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Integrated Outpatient Code Editor Software

Installation Manual for Java

v.25.1

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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.

Chapter 1: Introduction

The Integrated Outpatient Code Editor (IOCE) program edits patient data to help identify possible errors in coding. Edits are generated by the program when a possible problem area is detected.

The software also 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.

This chapter contains information on the versions of the software installed in the current release. For a list of edits performed by the program, see "Edits in the software" on page 11 The IOCE Software User's Manual (PBL–020) contains more information on the features and functionality of the program.

The current version of the software was developed and tested in the following environment:

- z/OS version 2.5
- IBM Enterprise COBOL for z/OS 6.2.0
- IBM SDK for z/OS(R), Java Technology Edition version 8
- LE run-time environment

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

Version	Effective date range
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
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 9) will be updated to reflect the versions of the program contained in the current release.

Edits in the software

The following table describes the OPPS edits in the IOCE software. Program edits are described in detail in the Integrated OCE Software User's Manual.

OPPS edits

Table 2. List of OPPS program edits

Edit number	Edit description
1	Invalid diagnosis code
2	Diagnosis and age conflict
3	Diagnosis and sex conflict (v1.0–v25.1 only)
4	Medicare secondary payer alert (v1.0 and v1.1 only)[a]
5	External cause of morbidity code cannot be used as principal diagnosis
6	Invalid procedure code
7	Procedure and age conflict
8	Procedure and sex conflict (v1.0–v25.1 only)
9	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion
10	Service submitted for denial (condition code 21)
11	Service submitted for MAC review (condition code 20)
12	Questionable covered service
13	Separate payment for services is not provided by Medicare (v1.0–v6.3 and v.18.0-)
14	Code indicates a site of service not included in OPPS (v1.0–v6.3 only)[a]
15	Service unit out of range for procedure (Inactive)
16	Multiple bilateral procedures without modifier 50 (v1.0–v6.2 only)[a]
17	Inappropriate specification of bilateral procedure
18	Inpatient procedure

Edit number	Edit description
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]
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present
21	Medical visit on same day as a type T or S procedure without modifier 25
22	Invalid modifier
23	Invalid date
24	Date out of OCE range
25	Invalid age
26	Invalid sex
27	Only incidental services reported
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available
29	PHP/IOP service for non-applicable diagnosis
30	Insufficient services on day of partial hospitalization (v1.0–24.3 only)[a]
31	Partial hospitalization on same day as ECT or type T procedure (v1.0–v6.3 only)[a]
32	Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days (v1.0–v9.3)[a]
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services (v1.0–v9.3)[a]
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria (v1.0–v9.3)[a]
35	Only Mental Health education and training services provided
36	Extensive mental health services provided on day of ECT or type T procedure (v1.0–v6.3 only)[a]
37	Terminated bilateral procedure or terminated procedure with units greater than one
38	Inconsistency between implanted device or administered substance and implantation or associated procedure
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]

Edit number	Edit description
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present
41	Invalid revenue code
42	Multiple medical visits on same day with same revenue code without condition code G0
43	Transfusion or blood product exchange without specification of blood product
44	Observation revenue code on line item with non-observation HCPCS code
45	Inpatient separate procedures not paid
46	Partial hospitalization condition code 41 not approved for type of bill
47	Service is not separately payable
48	Revenue center requires HCPCS
49	Service on same day as inpatient procedure
50	Non-covered under any Medicare outpatient benefit, based on statutory exclusion
51	Observation code G0378 not allowed to be reported more than once per claim
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions (v3.0–v6.3 only)[a]
53	Codes G0378 and G0379 only allowed with bill type 13x or 85x
54	Multiple codes for the same service[a]
55	Non-reportable for site of service
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]
57	E/M condition not met for observation and line item date for code G0378 is 1/1
58	G0379 only allowed with G0378
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis (deleted, retroactive to the earliest included version)[a]
60	Use of modifier CA with more than one procedure not allowed
61	Service can only be billed to the DMERC
62	Code not recognized by OPPS; alternate code for same service may be available

Edit number	Edit description
63	This OT code only billed on partial hospitalization claims (v1.0–v13.3 only)[a]
64	AT service not payable outside the partial hospitalization program (v1.0–v13.3 only)[a]
65	Revenue code not recognized by Medicare
66	Code requires manual pricing
67	Service provided prior to FDA approval
68	Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval
69	Service provided outside approval period
70	CA modifier requires patient discharge status indicating expired or transferred
71	Claim lacks required device code (v6.1–v15.3 only)[a]
72	Service not billable to the Medicare Administrative Contractor
73	Incorrect billing of blood and blood products
74	Units greater than one for bilateral procedure billed with modifier 50
75	Incorrect billing of modifier FB or FC (v8.0–v15.3 only)[a]
76	Trauma response critical care code without revenue code 068x and CPT 99291
77	Claim lacks allowed procedure code (v6.1–v15.3 only)[a]
78	Claim lacks required radiolabeled product (v9.0–v14.3 only)[a]
79	Incorrect billing of revenue code with HCPCS code
80	Mental health code not approved for partial hospitalization
81	Mental health service not payable outside the partial hospitalization program
82	Charge exceeds token charge ($1.00)
83	Service provided on or after effective date of NCD non-coverage
84	Claim lacks required primary code
85	Claim lacks required device code or required procedure code (v13.0–v14.3 only)[a]
86	Manifestation code not allowed as principal diagnosis.
87	Skin substitute application procedure without appropriate skin substitute product code

Edit number	Edit description
88	FQHC payment code not reported for FQHC claim
89	FQHC claim lacks required qualifying visit code
90	Incorrect revenue code reported for FQHC payment code
91	Item or service not covered under FQHC PPS or for RHC
92	Device-intensive procedure reported without device code
93	Corneal tissue processing reported without cornea transplant procedure
94	Biosimilar HCPCS reported without biosimilar modifier (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 (v17.2 only-RTP, v18.3-present, LIR) (Information only)
96	Partial hospitalization interim claim From and Through dates must span more than 4 days (deactivated to implementation date)[a]
97	Partial hospitalization services are required to be billed weekly (deactivated to implementation date)[a]
98	Claim with pass-through device lacks required procedure
99	Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure
100	Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services
101	Item or service with modifier PN not allowed under PFS
102	Modifier pairing not allowed on the same line
103	Modifier reported prior to FDA approval date (v19.0 only)
104	Service not eligible for all-inclusive rate
105	Claim reported with pass-through device prior to FDA approval for procedure
106	Add-on code reported without required primary procedure code
108	Add-on code reported without required primary procedure or without required contractor-defined primary procedure code
109	Code first diagnosis present without mental health diagnosis as the first secondary diagnosis
110	Service provided prior to initial marketing date
111	Service cost is duplicative; included in cost of associated biological
112	Information only service(s)

Edit number	Edit description
113	Supplementary or additional code not allowed as principal diagnosis
114	Item or service not allowed with modifier CS (v21.3-24.1 only)
115	COVID-19 lab add-on code reported without required primary procedure (v22.0-24.1 only)
116	Opioid treatment program service not payable outside the opioid treatment program
117	Token charge less than $1.01 billed by provider
118	Invalid bill type
119	Invalid claim processing receipt date
120	Incorrect reporting of modifier PT
121	Non-covered service reported with inpatient only procedure where patient expired or transferred
122	340B-acquired drug modifier(s) reported inappropriately
123	Modifier used after CMS termination date
124	HCPCS reported after CMS termination date
125	Incorrect billing of IMRT planning and delivery
126	Incorrect reporting of telehealth modifier
127	Service not allowed for Part B Inpatient claim
128	Insufficient services on day of IOP
129	7-day spanning IOP services require a minimum of 9 hours of service
130	Incorrect reporting of modifier on RHC IOP claim
131	Insufficient services on day of PHP
132	Mental health code not approved for Intensive Outpatient Program
133	Mental health service not payable outside the Intensive Outpatient program
134	Service provided outside designated approval period
135	Claim Day lacks required device code
136	Reserved
137	Reserved
138	Reserved
139	Reserved
140	Reserved

Edit number	Edit description
141	Reserved
142	Reserved
143	Reserved
144	Reserved
145	Reserved
146	Reserved
147	Reserved
148	Reserved
149	Reserved
150	Reserved
151	Reserved
152	Reserved
153	Reserved
154	Reserved
155	Reserved
156	Reserved
157	Reserved
158	Reserved
159	Reserved
160	Reserved
161	Reserved
162	Reserved
163	Reserved
164	Reserved
165	Reserved
166	Reserved
167	Reserved
168	Reserved
169	Reserved
170	Reserved
171	Reserved

Edit number	Edit description
172	Reserved
173	Reserved
174	Reserved
175	Reserved
176	Reserved
177	Reserved
178	Reserved
179	Reserved
180	Reserved
181	Reserved
182	Reserved
183	Reserved
184	Reserved
185	Reserved
186	Reserved
187	Reserved
188	Reserved
189	Reserved
190	IOP Primary service not reported for IOP day
191	PHP Primary service not reported for PHP day
192	Reserved
193	Reserved
194	Reserved
195	Reserved
196	Reserved
197	Reserved
198	Reserved
199	Reserved

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

Non-OPPS edits

The following table describes the subset of IOCE edits currently applied to claims from non-OPPS hospitals. Program edits are described in detail in the Integrated OCE Software User's Manual.

