contractor	Claim returned to provider
74. Units greater than one for bilateral procedure billed with modifier 50	Claim returned to provider
83. Service provided on or after effective date of NCD non-coverage	Line item denial
84. Claim lacks primary code (v13.0–18.1 only)	Claim returned to provider
86. Manifestation code not allowed as principal diagnosis	Claim returned to provider
88. FQHC payment code not reported for FQHC claim	Claim returned to provider
89. FQHC claim lacks required qualifying visit code	Claim returned to provider
90. Incorrect revenue code reported for FQHC payment code	Claim returned to provider
91. Item or service not covered under FQHC PPS or for RHC	Line item rejection
93. Corneal tissue processing reported without cornea transplant procedure	Line item rejection
94. Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)	Claim returned to provider
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	Claim returned to provider
102. Modifier pairing not allowed on the same line	Claim returned to provider
103. Modifier reported prior to FDA approval date (v19.0 only)	Line item denial
104. Service not eligible for all-inclusive rate	Line item rejection
106. Add-on code reported without required primary procedure code	Line item denial
107. Add-on code reported without required contractor-defined primary procedure code	Line item denial

Edit	Edit disposition
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	Line item denial
110. Service provided prior to initial marketing date	Line item rejection
111. Service cost is duplicative; included in cost of associated biological.	Line item rejection
112. Information only service(s)	Line item rejection
113. Supplementary or additional code not allowed as principal diagnosis	Claim returned to provider
116. Opioid treatment program service not payable outside the opioid treatment program	Claim returned to provider
118. Invalid bill type	Claim returned to provider
119. Invalid claim processing receipt date	Claim returned to provider
120. Incorrect reporting of modifier PT	Claim returned to provider
123. Modifier used after CMS termination date	Claim returned to provider
124. HCPCS reported after CMS termination date	Claim returned to provider
125. Incorrect billing of IMRT planning and delivery	Claim returned to provider
126. Incorrect reporting of telehealth modifier	Claim returned to provider
127. Service not allowed for Part B Inpatient claim	Line item rejection
134. Service provided outside designated approval period	Line item rejection

a. Edits are active only on claims that are more than 7 years old that are processed with previously archived software.

Chapter 5: Non-OPPS program edits

This chapter contains information on the condition(s) which, when present, will generate an edit in the Integrated Outpatient Code Editor (IOCE) program for non-OPPS claims.

At the end of this chapter, see "Special logic information" on page 152 for additional information about specific non-OPPS editing logic in the IOCE.

The following table summarizes when edits are generated and also includes other relevant information. Note that edits are not numbered sequentially; IOCE edits that are not currently applied to non-OPPS hospital claims are not listed. For edit dispositions and overall claim disposition information, see "Dispositions" on page 36.

Edit summary for non-OPPS

Table 27. Edit summary

Edit	Generated when ...
1. Invalid diagnosis code	The principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid. Effective with v22.2, edit 1 is bypassed if a claim with a From-Through date spanning the quarter boundary (e.g., 09/29/-10/01) reports a diagnosis code that is valid in at least one quarter. If the diagnosis code is not valid in either of the quarters edit 1 is applied.
2. Diagnosis and age conflict	The diagnosis code includes an age range, and the age is outside that range.
3. Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim (v1.0–v25.1 only).
5. External cause of morbidity code cannot be used as principal diagnosis	The principal diagnosis code is in the range V00-Y99.
6. Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.
7. Procedure and age conflict	The age of the patient does not fall within the age range(s) designated for the procedure code reported. Note: Ages are based on published CMS/AMA information. This is an information only edit that sets the Line Item Denial Rejection flag = 3.

Edit	Generated when ...
8. Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure coded on the record. This edit is bypassed if condition code 45 is present on the claim (v1.0–v25.1 only).
9. Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	The procedure code is flagged as Non-covered for reasons other than statute exclusion or Revenue code is 099x with SI of E1 and is submitted without a HCPCS code. This edit is bypassed when code G0428 is present with E1. See edit 50 for non-covered statutory exclusions editing.
10. Service submitted for denial	The claim submitted has condition code 21 present. NOTE: Prior to the implementation of v22.0 edit 10 terminated processing early and returned Claim Processed Flag value 3 (Claim could not be processed (edit 10 condition code 21 is present)), and Return Code 20 (Claim was not processed, condition code 21 exists). Effective with v22.0, edit 10 no longer terminates processing but instead just returns the edit and all other edits if present on the claim.
11. Service submitted for MAC review (condition code 20)	The claim has a condition code 20.
12. Questionable covered service	The procedure code has a Questionable covered service flag.
13. Separate payment for services is not provided by Medicare	The claim is OPPS and the bill type is 12x, 13x, 14x, or 76x and the HCPCS code has status indicator E2.
15. Service unit out of range for procedure (inactive)[a]	The maximum units allowed is greater than zero and The sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure and Modifier p is not present or modifier 91 is present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. Units for all line items with the same HCPCS code on the same day are added together when applying this edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS code is on a list of codes that are exempt, the unit edits are not applied.

