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January 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.0

MLN Matters Number: MM11068
Related Change Request (CR) Number: 11068
Related CR Release Date: December 21, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4185CP
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11068 provides the instructions and specifications for the I/OCE that Medicare uses under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR 11068 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for January 1, 2019. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single I/OCE.

The modifications of the ICE for the **January 2019 V20.0** release are summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column. The I/OCE specifications for the January 2019 V20.0 will be posted to the Centers for Medicare & Medicaid Services (CMS) website at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html.

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Table 1: January 2019 V20.0 I/OCE Modifications

Effective Date	Edits Affected	Modification
1/1/2017		Add new payment adjustment flag (23) to be returned if a radiological procedure is on the coinsurance deductible not applicable list as well as subject to a payment reduction due to the presence of the FX modifier.
1/1/2018		Add new payment adjustment flag (24) to be returned if a radiological procedure is on the coinsurance deductible not applicable list as well as subject to a payment reduction due to the presence of the FY modifier.
1/1/2019		Add new payment method flag (A) to be returned if an off-campus provider-based outpatient department submits clinic visit code G0463 with modifier PO on a claim (bill type 13x w/ or w/o Condition Code (CC) 41). See Hospital off-campus provider-based outpatient departments submitting claims with Modifier PO:
1/1/2019	102	Update Edit 102 and its conditions to not allow any conflicting modifiers to be reported together on the same HCPCS line. To see a list of conflicting modifiers, please reference the data files for a report named “Modifier Pairs”. **Note:** This edit change is applied retroactively to the inception of the activation date of each conflicting modifier pairing
10/1/2018	109	Implement new edit 109: Code first diagnosis present without mental health diagnosis as the first secondary diagnosis. Edit criteria: A code first diagnosis is submitted on a Partial Hospitalization Program (PHP) claim (Bill type 76x or 13x with CC41) without a mental health diagnosis in the sdx position. (See PHP Processing logic or Edit description/generation table for more information related to this edit.)
7/1/2018	110	Implement new edit 110: Service provided prior to initial marketing date. Edit Criteria: The line item date of service of a code is prior to the initial marketing date for which it can be reported.
1/1/2019	22	Add the following new modifiers to the valid modifier list: - ER: Items and services furnished by a provider-based off-campus emergency department - CO: Outpatient occupational therapy service provided by occupational therapy assistant - CQ: Outpatient physical therapy service provided by physical therapy assistant - G0: Telestroke
1/1/2019		Update the Comprehensive Ambulatory Payment Classification (APC) Assignment Rules and Criteria section to note that any procedure assigned to a New Tech APCs is excluded from packaging under Comprehensive APC processing, effective 1/1/2019.
1/1/2019		Update the Radiological Processing sections to include the modifier conflict conditions as well as to reference the conditions needed in order to obtain the new payment adjustment flags 23 and 24.

Effective Date	Edits Affected	Modification
1/1/2019		Add new section under Section 603 processing logic for the new conditions related to hospital off-campus provider-based outpatient departments submitting claims with Modifier PO.
1/1/2019		Update Federally Qualified Health Center (FQHC) processing section to note that line items submitted on a claim with bill type 770 (no payment claim) are submitted to the I/OCE with Line Item Action Flag 5; edit 91 is not returned nor is any other editing performed. This is a documentation update only as this is how claims with bill type 770 currently process.
1/1/2019		Update the following lists for the release (see quarterly data files): - Add on Type I (edit 106) - Comprehensive APC list (Updated list and Rank) - C-APC Exclusions list - Comprehensive APC code pairs - Device and Device-Procedure lists (edit 92) - Terminated Device Procedures for offset APC - Pass-through device offset amounts - Pass-through radiopharmaceutical for offset APC (edit 99) - Pass-through skin substitute product for offset APC (edit 99) - Pass-through contrast for offset APC (edit 99) - Pass-through stress agent for offset APC (edit 99) - Radiological HCPCS reported with FX or FY modifier - Skin Substitute Hi and Low-Cost lists (edit 87) - Non-covered service (edit 9) - Service not paid by Medicare (edit 13) - Not recognized by Medicare (edit 28) - Not recognized by OPPS (edit 62) - Contrast HCPCS - Male only procedure list (edit 8) - Code first diagnoses list (edit 109) - Mental health diagnosis list (edit 29) - Daily mental health services list - Mental health not approved for PHP (edit 80) - PHP Primary Services list (list B) - Rural Health Clinic (RHC) CG modifier non-payable list - FQHC non-covered list - FQHC flu ppv list - FQHC Chronic Care Management procedure list - Modifier pairs (new table for conflicting modifiers) - Edit 99 Exclusions list - Inherently bilateral procedure list - Conditionally bilateral procedure list
1/1/2019		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).

Effective Date	Edits Affected	Modification
1/1/2019	20, 40	Implement version 25.0 of the NCCI (as modified for applicable outpatient institutional providers).

ADDITIONAL INFORMATION

The official instruction, CR10068, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4185CP.pdf.

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

DOCUMENT HISTORY

Date of Change	Description
December 26, 2018	Initial article released.