Table 3. List of non-OPPS program edits

Edit number	Edit description
1	Invalid diagnosis code
2	Diagnosis and age conflict
3	Diagnosis and sex conflict (v1.0–v25.1 only)
5	External cause of morbidity code cannot be used as principal diagnosis
6	Invalid procedure code
7	Procedure and age conflict
8	Procedure and sex conflict (v1.0–v25.1 only)
9	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion
10	Service submitted for denial (condition code 21)
11	Service submitted for MAC review (condition code 20)
12	Questionable covered service
13	Separate payment for services is not provided by Medicare
15	Service unit out of range for procedure (Inactive)
17	Inappropriate specification of bilateral procedure
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present
22	Invalid modifier
23	Invalid date
24	Date out of OCE range
25	Invalid age
26	Invalid sex
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present
41	Invalid revenue code

Edit number	Edit description
44	Observation revenue code on line item with non-observation HCPCS code
46	Partial hospitalization condition code 41 not approved for type of bill
48	Revenue center requires HCPCS
50	Non-covered under any Medicare outpatient benefit, based on statutory exclusion
51	Observation code G0378 not allowed to be reported more than once per claim
53	Codes G0378 and G0379 only allowed with bill type 13x or 85x
54	Multiple codes for the same service[a]
55	Non-reportable for site of service
61	Service can only be billed to the DMERC
62	Code not recognized by OPPS; alternate code for same service may be available
65	Revenue code not recognized by Medicare
67	Service provided prior to FDA approval
68	Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval
69	Service provided outside approval period
72	Service not billable to the Medicare Administrative Contractor
74	Units greater than one for bilateral procedure billed with modifier 50
83	Service provided on or after effective date of NCD non-coverage
84	Claim lacks required primary code
86	Manifestation code not allowed as principal diagnosis
88	FQHC payment code not reported for FQHC claim
89	FQHC claim lacks required qualifying visit code
90	Incorrect revenue code reported for FQHC payment code
91	Item or service not covered under FQHC PPS or for RHC
93	Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)
94	Biosimilar HCPCS reported without biosimilar modifier (v17.0–v19.0 only)
100	Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services
102	Modifier pairing not allowed on the same line

Edit number	Edit description
103	Modifier reported prior to FDA approval date (v19.0 only)
104	Service not eligible for all-inclusive rate
106	Add-on code reported without required primary procedure code
107	Add-on code reported without required contractor-defined primary procedure code
108	Add-on code reported without required primary procedure or without required contractor-defined primary procedure code
110	Service provided prior to initial marketing date
111	Service cost is duplicative; included in cost of associated biological
112	Information only service(s)
113	Supplementary or additional code not allowed as principal diagnosis
114	Item or service not allowed with modifier CS (v21.3-24.1 only)
115	COVID-19 lab add-on code reported without required primary procedure (v22.0-24.1 only)
116	Opioid treatment program service not payable outside the opioid treatment program
118	Invalid bill type
119	Invalid claim processing receipt date
120	Incorrect reporting of modifier PT
123	Modifier used after CMS termination date
124	HCPCS reported after CMS termination date
126	Incorrect reporting of telehealth modifier
127	Service not allowed for Part B Inpatient claim
134	The service reported was provided outside of the period approved by CMS.

Chapter 2: Installing the software

This chapter describes the installation of the Integrated Outpatient Code Editor (IOCE) software. The installation download contains the compiled object code for the program, written in IBM® Assembler language. It also contains a test database, ancillary description files, and a library of the source programs and load library modules. The following table lists the files contained in the E-download.

Table 4. Installation files

File	Name	Description
1	OBJLIB	Library of object modules
2	SRCLIB	Library of source programs
3	LOADLIB	Library of load programs
4	JAR	Binary jar files and ASCII control files for the Unix system

There are three basic parts to the installation procedure:

1. Downloading all files shown in the preceding table.
2. Running the COBOL test program.
3. Selecting and using the files required for your facility.

Downloading the files

The following table lists physical characteristics of the files, their comparable disk representations, and their space allocations on 3390 disk packs.

Table 5. Installation file characteristics

File	Description	LRECL	BLKSIZE	DSORG Tape	DSORG Disk	Space
1	Sample JCL for program download	80	3120	PS	PO	1 track
2	Library of object modules	80	27920	PS	PO	2 cylinders
3	Installation test database	300	27900	PS	PS	20 cylinders
4	DXDSC English description file	80	27920	PS	PS	10 cylinders
5	HCPCS English description file	55	11000	PS	PS	2 cylinders

File	Description	LRECL	BLKSIZE	DSORG Tape	DSORG Disk	Space
6	APC English description file	130	27950	PS	PS	10 tracks
7	Library of source programs	80	27920	PS	PO	2 cylinders
8	Library of load programs	0	6233	PS	PO	2 cylinders

1. Click the link to download the software.

   We recommend that you save the zipped product file on your computer and then unzip and install the files from that location.

2. Unzip the downloaded product file.

   The program MVS files shown in the preceding table are now in the directory you chose to save the zipped product file. The compiled load modules and the object code for the IOCE Software are now written in Java and Enterprise COBOL for z/OS 6.2.0. Tables are also an integral part of the IOCE Software.

   All required software for executing the IOCE Software programs is contained in the folders in this directory. The directory contains the following folders:

   IMPORTANT! *Load module files and object module files must be FTP'd in BINARY mode.*

   - Miscellaneous library - Sample JCL, test database, and description files.
   - Load library - IOCE load modules
   - Object library - IOCE object modules
   - Source library - IOCE source programs
   - Java jar
   - Environment file

3. FTP the files to the mainframe.

Install the downloaded files

This section assumes you have already downloaded the zipped IOCE product file to your computer and have unzipped that file producing the folders of program files shown in the installation files table (page 23).

Note: Where there is a generic reference v###, the ### represents the program version number. You should replace 251 with the appropriate program version number.

FTP the files

Certain rules must be followed when working with the unzipped program files. JCL in the Miscellaneous folder, LOADLIB, OBJLIB, SRCLIB must be copied to partitioned datasets.

The procedure is explained in detail in the following sections.

Sample JCL

The JCL file library contains sample JCL to run the sample COBOL interface program. The following table lists the files in the JCL library.

Table 6. Files contained in JCL library

Member	Function
BLDPDSE	Sample JCL used for electronic download
COBTEST	Run sample COBOL program
COBTSTGO	Run test database executing LOADLIB members
INSTLCNT	Readme for install test database record counts

The following steps transfer the IOCE JCL library.

1. Allocate a PDSE on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.JCL]
   - RECFM = FB
   - LRECL = 80
   - BLKSIZE = 3120
   - SPACE = (TRK,(2,1,5),RLSE)
2. FTP in ASCII mode all of the files in the JCL library folder into the allocated PDSE defined in step 1 above.

IOCE description files

Use the following steps to download the DXDSC (contains ICD-10-CM), HCPCS, and APC English descriptions. Files are written as sequential data sets. Description files are included for convenience purposes only and downloading them to disk is optional.

HCPCS file consists of a 5-byte code, 3-byte low version number, 3-byte high version number, and description.

APCDSC consists of a 5-byte APC number, 3-byte low version number, 3-byte high version number, and description.

DXDSC consists of a code type indicator (0 for ICD-10-CM), 7-byte code, 3-byte low version number, 3-byte high version number, and description.

APC description file

The following steps transfer the APC description file.

1. Allocate a sequential file on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.APCDSC]
   - RECFM = FB
   - LRECL = 130
   - BLKSIZE = 27950
   - SPACE = (TRK,(10),RLSE)
2. FTP in ASCII mode the description file into the sequential file allocated in step 1 above.
3. Modify the DSN to conform to the naming conventions at your site.

DXDSC description file

The following steps transfer the DXDSC (contains ICD-10-CM description file).

1. Allocate a sequential file on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.OCEAPC.v###.JAVA.DXDSC]
   - RECFM = FB
   - LRECL = 80
   - BLKSIZE = 27920
   - SPACE = (CYL,(10),RLSE)
2. FTP in ASCII mode the description file into the sequential file allocated in step 1.
3. Modify the DSN to conform to the naming conventions at your site.