Edit	Generated when ...
17. Inappropriate specification of bilateral procedure	The same inherent bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant bilateral procedure lines, except when modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code. Exception: For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17. For CAHs (085x), a professional service revenue code (096x, 097x, 098x) must be present on at least one of the multiple occurrences of the same inherently bilateral code to bypass editing.
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The procedure is identified as part of another procedure on the claim coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
22. Invalid modifier	The modifier is not in the list of valid modifier entries and the revenue code is not 540.
23. Invalid date	The service date and/or the from and through dates are invalid. Or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. Edit 10, and edits 23 and 24 for from /through dates, are IOCE program errors that are applicable to each bill type. Exception: Home Health claims (32x) reporting a HIPPS code with revenue code 0023 do not have edit 23 applied if the line item date of service is outside the claim From Date and Through Dates. Home Health adjustment claims (032G) do not have edit 23 applied to any line items that report a service date outside the claim From-Through dates. **Note**: If edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates and processing continues.
24. Date out of OCE range	The From/Through date falls outside the date range of any version of the program. Presence of this edit condition terminates processing for the claim. Edit 10, and edits 23 and 24 for from /through dates, are IOCE program errors that are applicable to each bill type.

Edit	Generated when ...
25. Invalid age	The age field is blank, non-numeric or outside the range of 0-124 years.
26. Invalid sex	The sex field is blank, non-numeric or outside the range of 0-2. This edit is bypassed if condition code 45 is present on the claim.
28. Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare' indicator.
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
41. Invalid revenue code	The revenue code is not in the list of valid revenue codes or the revenue code is reported prior to/exceeding its NUBC effective date. Effective with the July 1, 2021 (v22.2) release, revenue codes are validated based on the claims processing receipt date, as revenue codes are considered a non-medical code set and should be validated not based on claim From-through dates but per the date in which CMS received the claim.
44. Observation revenue code on line item with non-observation HCPCS code	A 762 (observation) revenue code is used with a HCPCS other than G0378 or G0379.
46. Partial hospitalization condition code 41 not approved for type of bill	Bill type 043x is present with condition code 41. Prior to January 1, 2024, edit 46 returned for bill types 012x or 014x when condition code 41 was reported. Edit 46 terminates processing only for those bill types where no other edits are applied.
48. Revenue center requires HCPCS	The bill type is 13x, 74x, 75x, 76x, or 12x/14x without condition code 41, HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed when the revenue code is 100x, 210x, 310x, 099x, 0905-0907, 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932, 0521, 0522, 0524, 0525, 0527, 0528, 0637, or 0948; see also edit 65.
50. Non-covered under any Medicare outpatient benefit, based on statutory exclusion	The HCPCS reported is on 'statutory exclusion' list or the revenue code center reported is on the "statutory exclusion" list with status indicator E1 and submitted without a HCPCS code.

Edit	Generated when ...
51. Observation code G0378 not allowed to be reported more than once per claim	HCPCS code G0378 is reported more than once on a 13x or 85x claim/bill type. The edit is applicable to the subsequent lines of G0378 only. Edit 51 is bypassed if the subsequent G0378 line(s) has a line item action flag of 2, 3, or 4.
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.
54. Multiple codes for the same service[a]	Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035.
55. Non-reportable for site of service	The procedures reported are non-reportable for the site of service indicated.
61. Service can only be billed to the DMERC	The procedure code has a 'DMERC billable only' flag indicator set and SI=Y.
62. Code not recognized by OPPS; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare for OPPS' indicator. Services with a status indicator of B always return edit 62.
65. Revenue code not recognized by Medicare	The revenue code is 100x, 210x, 310x, 0500, 0509, 0583, 0660-0663, 0669, 0905-0907, 0931, or 0932.
67. Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.
68. Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval	The line item date of service of a code is prior to the code activation date as determined by National Coverage Determination (NCD) or approval of a Demonstration.
69. Service provided outside approval period	The service was provided outside the period approved by CMS.
72. Service not billable to the Medicare Administrative Contractor	A code has a status indicator M. This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x. This edit is also bypassed when the bill type is 81x or 82x and the revenue code is 657. **Note**: The status indicator for the HCPCS code is changed from M to A.
74. Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same or multiple lines, and the bill type is 85x with revenue code 96x, 97x, or 98x.

