DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN):

- "Medicare Enrollment and Claim Submission Guidelines", Booklet, ICN 906764, Downloadable and hard copy

MLN Matters® Number: MM8548	Related Change Request (CR) #: CR 8548
Related CR Release Date: December 13, 2013	Effective Date: January 1, 2014
Related CR Transmittal #: R2838CP	Implementation Date: January 6, 2014

January 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.0

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the Home Health Prospective Payment System or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider Action Needed

This article is based on Change Request (CR) 8548 which informs the MACs that the I/OCE was updated for January 1, 2014. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

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Background

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications is available at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html on the Centers for Medicare & Medicaid Services (CMS) website. There is a summary of the changes for January 2014 in Appendix M of Attachment A of CR8548 and that summary is captured in the following key points.

Effective January 1, 2014, (except as noted below) Medicare will:

- Modify Extended Assessment and Management (EAM) composite Ambulatory Payment Classification (APC) assignment criteria (appendix K) by:
  - Deleting composite APCs 8002 and 8003
  - Adding new EAM composite 8009
- Deactivate special logic to make separate payment for certain skin substitute products when billed with specified skin substitute application procedures (appendix N).
- Implement new edit to require that specific skin substitute products (high cost vs. low cost) be submitted with specific skin substitute application procedures (appendix N). Edit 87 is affected.

  Edit description: Skin substitute application procedure without appropriate skin substitute product code (Return to Provider (RTP))

  Edit criteria: A list A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service.
- Change the Status Indicator (SI) from N to A for any laboratory code (code list) submitted on 14x bill type.
- Deactivate the logic for assignment of payment adjustment flags 7 and 8 with modifiers FB and FC for offset payment reduction.
- Deactivate Payment Adjustment Flags 7 and 8.
- Modify edit 75 (Incorrect billing of modifier FB or FC) to apply if modifier FB or FC is submitted on any line/any SI on a claim.
- Deactivate edit 78 ((Nuclear medicine)- Claim lacks required radiolabeled product).
- Deactivate edit 85 (Claim lacks required device code or required procedure code).
- Add code 97610 to the 'Sometimes Therapy' list/logic (Change SI to A if submitted with a therapy revenue code or therapy modifier).

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- Implement mid-quarter Food and Drug Administration (FDA) approval coverage for code 90688. Edit 67 is affected. Effective August 16, 2013.
- Make HCPCS/APC/SI changes as specified by CMS (data change files).
- Implement version 20.0 of the NCCI (as modified for applicable institutional providers). [All edits combined in a single file, in code1/code2 format; mutually exclusive pairs no longer differentiated]. Edits 20 and 40 are affected.
- Add new modifier PM (Post mortem) to the valid modifier list. Edit 22 is affected.
- Update procedure/sex conflict edit list. Edit 8 is affected.
- Update procedure/device & device/procedure edit requirements. Edits 71 and 77 are affected.
- Update the add-on/primary procedure pair edit requirements for Partial Hospitalization Program (PHP) claims (G0463 added as a primary code when reported with psychiatric add-on codes) - edit 84.
- Revise SI descriptions as follows:

  S = Procedure or service, not discounted when multiple

  T = Procedure or service, multiple reduction applies
- Update appendix F, G, K, N.
- Add new flags & code lists to data files (HcpcsMap) and user manuals (app B) for edit 87.
- Remove code lists from user manuals (app B, C) for deactivated edit (78) & modifier FB/FC logic.

Additional Information

The official instruction, CR 8548 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2838CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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