HCPCS description file

The following steps transfer the HCPCS description file.

1. Allocate a sequential file on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.HCPCSDSC]
   - RECFM = FB
   - LRECL = 55

- BLKSIZE = 11000
- SPACE = (CYL,(2),RLSE)

2. FTP in ASCII mode the description file into the sequential file allocated in step 1 above.
3. Modify the DSN to conform to the naming conventions at your site.

Object library

The OBJLIB folder contains the IOCE library of all programs. The following table lists the files in the object library.

Table 7. System object library members

Number	Name	Description
1	COBTEST	Sample COBOL program
2	OCE251JV	COBOL Java wrapper control program

The following steps transfer the IOCE object library.

1. Allocate a PDSE on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.OBJLIB]
   - RECFM = FB
   - LRECL = 80
   - BLKSIZE = 27920
   - SPACE = (CYL,(2,1,5),RLSE)
2. FTP in BINARY mode all of the files in the object library folder into the PDSE allocated in step 1 above.

Load library

The LOADLIB has been saved as a sequential file, FTPload. Members are listed in the following table. LOADLIB is an optional file.

Table 8. Load library members

Number	Name	Description
1	COBTEST	Sample COBOL program
2	OCE251JV	COBOL Java wrapper control program

The following steps transfer the IOCE load library.

1. Allocate a sequential dataset on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.FTPLOAD]
   - RECFM = FB
   - LRECL = 80
   - BLKSIZE = 3120
   - SPACE = (CYL,(1,5),RLSE)
2. FTP in BINARY mode the file FTPLOAD into the sequential dataset allocated in step 1 above.
3. Allocate a load library (a PDSE) on your mainframe with the following characteristics.
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.LOADLIB]
   - RECFM = U
   - BLKSIZE = 6233
   - SPACE = (CYL,(2,3,5),RLSE)
   - DSNTYPE = (LIBRARY)
4. Create BLDPDSE JCL (shown below).

   Note: BLDPDSE was FTP'd to the mainframe from the JCL library. This JCL will execute the utility, IKJEFT01, a terminal monitor program that will execute TSO commands via batch processing. This will populate the LOAD LIBRARY from the FTP'd load sequential dataset.

   - Add your JOBCARD
   - Modify dataset names as necessary
     - INDATASET = sequential dataset that was FTP'd to the mainframe in step 1 above.
     - DATASET = allocated load library PDSE created in step 3 above.
5. Execute the JCL modified in step 4 above.

Source library

The SRCLIB folder contains the source library with the members shown in the following table.

Table 9. System source library members

Number	Name	Description
1	COBTEST	Sample COBOL program
2	OCE251JV	COBOL Java wrapper control program

The following steps transfer the IOCE source library.

1. Allocate a PDSE on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.SRCLIB]
   - RECFM =FB
   - LRECL = 80
   - BLKSIZE = 27920
   - SPACE = (CYL,(2,2,5),RLSE)
2. FTP in ASCII mode all of the files in the source library folder into the PDSE allocated in step 1 above.

Test database

The TESTDB file contains a test database to test successful execution of the IOCE Software once it has been installed. The test database consists of a series of fixed-format, sequential, 300-byte records.

The following steps transfer the test database.

1. Allocate a sequential file on your mainframe with the following characteristics:
   - DSN = [e.g. YOURID.IOCE.v###.JAVA.TESTDB]
   - RECFM =FB
   - LRECL = 300
   - BLKSIZE = 27900
   - SPACE = (CYL,(20,1),RLSE)
2. FTP in ASCII mode the test database file into the sequential file allocated in step 1 above.
3. Modify the DSN to conform to the naming conventions at your site.

Java jar library

The IOCE version 25.1 software is provided to users to allow them to group IOCE claims using the v25.1 software in a Java® environment and can be called from an outside program.

The following files are needed to execute the IOCE version 25.1 software:

- IOCEMFV251.jar – the jar file to be run by calls from an outside program.

Users wishing to embed this jar in their own applications may do so by invoking the following method:

```
String results = grouper.process(inputRecord)
```

The method takes a String in the specified input format and returns the grouping results as a String in the specified output format.

1. On the USS system, create a folder 'dist' and FTP the modules in the java-jar folders in Binary mode into That folder. ONE member is included: IOCEMFV251.jar file
2. FTP the IOCEENV251 file in ASCII mode and place the file at the same level as the dist folder.
3. Update the above files with the correct path in your environment.
4. Min and max default heap size set to 1024 in the IOCEENV251 file.

Interface methods

Users wishing to embed this jar in their own applications may do so by invoking the following static method:

```
String results = MainframeAPI.process(inputRecord)
```

The method takes a String in the format specified in Table 8 and returns the grouping results as a String in the format specified in Table 9.

An example program (alternative method) that calls the editor might look something like this:

```
public void myProgram() {
```

Note: Input & output formats to/from jar and to/from OO cobol wrapper program IOCE251JV

```
    String inputRecord = null;
    // populate the inputRecord string then send to .process()
    String results = MainframeAPI.process(inputRecord);
    // Review Results
}
```

Running the test program

Note: We strongly recommend running the test program to ensure that the software is correctly installed.

This section describes the COBTEST program provided with the software to allow you to test the results of the installation procedure. COBTEST is a testing and demonstration program that reads a test database and calls the IOCE for each claim. On return from the call, it compares the results to expected results, which are included in the database. If differences are found, error

information, including the number of claims with mismatches, is sent to Sysprint to aid in finding the source of the problem.

The test database consists of a series of fixed-format, sequential, 300-byte records. If the test is successful, the output results will match the expected results record in the test database.

The sample JCL to compile, link, and execute the COBOL test program is member COBTEST see "Sample JCL" on page 25.

Expected test run results

The expected number of claims and records processed in a successful test run of the installation is given in member INSTLCNT in the JCL library folder. A message describing the status of the installation will be the final line reported. Errors will also be reported. The reported errors will include the test database claim number and the actual and expected results.

Record types and layouts

Each record in the test database begins with a letter to indicate its type. The remaining characters of each record depend on the record type.

Basically, there are two types of records: those associated with claims data, and those associated with the processing results (i.e., expected results).

The following two tables list the record types contained in the test database, the source of the kind of information contained in the record, a description of the type of information in the record, and the contents of the record.

Claims record types

Table 10. Claims record types

Type	Description	Contents
C	Header information	Demographic (age, sex, patient status) data, From and Through dates for the claim, OPPS/non-OPPS flag, and a patient ID number

Type	Description	Contents
D	Diagnosis codes	Diagnosis codes 1–28, left-justified; the first three codes are the reason for visit diagnoses (RVDX); the fourth code is the principal diagnosis (PDX); the remaining diagnoses are secondary; input must be contiguous; the program interprets the first blank non-RVDX field as the end of the listing. DX code is listed in first 7 bytes, left-justified, blank-filled. The eighth byte in each dx input space is reserved for POA Indicator (future use).
E	Value codes - part 1	Value codes 1-21
F	Value codes - part 2	Value codes 22-36
L	Line item information	Data for each service applicable to the claim

Processing results types

Table 11. Processing results types

Type	Description	Contents
M	Claim return buffer - part 1	Claim information from OCE251JV return buffer
N	Claim return buffer - part 2	Claim information from OCE251JV return buffer
O	Diagnosis edit buffer - part 1	Diagnoses 1–9 edit information
P	Diagnosis edit buffer - part 2	Diagnoses 10–18 edit information
Q	Diagnosis edit buffer - part 3	Diagnoses 19–28 edit information
R	Line item buffer - part 1	Line item information from APC return buffer and procedure edit buffer
S	Line item buffer - part 2	Line item information from modifier edit buffer, date edit buffer, and revenue edit buffer

Claims records

Each claim in the input file must contain at least 5 input records (C, D, E, F and L, in that order), and may contain as many as 454 input records (1 C record, 1 D record, 1 E record, 1 F record and 450 L records). The end of each claim is detected when the next C record is read, or when the end of the file is reached. Note that pass-through fields, such as provider number, are not included as they have no relevance for testing the software.

The following five tables contain the layouts for the claims record types (C,D,E,F,L) named in "Record types and layouts". The tables give the positions on the record for specific field information, the length of the field, and the field description.

C record layout

Table 12. C record layout

Position	Length	Description
1	1	Uppercase C
2	17	Claim identification number unique to each claim in the input file
19	3	Age (max age = 124); right-justified, blank-filled
22	1	Sex (0=unknown, 1=male, 2=female)
23	8	From date; opening date of claim in yyyymmdd format
31	8	Through date; closing date of claim in yyyymmdd format
39	22	Filler
61	3	Bill type
64	13	National Provider Identifier (NPI)
77	6	CMS Certification Number (CCN); formerly known as OSCAR number
83	2	Patient status code
85	1	OPPS/non-OPPS flag (1=OPPS, 2=non-OPPS; default value=1)
86	60	List of up to 30 two-byte occurrence codes, left-justified, blank-filled; input must be contiguous; the program interprets the first blank field as the end of the listing.