Edit	Generated when ...
83. Service provided on or after effective date of NCD non-coverage	The line item date of service of a code is after the date of non-coverage determination.
84. Claim lacks required primary code	Certain claims are returned to the provider if a specified add-on code is submitted without a code for a required primary procedure on the same date of service (edit 84). Add-on codes 33225, 90785, 90833, 90836 or 90838 are submitted without one of the required primary codes on the same day. **Note**: PHP add-on codes are editing with 84 until version 18.1 where PHP add-on code editing is terminated; add-on editing for 33225 is active until version 16.0. For v15.3–v16.0, FQHC claims reporting psychotherapy add-on codes without a primary service are edited with 84.
86. Manifestation code not allowed as principal diagnosis	A diagnosis code considered to be a manifestation code from the Medicare Code Editor (MCE) manifestation diagnosis list is reported as the principal diagnosis code on a hospice bill type claim 81X, 82X.
88. FQHC payment code not reported for FQHC claim	FQHC payment code not reported for a claim with bill type 77x and without condition code 65. Note: If the bill type is 770 (No payment claim), edit 88 is not applicable. **Note**: Edit 88 is bypassed on FQHC PPS claims that do not report the FQHC payment code for the following: Telehealth originating site services, Chronic Care Management and the Opioid Use Disorder (OUD) Demonstration Model; also edit 88 is bypassed for FQHC when only FQHC non-covered services are present with edit 91.
89. FQHC claim lacks required qualifying visit code	FQHC payment code reported for FQHC claim (bill type is 77x without condition code 65) without a qualifying visit HCPCS. **Note**: Edit 89 is bypassed on FQHC PPS claims that report the FQHC payment code and not the qualifying visit for the following: Telehealth originating site services, Chronic Care Management and the Opioid Use Disorder (OUD) Demonstration Model; also edit 89 is bypassed for FQHC when only FQHC non-covered services are present with edit 91.
90. Incorrect revenue code reported for FQHC payment code	FQHC payment code not reported with revenue code 519, 52X or 900.

Edit	Generated when ...
91. Item or service not covered under FQHC PPS or for RHC	A service considered to be non-covered under FQHC PPS or for RHC is reported.
93. Corneal tissue processing reported without cornea transplant procedure	Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date.
94. Biosimilar HCPCS reported without biosimilar modifier	A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier. This edit applies to v17.0–v19.0 only.
100. Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services.
102. Modifier pairing not allowed on the same line	A line item is reported with a pair of modifiers that have conflicting meaning and should not be reported together. Please reference the data files for a report named Modifier Pairs, which contains an up to date list of modifiers not allowed to be reported on the same line.
103. Modifier reported prior to FDA approval date	A modifier is reported prior to the mid-quarter activation date. This edit applies to v19.0 only.
104. Service not eligible for all-inclusive rate	An RHC claim (71x) is reported with a line containing the CG modifier.
106. Add-on code reported without required primary procedure code	A claim is submitted with a Type I add-on code(s) without the applicable defined primary procedure(s). The edit is returned on the add-on code line(s) when conditions of the edit are not met.
107. Add-on code reported without required contractor-defined primary procedure code	A claim is submitted with a Type II add-on code(s) reported with a professional services revenue code (096x, 097x or 098x), to allow for contractors to review and define the primary procedure on the claim. See Add-on Code Edit Processing for more information.
108. Add-on code reported without required primary procedure or without required contractor-defined primary procedure code	A claim is submitted with a Type III add-on code(s) without a defined primary(s) or contractor defined primary(s) procedure. This edit is returned on the add-on code line(s) when conditions are not met.
110. Service provided prior to initial marketing date	The reported line item date of service of a code is prior to the initial marketing date, for which it can be reported.