Position	Length	Description
146	60	List of Condition Codes (Max. 30, 2-byte fields) **Note**: Each entry must be contiguous: the first blank condition code is assumed to signify the end of the condition code list.
206	8	Claims Processing Receipt Date (format: YYYYMMDD)
214	87	Optional User Data. Passed directly to output, will not impact OCE logic.

D record layout

Table 13. D record layout

Position	Length	Description
1	1	Uppercase D
2	17	Claim identification number
19	24 (3x8)	List of Reason for Visit (RVDX) Codes Diagnosis codes in positions 1–3 identify the reason for visit diagnoses and may be blank. The RVDX code is listed in the first 7 bytes, left-justified, blank filled. The 8th byte of each diagnosis input space is reserved for POA indicator (future use).
43	8	Principal (PDX) Code Diagnosis code in position 4 identifies the principal diagnosis code and cannot be blank. The PDX code is listed in the first 7 bytes, left-justified, blank filled. The 8th byte of each diagnosis input space is reserved for POA indicator (future use).

Position	Length	Description
51	192 (24x8)	List of Secondary (SDX) Codes Diagnosis codes listed in position 5–28 are secondary diagnosis codes and must be in contiguous locations. The first blank SDX diagnosis code is assumed to signify the end of the diagnosis code list. The SDX code is listed in the first 7 bytes, left-justified, blank filled. The 8th byte of each diagnosis input space is reserved for POA indicator (future use).
243	58	Unused; blank-filled

E record layout

Table 14. E record layout

Position	Length	Description
1	1	Uppercase E
2	17	Claim identification number
19	273 (13x21)	Value codes and amounts The Value code is listed in the first 2 bytes The Value code amount is listed in the last 11 bytes
292	9	Unused; blank-filled

F record layout

Table 15. F record layout

Position	Length	Description
1	1	Uppercase F
2	17	Claim identification number

Position	Length	Description
19	195 (13x15)	Value codes and amounts The Value code is listed in the first 2 bytes The Value code amount is listed in the last 11 bytes
214	87	Unused; blank-filled

L record layout

Table 16. L record layout

Position	Length	Description
1	1	Uppercase L
2	17	Claim identification number
19	3	Line item ID number unique to each line item within the claim
22	5	HCPCS procedure code
27	10 (5x2)	HCPCS modifiers. May be blank; up to 5, 2-character modifiers allowed per single line item; validated in the order received.
37	8	Service date in yyyymmdd format, required for all line items as of 10/01/2003
45	4	Revenue code; right-justified, zero or blank-filled
49	9	Service units; right-justified, zero-filled, a blank or zero value defaults to 1
58	10	Charge; right-justified, zero-filled; used by pricer; pic 9(8)v99 format
68	1	Line item action flag
69	12	Contractor bypass edits; 4, 3-byte alpha-numeric characters allowed per single line item; right-justified, zero-filled, default: 000
81	5	Contractor bypass APC; Alphanumeric; right-justified, zero-filled, default: 00000 Non-OPPS claim defaults to blanks. OPPS claim, defaults to 00000.

Position	Length	Description
86	2	Contractor bypass status indicator; Alphanumeric; right-justified, zero-filled, default: 00 **Note:** If the SI value is one character, it must be reported with a leading blank value instead of 0 (example, " bA" "A")
88	2	Contractor bypass payment indicator; Alphanumeric; blank-filled, default: b0
90	1	Contractor bypass discounting formula; Numeric; zero-filled, default: 0
91	1	Contractor bypass line item denial or rejection flag; Numeric; zero-filled, default: 0
92	1	Contractor bypass packaging flag; Numeric; zero-filled, default: 0
93	2	Contractor bypass payment adjustment flag 1. **Note**: Accepts numeric values only.
95	1	Contractor bypass payment method flag
96	2	Contractor bypass payment adjustment flag 2. **Note**: Accepts numeric values only.
98	203	Unused

Processed records

The following tables contain the layouts for the processing results record types (M,N,O,P,Q,R,S) named in "Record types and layouts". The tables give the positions on the record for specific field information, the length of the field, and the field description. The data in these records is compared against the actual results.

M record layout

Table 17. M record layout

Position	Length	Description
1	1	Uppercase M
2	17	Claim identification number (copied from C record)

Position	Length	Description
19	1	Claim processed flag
20	1	Overall claim disposition
21	1	Claim rejection disposition
22	1	Claim denial disposition
23	1	Claim returned to provider disposition
24	1	Claim suspension disposition
25	1	Line item rejection disposition
26	1	Line item denial disposition
27	12	Claim rejection reasons (4 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
39	24	Claim denial reasons (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
63	90	Claim return to provider re.asons (30 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
153	130	Payer Value Code and Payer Value Code Amount. 10 thirteen-character fields (2-character value code (QN-QW) followed by 11-character amount (nnnnnnnnnnn.nn*)). Assigned by IOCE based on criteria for APC payment offset. QN–First APC device offset QO–Second APC device offset QP–Placeholder reserved for future use QQ - Terminated procedure with pass-through device OR condition for device credit present QR–First APC pass-through drug or biological offset QS–Second APC pass-through drug or biological offset QT–Third APC pass-through drug or biological offset

Position	Length	Description
		QU–Condition for device credit present QV–Reserved for future use Assigned by IOCE based on PHP weekly processing criteria QW–Partial week present on interim PHP claim **Note**: The value code amount following Payer Value Code QW, zero-fill the first 4 values, the next 5 values represent an IOCE calculated amount for total days and hours of PHP services. One byte for days and 4 bytes to record full and partial hours. For example, 2 days and 8 and ½ hours converts to the following value code amount 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.
283	18	Unused; blank-filled

N record layout

Table 18. N record layout

Position	Length	Description
1	1	Uppercase N
2	17	Claim identification number (copied from C record)
19	48	Claim suspension reasons (16 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
67	36	Line item rejection reasons (12 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.

Position	Length	Description
103	18	Line item denial reasons (6 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
121	1	APC return buffer flag
122	13	NPI (National Provider Identifier -- from input)
135	6	CMS Certification Number (from input)
141	3	Number of line items (from input)
144	8	ID of the software version used to process the claim in yy.vv.rr format; left-justified and blank-filled
152	2	Patient status code, transferred from input
154	1	OPPS/non-OPPS flag, transferred from input
155	1	Non-OPPS Bill Type Flag 0 = N/A 1 = Bill type should be 83x (v8.2–v8.3 only) 2 = Bill type should not be 83x
156	20	Condition codes (10 codes, 2-byte fields, used for output)
176	2	Claim return code. Two digit code that describes how the claim processed successfully, or if errors occurred, which prevented further processing.
178	123	Unused; blank-filled

O record layout

Table 19. O record layout

Position	Length	Description
1	1	Uppercase O
2	17	Claim identification number (copied from C record)

Position	Length	Description
19	24	Diagnosis 1 (RVDX1) edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
43	24	Diagnosis 2 (RVDX2) edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
67	24	Diagnosis 3 (RVDX3) edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
91	24	Diagnosis 4 (PDX) edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
115	24	Diagnosis 5 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
139	24	Diagnosis 6 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
163	24	Diagnosis 7 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
187	24	Diagnosis 8 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
211	24	Diagnosis 9 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
235	66	Unused; blank-filled

P record layout

Table 20. P record layout

Position	Length	Description
1	1	Uppercase P
2	17	Claim identification number (copied from C record)

Position	Length	Description
19	24	Diagnosis 10 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
43	24	Diagnosis 11 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
67	24	Diagnosis 12 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
91	24	Diagnosis 13 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
115	24	Diagnosis 14 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
139	24	Diagnosis 15 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
163	24	Diagnosis 16 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
187	24	Diagnosis 17 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
211	24	Diagnosis 18 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
235	66	Unused; blank-filled

Q record layout

Table 21. Q record layout

Position	Length	Description
1	1	Uppercase Q
2	17	Claim identification number (copied from C record)

Position	Length	Description
19	24	Diagnosis 19 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
43	24	Diagnosis 20 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
67	24	Diagnosis 21 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
91	24	Diagnosis 22 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
115	24	Diagnosis 23 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
139	24	Diagnosis 24 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
163	24	Diagnosis 25 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
187	24	Diagnosis 26 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
211	24	Diagnosis 27 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
235	24	Diagnosis 28 edits (8 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
259	42	Unused; blank-filled

R record layout

Table 22. R record layout

Position	Length	Description
1	1	Uppercase R
2	17	Claim identification number (copied from C record)
19	3	Line item number (copied from the L record associated with these edits)
22	5	Payment APC Note: Zero is returned on non-OPPS claims.
27	5	HCPCS APC
32	2	Status indicator[a]; right-justified, blank-filled
34	2	Payment indicator[a]; right-justified, blank-filled
36	1	Discounting formula[a]
37	1	Line item denial or rejection flag[a]
38	1	Packaging flag[a]
39	2	Payment adjustment flag 1[a]; right-justified, blank-filled
41	1	Payment method flag[a]
42	9	Service units (from input)
51	90	Procedure edits (30 three-byte fields). Edit lists are left justified, blank filled. Edits are right justified, zero filled.
141	5	HCPCS procedure code (from input)
146	1	Line item action flag[a] (from input)
147	2	Composite Adjustment Flag
149	4	HCPCS-Modifier (2x2) (future use)
153	2	Payment Adjustment Flag 2[a]; right-justified, blank-filled (future use)
155	146	Unused

a. Not activated for claims with OPPS flag = 2 (blanks are returned in the APC return buffer), unless the contractor edit bypass logic is applied and Payment Method Flag of Y or Z is output to identify that the lines(s) payment is determined by the contractor.

S record layout

Table 23. S record layout

Position	Length	Description
1	1	Uppercase S
2	17	Claim identification number (copied from C record)
19	3	Line item number (copied from the L record associated with these edits)
22	12	Modifier 1 edits (4 three-byte fields). Edit lists are left-justified, blank filled. Edits are right justified, zero filled.
34	12	Modifier 2 edits (4 three-byte fields). Edit lists are left-justified, blank filled. Edits are right justified, zero filled.
46	12	Modifier 3 edits (4 three-byte fields). Edit lists are left-justified, blank filled. Edits are right justified, zero filled.
58	12	Modifier 4 edits (4 three-byte fields). Edit lists are left justified, blank filled. Edits are right-justified, zero filled.
70	12	Modifier 5 edits (4 three-byte fields). Edit lists are left justified, blank filled. Edits are right-justified, zero filled.
82	12	Date edits (4 three-byte fields). Edit lists are left-justified, blank filled. Edits are right justified, zero filled.
94	15	Revenue edits (5 three-byte fields). Edit lists are left-justified, blank filled. Edits are right justified, zero filled.
109	10	Charge (from input)
119	182	Unused; blank-filled

Chapter 3: Interfacing with the software

Information is passed to the Integrated Outpatient Code Editor (IOCE) program by means of pointers in a control block that functions as the main point of reference for locating input data and determining where to place output information.

Interface functions

To execute the IOCE program, you must write an interface program that will perform the following functions:

- Format the input as required
- Call the OCE251JV main program
- Act on the output information returned

If for any reason the program terminates with a fatal error, see return codes on page 81

Interface test and template

A COBOL test interface program, called COBTEST, is included with the software. The main purpose of COBTEST is to ensure that the installation was performed correctly, but it also serves as a template for users. For a description of COBTEST, see "Running the test program" on page 30. For a description of the source code included in the source library, see "Source library" on page 28.

The control block

The total length of the input buffer is 35,083 bytes. The expected format of the input for this program is outlined in the following table:

Table 24. Input format to invoke jar and to call OO Cobol wrapper program OCE251JV

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
17	1	17			Claim Identifier. This ID must be unique to each claim in the input file.
3	18	20			Age (0-124)
1	21	21			Sex. See sex codes table.
8	22	29			Start Date. Starting date of claim (format: YYYYMMDD)

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
8	30	37			End Date. Ending date of claim (format: YYYYMMDD)
3	38	40			Bill Type
13	41	53			NPI Medicare Provider Number
6	54	59			CMS Certification Number
2	60	61			Patient Status Code
1	62	62			OPPS/Non-OPPS flag. [1=OPPS; 2=Non-OPPS]
60	63	122			List of Occurrence Codes (Occurrences. 30, 2-byte fields)
60	123	182			List of Condition Codes (Occurrences. 30, 2-byte fields)
24	183	206			List of Reason for Visit (RVDX) Codes (Occurrences. 3, 8-byte fields)
8	207	214			Primary (PDX) Codes (Occurrences. 1, 8-byte field)
192	215	406			List of Secondary (SDX) Codes (Occurrences. 24, 8-byte fields)
468	407	874			Value Codes and Amounts (Occurrences. 36, 13-byte fields, Input)
8	875	882			Receipt Date. Receipt date of claim (format: YYYYMMDD)
1	883	883			Debug Flag='1' = on, off for anything else (for internal use only)
8	884	892	1	8	Service Date (format: YYYYMMDD)
4	892	896	9	12	Revenue Code
5	896	901	13	17	Procedure Code
10	901	911	18	27	List of Procedure Modifiers (Occurrences. 5, 2-byte fields)
9	911	920	28	36	Service Units
10	920	930	37	46	Charge
1	930	931	47	47	Line Item Action Flag
12	931	943	48	59	Contractor Bypass Edits (Occurrences. 4, 3-byte fields)

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
5	943	948	60	64	Contractor Bypass APC Note: Accepts alphanumeric APC values.
2	948	950	65	66	Contractor Bypass Service Indicator Note: Accepts alphanumeric service indicator values. Single character SI's must be right justified with spaces.
2	950	952	67	68	Contractor Bypass Payment Indicator
1	952	953	69	69	Contractor Bypass Discounting Formula Note: Accepts numeric values only.
1	953	954	70	70	Contractor Bypass Line Item Denial/Rejection Flag Note: Accepts numeric values only.
1	954	955	71	71	Contractor Bypass Packaging Flag Note: Accepts numeric values only.
2	955	957	72	73	Contractor Bypass Payment Adjustment Flag 1 Note: Accepts numeric values only.
1	957	958	74	74	Contractor Bypass Payment Method Flag
2	958	960	75	76	Contractor Bypass Payment Adjustment Flag 2 Note: Accepts numeric values only.

The total length of the output buffer is 97840 bytes. The expected format of the output from this program is outlined in the following table:

Table 25. Output format from jar and OO Cobol wrapper program OCE251JV

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
17	1	17			Claim Identifier. This ID must be unique to each claim in the input file.
1	18	18			Claim Processed Flag
1	19	19			Overall Claim Disposition
1	20	20			Claim Rejection Disposition
1	21	21			Claim Denial Disposition

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
1	22	22			Claim Returned to Provider Disposition
1	23	23			Claim Suspension Disposition
1	24	24			Line Item Rejection Disposition
1	25	25			Line Item Denial Disposition
12	26	37			List of Claim Rejection Edits (Occurrences. 4, 3-byte fields)
24	38	61			List of Claim Denial Edits (Occurrences. 8, 3-byte fields)
90	62	151			List of Claim Return to Provider Edits (Occurrences. 30, 3-byte fields)
48	152	199			List of Claim Suspension Edits (Occurrences. 16, 3-byte fields)
36	200	235			List of Line Item Rejection Edits (Occurrences. 12, 3-byte fields)
18	236	253			List of Line Item Denial Edits (Occurrences. 6, 3-byte fields)
1	254	254			APC/ASC Return Buffer Flag
8	255	262			OCE Version Used to Process Claim (format: YY.VV.RR, e.g. 2.1.0)
1	263	263			Nopps Bill Flag [1=Bill Type should be 83x; 2=Bill Type should not be 83x]
130	264	393			Value Codes and Amounts (Occurrences. 10, 13-byte fields, output)
20	394	413			Condition Codes (10 codes, 2-byte fields, used for output)
2	414	415			Claim Return Code
24	416	439			Diagnosis 1 Edits (Occurrences. 8, 3-byte fields). (Reason for Visit Diagnosis)

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
24	440	463			Diagnosis 2 Edits (Occurrences. 8, 3-byte fields). (Reason for Visit Diagnosis)
24	464	487			Diagnosis 3 Edits (Occurrences. 8, 3-byte fields). (Reason for Visit Diagnosis)
24	488	511			Diagnosis 4 Edits (Occurrences. 8, 3-byte fields). (Principal Diagnosis)
24	512	535			Diagnosis 5 Edits (Occurrences. 8, 3-byte fields)
24	536	559			Diagnosis 6 Edits (Occurrences. 8, 3-byte fields)
24	560	583			Diagnosis 7 Edits (Occurrences. 8, 3-byte fields)
24	584	607			Diagnosis 8 Edits (Occurrences. 8, 3-byte fields)
24	608	631			Diagnosis 9 Edits (Occurrences. 8, 3-byte fields)
24	632	655			Diagnosis 10 Edits (Occurrences. 8, 3-byte fields)
24	656	679			Diagnosis 11 Edits (Occurrences. 8, 3-byte fields)
24	680	703			Diagnosis 12 Edits (Occurrences. 8, 3-byte fields)
24	704	727			Diagnosis 13 Edits (Occurrences. 8, 3-byte fields)
24	728	751			Diagnosis 14 Edits (Occurrences. 8, 3-byte fields)
24	752	775			Diagnosis 15 Edits (Occurrences. 8, 3-byte fields)
24	776	799			Diagnosis 16 Edits (Occurrences. 8, 3-byte fields)
24	800	823			Diagnosis 17 Edits (Occurrences. 8, 3-byte fields)