Edit	Generated when ...
111. Service cost is duplicative; included in cost of associated biological	The reported line item is considered duplicative as the routine costs of all steps in creating a biological are bundled into the covered benefit, the biological. Any procedure identified as being "bundled into biological," and reported as a line item are rejected. Additionally, this edit is returned if revenue codes 870-873 are submitted as line items with blank HCPCS.
112. Information only service(s)	The reported line item is a non-covered service as it is for informational reporting purposes only. Any HCPCS identified as being an information only service is assigned a non-covered status indicator and is line item rejected and has no impact on payment.
113. Supplementary or additional code not allowed as principal diagnosis	The principal diagnosis code reported is considered supplementary or an additional code and cannot be used as the principal diagnoses. The unacceptable principal diagnosis list is defined by the Medicare Code Editor (MCE), but there are some exclusions to the MCE list due to current OPPS coding requirements and guidelines. Any diagnosis code flagged as being an exclusion to the Unacceptable Principal Diagnosis list does not return edit 113.
114. Item or service not allowed with modifier CS	Modifier CS is reported on an item or service that is not on the coinsurance waiver eligible list. Modifier CS should only be reported on items that are identified by CMS as being eligible for a coinsurance waiver. Refer to the DATA_HCPCS table and column for named coinsurance_waiver_eligible for the list of services that are appropriate to report with modifier CS. (v21.3-24.1 only)
115. COVID-19 lab add-on code reported without required primary procedure	HCPCS U0005 is reported on a claim without one of its primary procedures U0003 or U0004 on the same date of service. (v22.0-24.1 only) **Note**: U0005 may be considered a Type I add-on code but it has been given a separately distinct function than regular addon code edit 106. This add-on code is only subject to edit 115 in the IOCE.
116. Opioid treatment program service not payable outside the opioid treatment program	Opioid Treatment Program HCPCS codes are reported on a bill type that is not approved for an Opioid Treatment Program provider. Opioid Treatment Program HCPCS codes should only be reported on claims with bill types 87x, 13x with condition code 89, or 85x with condition code 89x.

Edit	Generated when ...
118. Invalid bill type	A claim is submitted with a bill type that is not programmed to process in the IOCE. The presence of this edit terminates the processing of the claim, claim processed flag value 1 and return code 18 are provided. Edit 118 is not specified in the Edits by bill type table as this edit can only be applied to bill types that are not programmed in the IOCE.
119. Invalid claim processing receipt date	The claims processing receipt date is invalid (malformed) or the date falls outside the date range of any version of the IOCE program. This edit is an IOCE program error and is applicable to being returned on all programmed bill types. The claim processed flag value 1 and return code 29 are provided if edit 119 is applied.
120. Incorrect reporting of modifier PT	A single day claim or a single date of service on a multiple day claim is submitted with modifier PT present and no Colorectal procedure is reported for the same service date. This edit is returned at the line level. Refer to the DATA_HCPCS table and the column named Colorectal, for a list of procedures that are to be reported in the presence of modifier PT. This edit is also returned for Non-OPPS bill type 085x (Critical Access Hospitals). Note: A line item action flag of 1 overrides this edit when input by the MAC.
123. Modifier used after CMS termination date	The reported claim is submitted with a HCPCS reporting modifier which is after the CMS termination date.
124. HCPCS reported after CMS termination date	The reported claim is submitted with a HCPCS on a date of service after the CMS termination date. Refer to the DATA_HCPCS table and the column named "CMS_Mid-Quarter_Termination" for a list of codes applicable.
125. Incorrect billing of IMRT planning and delivery	A code is present that should not be reported on the same claim as 77301 (Intensity Modulated Radiotherapy planning). Refer to the Map_IMRT table for the list of applicable codes. Note: The applicable codes are not separately reportable on the same claim since they are already included in the APC payment or should not be reported for verification of the treatment field during a course of IMRT.
126. Incorrect reporting of telehealth modifier	A code not flagged as "Telehealth" is present with modifiers 95, GT or GQ. Refer to the Telehealth column in Data_HCPCS for allowable Telehealth service codes as designated by CMS.

Edit	Generated when ...
127. Service not allowed for Part B Inpatient claim	The revenue code reported is not on the allowable list for the Part B Inpatient claim, bill type 12x. **Note**: Edit 127 is bypassed when there is an allowable HCPCS present without a Part B Inpatient billable revenue code. Additionally, this edit is bypassed when condition code W2 is present. For a list of allowable revenue codes, see the Part B Billable Inpatient Revenue list in Data_Revenue. For a list of allowable HCPCS codes, see the Part B Billable Inpatient HCPCS list in Data_HCPCS.
134. Service provided outside designated approval period	The service reported was provided outside of the period approved by CMS.