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
24	824	847			Diagnosis 18 Edits (Occurrences. 8, 3-byte fields)
24	848	871			Diagnosis 19 Edits (Occurrences. 8, 3-byte fields)
24	872	895			Diagnosis 20 Edits (Occurrences. 8, 3-byte fields)
24	896	919			Diagnosis 21 Edits (Occurrences. 8, 3-byte fields)
24	920	943			Diagnosis 22 Edits (Occurrences. 8, 3-byte fields)
24	944	967			Diagnosis 23 Edits (Occurrences. 8, 3-byte fields)
24	968	991			Diagnosis 24 Edits (Occurrences. 8, 3-byte fields)
24	992	1015			Diagnosis 25 Edits (Occurrences. 8, 3-byte fields)
24	1016	1039			Diagnosis 26 Edits (Occurrences. 8, 3-byte fields)
24	1040	1063			Diagnosis 27 Edits (Occurrences. 8, 3-byte fields)
24	1064	1087			Diagnosis 28 Edits (Occurrences. 8, 3-byte fields)
3	1088	1090			LinesProcessed
5	1091	1095	1	5	Payment APC/ASC
5	1096	1100	6	10	HCPCS APC/ASC
2	1101	1102	11	12	Status Indicator
2	1103	1104	13	14	Payment Indicator
1	1105	1105	15	15	Discounting Formula
1	1106	1106	16	16	Line Item Denial or Rejection Flag
1	1107	1107	17	17	Packaging Flag
2	1108	1109	18	19	Payment Adjustment Flag 1
1	1110	1110	20	20	Payment Method Flag
9	1111	1119	21	29	Service Units (output)

LEN	POS-ST	POS-END	POS-ST	POS-END	DESCRIPTION
90	1120	1209	30	119	Procedure Edits (Occurrences. 30, 3-byte fields)
1	1210	1210	120	120	Line Item Action Flag (output)
2	1211	1212	121	122	Composite Adjustment Flag
4	1213	1216	123	126	HCPCS Modifier Output (Occurrences. 4, 2-byte fields)
2	1217	1218	127	128	Payment Adjustment Flag 2
12	1219	1230	129	140	List of Modifier 1 Edits (Occurrences. 4, 3-byte fields)
12	1231	1242	141	152	List of Modifier 2 Edits (Occurrences. 4, 3-byte fields)
12	1243	1254	153	164	List of Modifier 3 Edits (Occurrences. 4, 3-byte fields)
12	1255	1266	165	176	List of Modifier 4 Edits (Occurrences. 4, 3-byte fields)
12	1267	1278	177	188	List of Modifier 5 Edits (Occurrences. 4, 3-byte fields)
12	1279	1290	189	200	List of Date Edits (Occurrences. 4, 3-byte fields)
15	1291	1305	201	215	List of Revenue Edits (Occurrences. 5, 3-byte fields)

Input formats

Descriptions of the input formats are given below.

CLAIM-AGE

The three-byte area containing the numeric age of the patient in years. Values range from 0 through 124.

CLAIM-SEX

The one-byte area containing the code representing the sex of the patient. Values are 0 = unknown, 1 = male, 2 = female.

FROM-DATE

The area containing a contiguous eight-byte area containing the From date in yyyymmdd format. The From date is used to determine which version of the program to run. If the From date is not within the date range for any of the versions, the claim will not be processed (edit 24).

TO-DATE

The area containing a contiguous eight-byte area containing the To date in yyyymmdd format. The To date is used to determine which version of the program to run. If the To date is not within the date range for any of the versions, the claim will not be processed (edit 24).

BILL-TYPE

The area containing the three-byte type of bill used to identify CMHC and claims pending under OPPS. It is presumed that the bill type has been edited for validity by the standard system before the claim is sent to OCE.

NPI

The area containing the 13-byte National Provider Identifier (NPI) value. The NPI is passed to the pricer. Blank-fill if not applicable.

CMS-CERTIFICATION-NUMBER

The area containing the six-byte CMS Certification Number (CCN). The CCN is passed to the pricer. Blank-fill if not applicable.

DISCHARGE-STATUS

The area containing the two-byte patient status value. This field identifies patient status on discharge from the hospital outpatient department (HOPD).

OPPS-NON-OPPS

The area containing the one-byte OPPS/non-OPPS flag (1=OPPS; 2=non-OPPS).

OCCURRENCE-CODES

The area containing up to 30 contiguous two-byte occurrence codes. The first blank code signifies the end of the list.

Condition codes

The area containing up to 30 contiguous two-byte condition codes. The first blank code signifies the end of the list.

Diagnosis codes

The area containing contiguous ICD-10-CM diagnosis codes. Each code field is eight bytes (7 for code, 1 for POA flag). Diagnosis codes apply to the whole claim and are not specific to a line item. Codes are left-justified and blank-filled.

The first three listed diagnoses are assumed to be the patient's reasons for visit diagnoses (RVDX) and may be left blank. The fourth listed diagnosis is assumed to be the principal diagnosis and cannot be blank. Additional diagnoses are secondary and must be in contiguous locations. The first blank non-RVDX diagnosis signifies the end of the list.

VALUE-CODES

The area containing up to 36 contiguous value codes and value code amounts. 2-character Value Code followed by amount (nnnnnnnnnnn.nn*). The first blank code signifies the end of the list.

Note: For the MAC input of Payer Value Code, Z9 (CMS determined mid-quarter termination date), 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) must also be reported. 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.

RECEIPT-DATE

An eight-byte area containing the Claims Processing Receipt Date in yyyymmdd format.

Line item inputs

Contains contiguous line item entries. The first complete blank line item entry signifies the end of the list. Verify that all fields in the line item input are blank and that there are no numeric values in any of the fields following the last valid line item. The line input for each entry must have this structure and contain the information shown in the following table.

Line item input

Table 26. Line item input

Field	Size (bytes)	Number	Comments
Service date	8	1	yyyymmdd format, required for all lines
Revenue code	4	1	Required for all lines
Procedure code	5	1	Left-justified, blank-filled; may be blank
List of procedure modifiers	2	5	The first blank modifier field is assumed to signify the end of the modifier list
Service units	9	1	A blank or zero value defaults to 1
Charge	10	1	Right-justified, zero-filled. Used by pricer; pic 9(8)v99 format.
Line item action flag	1	1	Numeric
Contractor bypass edit	12	4	4 occurrences of 3-byte alphanumeric characters allowed per single line item (12 bytes total); right-justified, zero-filled, default value per occurrence is 000.
Contractor bypass APC	5	1	Alphanumeric; right-justified, zero-filled, default: 00000 Non-OPPS claim defaults to blanks. OPPS claim, defaults to 00000.

Field	Size (bytes)	Number	Comments
Contractor bypass status indicator	2	1	Alphanumeric; right-justified, zero-filled, default: 00 **Note**: If the SI reported has only one character, it must be provided with a leading blank value. Examples: bA _A
Contractor bypass payment indicator	2	1	Alphanumeric; blank-filled, default: b0
Contractor bypass discounting formula	1	1	Numeric; zero-filled, default: 0
Contractor bypass line item denial or rejection flag	1	1	Numeric; zero-filled, default: 0
Contractor bypass packaging flag	1	1	Numeric; zero-filled, default: 0
Contractor bypass payment adjustment flag 1	2	1	Numeric; right-justified, zero-filled, default: 00
Contractor bypass payment method flag	1	1	Alphanumeric; zero-filled, default: 0
Contractor bypass payment adjustment flag 2	2	1	Numeric; right-justified, zero-filled, default: 00

Line item action flag

This flag is a variable set by the Medicare Administrative Contractor (MAC). It is used in the determination of the discount formula, and is also passed by the system to the pricer. Values are shown in the following table.

Line item action flag values

Table 27. Line item action flag values

Value	Description
0	OCE line item denial or rejection is not ignored.
1	OCE line item denial or rejection is ignored.
2	External line item denial. Line item is denied even if no OCE edits.
3	External line item rejection. Line item is rejected even if no OCE edits.
4	External line item adjustment. Technical charge rules apply.
5	Non-covered service excluded from payment under FQHC PPS.

Output formats

Descriptions of the output formats are given below.

Data in each return buffer is positionally representative of the source it contains information for, in the order in which that source was passed to the program. For example, the seventh diagnosis return buffer contains information on the seventh diagnosis, and the fourth modifier edit buffer contains information on the modifiers in the fourth line item.

Claim return fields

The following table contains the layout of the claim return buffer which summarizes the edits occurring on the claim.

Table 28. Claim return fields

Name	Size (bytes)	Number	Description
Claim processed flag	1	1	0 - Claim processed 1 - Claim could not be processed (edits 23, 24, 46, 118, 119) 2 - Claim could not be processed (claim has no line items) 3 - Claim could not be processed (Reserved) 4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted; exit immediately. 9 - Fatal error; OCE cannot run - the environment cannot be set up as needed; exit immediately.
Overall claim disposition	1	1	0 - No edits present on claim 1 - The only edits present are for line item denial or rejection 2 - Multiple-day claim with one or more days with lines that are 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
Claim rejection disposition	1	1	0 - Claim not rejected 1 - One or more edits are present that cause the claim to be rejected 2 - One or more edits are present that cause one or more days of a multiple-day claim to be rejected

Name	Size (bytes)	Number	Description
Claim denial disposition	1	1	0 - Claim not denied 1 - One or more edits are present that cause the claim to be denied 2 - One or more edits are present that cause one or more days of a multiple-day claim to be denied, or single day claim with all lines denied (edit 18 only)
Claim returned to provider disposition	1	1	0 - Claim is not returned to provider 1 - One or more edits are present that cause the claim to be returned to provider
Claim suspension disposition	1	1	0 - Claim is not suspended 1 - One or more edits are present that cause the claim to be suspended
Line item rejection disposition	1	1	0 - No line items are rejected 1 - One or more edits are present that cause one or more line items to be rejected
Line item denial disposition	1	1	0 - No line items are denied 1 - One or more edits are present that cause one or more line items to be denied
Claim rejection reasons	3	4	Three-digit code specifying the edits that caused the claim to be rejected. The edit that causes a claim to be rejected is 27.
Claim denial reasons	3	8	Three-digit code specifying the edit that caused the claim to be denied. The edit that causes a claim to be denied is 10.
Claim returned to provider reasons	3	30	Three-digit code specifying the edits that could cause the claim to be returned to the provider. Edits that cause a claim to be returned to provider are 1-3, 5, 6, 8, 14-17, 21-23, 25, 26, 29, 35, 37-38, 41-44, 46, 48, 50-52, 54-56, 58, 60-63, 70-74, 79-82, 86-90, 92, 96-102, 109, 113, 114, 116, 118-119, 120, 122-126, 130, 132-133, 135, 190-191.
Claim suspension reasons	3	16	Three-digit code specifying the edits that caused the claim to be suspended. Edits that cause a claim to be suspended are 11, 12, 24, 57, 66.
Line item rejection reasons	3	12	Three-digit code specifying the edits that caused the line item to be rejected. Edits that cause a line item to be rejected are 7, 13, 17, 20, 28, 40, 45, 47, 53, 65, 76, 91, 93, 95, 104, 110-112, 117, 122, 127-129, 131, 134.

Name	Size (bytes)	Number	Description
Line item denied reasons	3	6	Three-digit code specifying the edits that caused the line item to be denied. Edits that cause a line item denial are 9, 18, 30, 49, 67-69, 83, 103, 105-108, 115, 121.
APC return buffer flag	1	1	0 - APC return buffer filled in with default values; no services paid under OPPS 1 - APC return buffer filled in; one or more services paid under OPPS
Version used	8	1	ID of the program version used to process the claim in yy.vv.rr format (e.g., 4.1.5)
Non-OPPS bill type flag	1	1	Denotes whether the type of bill should or should not be 83x. (0=N/A; 1=Bill type should be 83x (v8.2–v8.3 only); 2=Bill type should not be 83x)
Payer Value Code and Payer Value Code Amount	13	10	Assigned by IOCE based on criteria for APC payment offset. 2-character Value Code followed by amount (nnnnnnnnnnn.nn*) zero-filled right justified QN–First APC device offset QO–Second APC device offset QP–Placeholder reserved for future use QQ–Terminated procedure with pass-through device OR condition for device credit present QR–First APC pass-through drug or biological offset QS–Second APC pass-through drug or biological offset QT–Third APC pass-through drug or biological offset QU–Condition for device credit present QV–Reserved for future use Assigned by IOCE based on PHP weekly processing criteria QW–Partial week present on interim PHP claim **Note**: If offset conditions do not exist, the value code label (QN-QW) is blank.

Name	Size (bytes)	Number	Description
Payer condition code	2	10	Payer-only Condition Code assigned by IOCE based on PHP weekly processing criteria MP–PHP Claim contains initial admit week MQ–PHP Claim contains final discharge week MV–Second portion of combined PHP week is not 20 hours
Return code	2	1	Two-digit code that describes how the claim processed successfully, or if errors occurred, which prevented further processing. Valid values are 00-29. A value other than 0 indicates that a fatal error has occurred. See Fatal errors for more information on these codes.

Diagnosis code edits

There is one 8 x 3 diagnosis edit return buffer for each of up to 28 diagnoses. Each three-digit code specifies an edit that applied to the diagnosis. Edits 1-5, 29, 86, 109, and 113 apply to diagnoses.

Number of line items

Up to 450; right-justified, zero-filled.

Line item return data

The area containing the APC return buffer, one for each of up to 450 line items. For a description of the Line item return data.

Line item return data

The following table contains the layout of the APC return buffer.

Table 29. Line item return data

Name	Size (bytes)	Description
Payment APC	5	APC used to determine payment. If no APC assigned to line item, the value 00000 is assigned. For partial hospitalization and some inpatient-only, and other procedure claims, the payment APC may be different than the APC assigned to the HCPCS code.
HCPCS APC	5	Alphanumeric value. APC assigned to the HCPCS code.
Status indicator[a]	2	Right-justified, blank-filled. Values are: A - Services not paid under OPPS; paid under fee schedule or other payment system (Effective 1/1/2023- Includes Unclassified drugs and biologicals reportable under HCPCS code C9399) 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 - Hospital Part B 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

Name	Size (bytes)	Description
		Q1 - STV-packaged codes Q2 - T-packaged codes Q3 - Codes that may be paid through a composite APC Q4 - Conditionally packaged laboratory service 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

Name	Size (bytes)	Description
Payment indicator[ar]	2	Right-justified, blank-filled. Values are: 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 E1, E2, M, Q, Q1, Q2, Q3, Q4, 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)[r] 6 - Payment based on charge adjusted to cost (status indicator H) 7 - Additional payment for new drug or new biological[g] 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) 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

Name	Size (bytes)	Description
Discount formula number[a]	1	One of the following nine discount formulas can be applied to a line item: 1 - 1.0 2 - (1.0 + D(U-1))/U 3 - T/U 4 - (1 + D)/U 5 - D 6 - TD/U 7 - D(1 + D)/U 8 - 2.0 9 - 2D/U Where D = discounting fraction (currently 0.5), U = number of units, T = terminated procedure discount (currently 0.5) Note: Effective 1/1/08 (v9.0), formula #6 and #7 are discontinued.
Line item denial or rejection flag[a]	1	0 - Line item is not denied or rejected 1 - Line item is denied or rejected (procedure edit return buffer for line item contains a 9, 13, 17, 18, 20, 28, 30, 40, 45, 47, 49, 53, 64-65, 67-69, 76, 83, 91, 93, 103-108, 110-112, 115, 117, 122, 127-129, 131, 134) 2 - The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/01/02 - v.3.0) 3 - Line item not denied or rejected; identified for informational alert only **Note**: If LIDR flag is set to 3, it may be overridden by LIDR flag 1 or 2 if other LID or LIR edits are present for the same line.
Packaging flag[a]	1	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)[c] 3 - Artificial charges for surgical procedures (submitted charges for surgical HCPCS < $1.01)[t] 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