Edits by bill type for non-OPPS

The bill type is a reference to the UB-04 form locator field 4, which provides information about the type of facility that is reported for claim submission to Medicare. Each Bill Type in the following table is programmed to apply the specified edits if the OPPS flag is set to 2 indicating Non-OPPS processing. If the APC Return Buffer is "Yes," this indicates the Type of Bill if reported has APC payment applied. If the APC Return Buffer is "No," this indicates this Type of Bill does not have APC payment applied. This table contains edit values for applicable bill types that are within the 28 prior quarters (7 years) for each release.

Table 28. Edits by bill type for non-OPPS

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
12x	Hospital Inpatient (Medicare Part B only)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 48, 50, 53, 61, 65, 67, 68, 69, 72, 74, 79, 82, 83, 87, 93, 94, 100, 102, 103, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 120, 123, 124, 127, 134	No
12x with condition code 41	Hospital Inpatient with Partial Hospitalization (Medicare Part B only)	23, 24, 118, 119	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
13x	Hospital Outpatient	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 44, 48, 50, 61, 65, 67, 68, 69, 72, 74, 76, 82, 83, 87, 93, 94, 100, 102, 103, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 120, 123, 124, 134	No
13x with condition code 41	Hospital Outpatient with Partial Hospitalization	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 48, 50, 61, 65, 67, 68, 69, 72, 74, 83, 94, 102, 103, 106, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	No
13x with condition code 89	Hospital Outpatient with Opioid Treatment Program	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 50, 53, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 112, 113, 114, 115, 119, 123, 124, 134	No
013x with condition code 92	Hospital Outpatient with Intensive Outpatient Program services	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 17, 20, 22, 23, 25, 26, 28, 40, 41, 48, 50, 61, 65, 67, 68, 69, 72, 74, 83, 102, 103, 106*, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
14x	Hospital – Laboratory services Provided to Non-Patients	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26,28, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 74, 83, 94, 102, 103, 106, 107, 108, 110, 112, 113, 115, 116, 119, 123, 124, 134	No
14x with condition code 41	Hospital – Laboratory services Provided to Non-Patients with Partial Hospitalization	23, 24, 118, 119	No
22x 23x	Skilled Nursing Inpatient (Medicare Part B Only) Skilled Nursing – Outpatient	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 28, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
32x	Home Health Services under a plan of treatment	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 65, 67, 68, 69, 72, 83, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
34x	Home Health Services not under a plan of treatment with no APC covered services on claim	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 65, 67, 68, 69, 72, 83, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
43x	Religious Non-Medical Health Care Institutions – Outpatient Services	10, 23, 24, 25, 26, 41, 55, 65, 119	No
71x	Clinic – Rural Health (RHC)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 22, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 91, 94, 102, 104, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
72x	Clinic – Hospital or Independent Renal Dialysis Center (ESRD)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 65, 67, 68, 69, 72, 83, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
73x	Clinic – Freestanding	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 79, 83, 106, 107, 108, 110, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
74x	Clinic – Outpatient Rehabilitation Facility (ORF)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
75x	Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
77x	Clinic – Federally Qualified Health Center (FQHC) (v15.3 – Current, FQHC-PPS)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 22, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 88, 89, 90, 91, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
77x	Clinic – Federally Qualified Health Center (FQHC) (Logic prior to v15.3 or CC 65 reported for payment not under the FQHC-PPS, **Discontinued 10/1/2020**)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 23, 24, 25, 26, 41, 48, 50, 53, 55, 61, 65, 67, 69, 72, 94, 106, 107, 108, 110, 112, 113, 114, 115	No
78x	Licensed Freestanding Emergency Medical Facility	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 111, 112, 113, 116, 119, 123, 124, 134	No
81x 82x	Hospice (Non-Hospital Based) Hospice (Hospital Based)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 50, 53, 55, 65, 67, 68, 69, 72, 83, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
83x	Ambulatory Surgery Center (ASC)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 61, 65, 67, 68, 69, 72, 79, 82, 87, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
84x	Freestanding Birthing Center (FBC)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124, 134	No
85x	Critical Access Hospital (CAH)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 17, 20, 21, 22, 23, 24, 25, 26, 28, 37, 40, 41, 44, 50, 51, 58, 61, 65, 67, 68, 69, 72, 74, 76, 79, 82, 83, 87, 93, 94, 100, 102, 103, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 120, 123, 124, 126, 134	No
85x with condition code 89	Critical Access Hospital (CAH) with Opioid Treatment Program	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 55, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 112, 113, 114, 115, 119, 123, 124, 126, 134	No

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
87x	Freestanding Non-Residential Opioid Treatment Program	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 112, 113, 114, 115, 119, 123, 124, 134	No
89x	Special Facility - Other	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 20, 22, 23, 24, 25, 26, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 83, 106, 107, 108, 110, 112, 113, 114, 115, 116, 119, 123, 124, 134	No

Special logic information

This section describes special conditions that apply to the IOCE software program logic for non-OPPS.

Critical Access Hospital (CAH) processing

Critical Access Hospitals (CAHs), identified as bill type 085x, are hospitals that provide a broader range of services in rural areas of the United States, including limited inpatient care and 24-hour emergency services, with a limited number of beds.

NCCI and add-on code editing for CAHs

CAHs submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have NCCI editing applied across facility and professional services appearing on the same day; NCCI editing is applied for the professional services separately from facility services. Additionally, claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have add-on code editing applied across facility and professional services; add on code editing is applied for the professional services separately from facility services.

Bilateral procedure processing for CAHs

Procedures identified as inherent bilateral are codes in which the procedure in and of itself is bilateral. Inherent bilateral procedures are treated as non-bilateral procedures since the bilateralism of the procedure is encompassed in the code. For CAH claims, in the instance that

the same inherent bilateral procedure code is reported by two or more lines or units, on the same service date, then all applicable bilateral procedure lines are line-item rejected with edit 17. Note that edit 17 is bypassed on a day in which an inherent bilateral code is reported for a total of two times, with one of the lines being a professional service revenue code (096x, 097x, 098x) line.

Opioid treatment program processing for CAHs

Hospital provider-based claims reporting bill type 085x (CAH) if submitted with condition code 89 are approved for reporting Opioid Treatment Program services. The presence of condition code 89 indicates that the claim is for Opioid Treatment Program services provided by a licensed Opioid Treatment Program provider.

It is expected that only approved OTP provider types are to report Opioid Treatment Program HCPCS (see Data_HCPCS for a list of HCPCS). If Opioid Treatment Program HCPCS are inappropriately billed on bill types not approved for reporting OTP services, edit 116 is applied.

Colorectal screening services for CAHs

The presence of HCPCS modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) is used to identify when there is a diagnostic or therapeutic procedure or service reported, that was converted from a colorectal cancer screening. If modifier PT is present for either a single day claim or a single date of service on a multiple day claim, there must also be a Colorectal procedure present for the same service date. In the instance that modifier PT is present and there is no Colorectal procedure reported for the same service date, edit 120 (RTP) is returned at the line level. (See the Data_HCPCS table, within the data files, for procedures identified as Colorectal).

Telehealth claims processing for CAHs

Telehealth, also referred to as telemedicine, is the electronic exchange of medical information from one site to another, in the efforts to improve a patient's health outcome. These services are typically done with general audio or internet access via a computer, tablet, smartphone and more recently Virtual Reality (VR) consoles. To report services provided as telehealth, the service must be identified on the list of Medicare telehealth services and reported with an appropriate Telehealth modifier. For a list of applicable Telehealth codes, see the Telehealth column in the Data_HCPCS table. Additionally, for a list of modifiers appropriate for use when reporting a Telehealth service, see the Telehealth column in the Data_Modifier table.

Effective July 1, 2023 (v24.2), For critical access hospitals, bill type 085x, if a HCPCS code, not on the Telehealth list, is reported with modifiers 95, GT, or GQ, the IOCE returns edit 126 (RTP).

Intensive Outpatient Program (IOP) claims processing for CAHs

Critical Access Hospitals (CAHs) providing IOP services for the day, report condition code 92, and continue to pay under 101% of reasonable costs. CAHs are not required to report a primary IOP service HCPCS code for this benefit.

Appendix A: Summary of changes

Modifications made to the current release of the Integrated Outpatient Code Editor (IOCE) are summarized in the following sections.