Name	Size (bytes)	Description
Payment adjustment flag 1[a]	2	Right-justified, blank-filled. Values are: 0 - No payment adjustment 1 - Paid standard amount for pass-through drug or biological (status indicator G) 2 - Payment based on charge adjusted to cost (status indicator H) 4 - Deductible not applicable (specific list of HCPCS codes) or condition code "MA" is present on the claim or modifier “PT” is reported on an applicable procedure 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[f] 8 - Item provided with partial credit to provider[f] 9 - Deductible/coinsurance not applicable or Q3 modifier is reported or CS modifier is reported on applicable visit codes[e] 10 - Co-insurance not applicable[e] 11 - Multiple service units reduced to one by IOCE processing; payment based on single payment rate[j] 12 - Offset for first device pass-through[k] 13 - Offset for second device pass-through[k] 14 - PAMA Section 218 reduction on CT scan[l] 15 – Placeholder reserved for future use 16 – Terminated procedure with pass-through device[o] 17 – Condition for device credit present[p] 18 – Offset for first pass-through drug or biological[q] 19 – Offset for second pass-through drug or biological[q] 20 – Offset for third pass-through drug or biological[q] 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

Name	Size (bytes)	Description
Payment method flag[a]	1	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 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 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
Service units	9	Transferred from input, for pricer. For line items assigned to APCs for daily mental health, PHP, composite APC, or comprehensive APC, the service units are always assigned a value of 1 by the IOCE even if the input service units were greater than 1, and payment adjustment flag 11 is provided. Service units are also assigned to one for payable conditionally packaged lines (SI = Q1, Q2) and FQHC payment codes; payment adjustment flag 11 is provided. Input service units also may be reduced for some Drug administration APCs.
List of procedure edits	3	There is one 30 x 3 procedure edit return buffer for each of up to 450 line items. Each three-digit code specifies an edit that applied to the procedure. Edits 6-9, 11-13, 17-18, 20-21, 28, 30, 35, 37-38, 40, 42-45, 47, 49-51, 53, 55, 57-58, 60-64, 66-74, 76, 79-84, 87-89, 91-95, 98-102, 104-108, 110, 112, 114-117, 120-122, 124-135 apply to procedures.

Name	Size (bytes)	Description
Line item action flag[a]	1	Used in determination of discount formula, and also passed to pricer. 0 - Line item denial or rejection is not ignored 1 - Line item denial or rejection is ignored (except when edit 30 is present) 2 - External line item denial. Line item is denied even if no edits are present 3 - External line item rejection. Line item is rejected even if no edits are present 4 - External line item adjustment. Technical charge rules apply 5 - Non-covered service excluded from payment under FQHC PPS
Composite Adjustment Flag[a]	2	00 - Not a composite 01–ZZ - First through the nth composite APC present; same composite flag identifies the prime and non-prime codes in each composite APC group. For FQHC PPS claims (bill type 77x) only, the following values are defined for composite adjustment flag[h]: 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
HCPCS Modifier	4 (2x2 bytes)	Assigned by IOCE for final payment determination Note: Up to 2 occurrences of 2 characters each may be returned, currently only one 2-character modifier is returned. V3 – Demonstration modifier 3
Payment adjustment flag 2[a]	2	Right-justified, blank-filled. Values are: 0 - No payment adjustment Reserved for future use
List of modifier edits	3	Each three-digit code specifies an edit that applied to the modifier. Edits 22, 75, and 103 apply to modifiers.
List of date edits	3	Each three-digit code specifies an edit that applied to line item dates. Edit 23 applies to line item dates.
List of revenue code edits	3	Each three-digit code specifies an edit that applied to the revenue center. Edits 0, 9, 41, 48, 50, 65, 90, 111, and 127 apply to revenue centers.

a. Not activated for claims with OPPS flag = 2 (blanks are returned in the APC return buffer), unless the contractor edit bypass logic is applied and Payment Method Flag of Z is output to

identify that the lines(s) payment is determined by the contractor.
b. Status indicator Q was replaced by status indicators Q(#) in January 2009 (v10.0).
c. Packaging flag 2 was replaced by the composite adjustment flag starting in January 2009 (v10.0)
d. Payment adjustment flag values 91-99 discontinued 1/1/09, replaced by the composite adjustment flag (v10.0).
e. Two new payment adjustment flags (9,10) added for January 2011.
f. Payment adjustment flag values 7 & 8 deactivated effective January 2014 (v15.0).
g. Discontinued 04/01/2002 and replaced by status indicator G for all drugs/biologicals.
h. Values defined for composite adjustment flag that are used only for FQHC PPS processing are output on claims with bill type 77x without condition code 65; no composite APCs are assigned (v15.3).
i. Status indicator X is deactivated as of January 1, 2015 (v16.0).
j. Description for payment adjustment flag 11 modified 4/1/2015 (v16.1).
k. Payment adjustment flags 12 and 13 are associated with conditions present for APC pass-through device offset; multiple conditions for the same claim requiring payment offset due to the presence of multiple device/procedure combinations may require the assignment of both payment adjustment flags 12 and 13.
l. Payment adjustment flag 14 is applied to a specific list of CT scan procedure codes; if there is a CT scan code from the specified list reported with modifier CT that is packaged with SI = N as a result of composite APC or comprehensive APC processing, payment adjustment flag 14 is not applied.
m. Status Indicators J2 and Q4 are added effective 1/1/2016 (v17.0).
n. Effective 1/1/2016, laboratory codes with SI = Q4 that result in a final SI = A are assigned PMF = 2
o. Payment adjustment flag 16 is assigned to a terminated device intensive procedure reported with modifier 73.
p. Payment adjustment flag 17 is assigned to a device intensive procedure if condition code 49, 50 or 53 is reported.
q. Payment adjustment flags 18-20 are assigned for conditions that may be present for pass-through drugs or biologicals requiring payment offset.
r. Effective 10/1/2016 (v17.3) payment indicator assignments for pass-through drugs (SI = G) and non-pass-through drugs (SI = K) change to a value of 2; payment indicator 5 is discontinued*.
s. Effective 1/1/2017 (v18.0) SI E is deactivated and replaced with new SI values E1 and E2.
t. Lines that have packaging flag = 3 with line item charges < $1.01 do not set the payment adjustment flag to 4, 9, or 10, if applicable.

Procedure code edits

There is one 30 x 3 procedure edit return buffer for each of up to 450 line items. Each three-digit code specifies an edit that applied to the procedure. Edits 6-9, 11-13, 17-18, 20-21, 28, 30, 35, 37-38, 40, 42-45, 47, 49-51, 53, 55, 57-58, 60-64, 66-74, 76, 79-84, 87-89, 91-95, 98-102, 104-108, 110, 112, 114-117, 120-122, 124-135 apply to procedures.

Modifier edits

There is one 4 x 3 modifier edit return buffer for each of the five modifiers for each of up to 450 line items. Each three-digit code specifies an edit that applied to the modifier. Edits 22, 75, and 103 apply to modifiers.

Date edits

There is one 4 x 3 date edit return buffer for each of up to 450 line items. Each three-digit code specifies an edit that applied to line item dates. Edit 23 applies to line item dates.

Revenue code edits

There is one 5 x 3 revenue center code edit return buffer for each of up to 450 line items. Each three-digit code specifies an edit that applied to the revenue center. Edits 9, 41, 48, 50, 65, 90, 111, and 127 apply to revenue centers.

Edits by bill type

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 30. 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
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

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
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
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 (1)	APC Return Buffer Completed
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
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

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
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
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

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (1)	APC Return Buffer Completed
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.

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 31. 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
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

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
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
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

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	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, 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
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

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
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
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

Return codes

Return Codes are integer-based values indicating whether the program ran successfully or not. A return code value of zero indicates the claim was processed successfully. Any non-zero return code indicates that the program failed to process a claim (see the table below for descriptions). Return Codes are returned to the program caller and may also exist in the return code field of the claim return buffer.

The additional presence of a claim processed flag value of 4 or 9 indicates that a detectable fatal error occurred.

Note: Not all fatal errors are detectable, some fatal errors may cause a program crash before a return code can be generated and returned to the caller or before a return code can be written to the claim return buffer. Any non ZERO return code indicates that claim was not processed successfully.

Value	**Meaning**
-1	Unspecified
0	Claim processed successfully
1	Reserved
2	Reserved
3	Reserved
4	Reserved
5	Reserved
6	Reserved
7	Read error loading Read-Only Table file
8	Reserved
9	Reserved
10	Reserved
11	Reserved
12	Zero line items
13	Invalid From date
14	Invalid Through date
15	Invalid date sequence
16	At least one line has an invalid date
17	From date outside of OCE version range
18	Invalid bill type

Value	Meaning
19	Reserved
20	Reserved
21	Reserved
22	Claim processing terminated due to bill type 012x or 014x present with CC 41
23	Reserved
24	Reserved
25	Reserved
26	Contractor Override - specified edit not present in EditBypass table
27	Contractor Override - non-numeric value specified for numeric-only field
28	Contractor Override - non-numeric value specified for value code amount field
29	Receipt Date - date invalid or outside of IOCE version range
97	JVM FAILURE OCCURRED - THIS CLAIM REJECTED. CHECK SYSOUT FOR JVM STACK

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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