Software

- Basic changes to accommodate table and date range modifications.
- IOCE will maintain only seven years of programs and codes. The earliest supported version in this release is 18.2.x and the earliest version date is 07/01/17.
- Implemented new return to the provider edit 135 (Claim lacks required device code) when certain device procedures are reported without a required devices on OPPS claims.
- For an FQHC IOP bill type (077x w/ CC 92), logic is corrected retroactively to ensure mental health visits package when performed on the same date of service as an IOP visit. Previously, mental visits were incorrectly paid in addition to IOP visits on the same date of service.
- For an FQHC IOP bill type (077x w/ CC 92), the logic is corrected retroactively to return the composite adjustment flag = 04 (FQHC Intensive Outpatient Program visit) only on the payable IOP service line. Previously, the composite adjustment flag returned for both the paid and packaged lines to identify all the lines within the IOP visit which was incorrect output for FQHCs.
- Correction to the Section 603 logic for Hospital Outpatient PHP (013x w/CC41) to ensure when modifier PN is reported on a PHP day, PHP service with SI = P have a change in APC assignment to a CMHC PHP APC (Level I or Level II), with Payment Method Flag = 7 applied. Previously, the logic did not account for the multi-level PHP APCs when 4 or more services are present.
- Correction to the Section 603 logic for Hospital Outpatient IOP (013x w/CC92) claims to ensure when modifier PN is reported on an IOP day, the IOCE assigns the payable line with SI = P to an applicable CMHC APC and Payment Method Flag = 7.
- Edits 81 and 133 are updated to only be applicable to Hospital Outpatient bill type (013x).
- The logic for an RHC IOP bill type (071x w/ CC 92), is modified retroactively to bypass edit 91 (Item or service not covered under FQHC PPS) for FQHC/RHC non-covered services reported for an IOP visit.
- The logic for edit 17 (Inappropriate specification of bilateral procedure) has been modified retroactively for the following condition when reported for Critical Access Hospitals (bill type 085x):
    - When an inherent bilateral procedure is reported more than once (lines or units) for the same service date, the line-items are rejected with edit 17. Note: This edit is bypassed for lines or units totaling less than 2, for a day in which the same inherent bilateral procedure with a non-professional service revenue code, is reported in addition to an

inherent bilateral procedure with a professional service revenue code (096x, 097x, 098x) on the same day.

- When Principal Illness Navigation Services (PIN) are reported for Partial Hospitalization (PHP) claims, they are assigned to status indicator = N and package into the PHP composite, when requirements are met.
  - Hospital Outpatient (013x w/CC41)
  - Community Mental Health Center (CMHC) (076x w/CC41)
- When Principal Illness Navigation Services (PIN) are reported for Hospital Outpatient Intensive Outpatient Program (IOP) claims, they are assigned to status indicator = N and package into the IOP composite, when requirements are met.
  - Hospital Outpatient (013x w/CC92)
  - Community Mental Health Center (CMHC) (076x w/CC92)
  - Federally Qualified Health Centers (FQHCs) (077x w/CC92)
- Logic for edit 3 (Diagnosis and sex conflict) is discontinued.
- Logic for edit 8 (Procedure and sex conflict) is discontinued.

Edits

- Added mid-quarter edit 67 (FDA approval) to the following HCPCS codes:
  - 90623: 10/20/2023
  - 90589: 11/9/2023
- The following codes had an SI= E1 for 4/1/2023 applied incorrectly during the October 2023 (v24.3) release. These codes are retroactively corrected and SI= E1 (Edit 9- LID) is applied effective 7/1/2023. See Summary of Data Changes for detailed changes.
  - 0001A
  - 0002A
  - 0003A
  - 0004A
  - 0011A
  - 0012A
  - 0013A
  - 0034A
  - 0051A
  - 0031A
  - 0053A

- 0054A
- 0052A
- 0071A
- 0072A
- 0064A
- 0074A
- 0081A
- 0073A
- 0083A
- 0091A
- 0082A
- 0093A
- 0094A
- 0092A
- 0111A
- 0112A
- 0113A
- 91300
- 91301
- 91306
- 91303
- 91305
- 91309
- 91307
- 91308
- 91311

- The following codes are applicable to the PHP_IOP_Reportable list and package (SI changed to N) when reported for PHP and IOP bill types.
  - 97550
  - 97551
  - 97552
  - 96202
  - 96203

- Implemented NCCI v30.1 for April 2024.
- Implemented the Add-on code files for April 2024.

Files

The code description file was updated; diagnosis and/or procedure codes have been updated with current additions, revisions, and deletions.

Tables

Updates were made to the following lists (please review the Quarterly Data Table Reports for additional detail). Due to the new table and file structure for Jan 2020, the tables that are updated that reference a list are specified below.

Updates were made to the following tables and lists:

- DATA_APC
  - Added new APCs and modified descriptions as applicable
- DATA_CAPC
  - Added new CAPCs
- DATA_DX10
  - Applied Unacceptable PDX and age edit restrictions
  - Removed Dx/sex restrictions (edit 3)
- DATA_EDIT_BYPASS
  - Added new edit 135 (Claim lacks required device code)
- DATA_HCPCS
  - Comprehensive APC exclusion list
  - Bypass Edit 92 list
  - Bypass Edit 72 list
  - Deductible Coinsurance N/A list
  - Device
  - Device Dependent Procedure (edit 135)
  - Device Procedure (edit 92)
  - FQHC Flu PPV list
  - FQHC non-covered list (edit 91)
  - IOP Addon

  - IOP Services
  - Mid Quarter Edit list (edit 67)
  - Non-Billable MAC list (edit 72)
  - Non-covered Service List (edit 9)
  - Non-reportable site of services list (edit 55)
  - Part B Billable Inpatient HCPCS
  - PHP Addon
  - PH Services
  - PHP/IOP Reportable (new)
  - Procedure/Age Conflict (edit 7)
  - Removed Procedure/Sex Conflict (edit 8)
  - Section 603 Override
  - Separate payment not provided by Medicare (edit 13)
  - Skin substitutes list (edit 87)
  - Terminated Device Procedure list
  - Vaccine (for HH Vaccine administration)
- DSC_EDIT
  - Added new edit and made description updates as applicable
- MAP_CAPC
  - Complexity Adjusted Code Pairs
- MAP_DEVICE PROCEDURE
  - Added new device dependent procedures and device pairings (edit 135)
- MAP_PH ADDON
  - Services not eligible to count towards PHP or IOP APC
- MAP_S603_OVERRIDE
  - Codes eligible to override section 603 logic
- OFFSET_APC
  - Modifications to offset payment amounts for applicable APCs
- OFFSET_CODEPAIR
  - Pass-through Device Offset Code Pairs modifications
- OFFSET_HCPCS
  - Terminated Device Procedure Offset modifications

The following Data Table Report(s) are updated to include or revise the following fields:

- DATA_HCPCS
  - Device_Dependent_Procedure (edit 135)

  Column Name Modifications
  - Principal_Illness_Navigation is changed to PHP_IOP_Reportable
  - Sometimes_Therapy is changed to Therapy_Conditionally_Paid
- MAP_DEVICE_PROCEDURE
  - Device Procedures and specified devices (edit 135)

Please review the File Layout document for the descriptions of all Data Table Reports, associated fields and field values.

Documentation

The following changes were made to the IOCE Specifications and Summary of Changes documents, IOCE Software Install, User, and PC Manuals:

- Corrected the documentation of the Daily Mental Health Composite APC Processing section for note that edit 133 is only applicable to bill type 013x.
- Both the IOCE Edits Applied by OPPS Hospital Bill Type Table [OPPS Flag = 1] and IOCE Edits Applied by Non-OPPS Hospital Bill Type Table [OPPS Flag = 2] have been updated and corrected for the following:
  - Remove edit 95 from bill type 076x w/CC92
  - Add edit 118 to bill type 014x w/CC41
  - Add edit 135 to applicable OPPS bill types
  - Re-add edit 88 to bill type 077x (OPPS and non-OPPS)
  - Remove edit 81 where not applicable
  - Remove edit 133 where not applicable
  - Add edit 101 to bill type 076c w/CC92
  - Remove edit 46 from bill types 12x and 14x w/CC41
- Community Mental Health Center (CMHC) IOP (076x w/ CC 92) claims work the same way as CMHC PHP (076x with CC41). IOP services with SI = P are not allowed with modifier PN and in the instance these services are submitted with modifier PN; edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.
- Updated the documentation for the Conditional APC Processing section to include additional information regarding logic processing when conditional APCs interact with other specified logic.

- Documentation section for Religious Nonmedical Health Care Institutions (RNHCI) (043x) notes that edit 46 applies.
- Edited Description and Reason for edit generation table:
  - Identified when edits are applied at the claim-level or line-level
  - Updated description for edit 46 as bill types 012x and 014x with CC41 are no longer applicable.
- Updated the SDOH Risk Assessment, Community Health Integration Services, and Principal Illness Navigation Services section to note that PIN services are packaged (SI=N) when reported for PHP or IOP applicable bill types.

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