

1 Integrated OCE (IOCE) CMS Specifications V24.3

Effective 10/1/2023

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2 Summary of Quarterly Release Modifications

The modifications of the IOCE for the **October 1, 2023, v24.3** release is 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 IOCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

Item #	Type	Effective Date	Edits Affected	Modification
1.	Logic	10/1/2023	24	Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. The earliest date/version included for this release is 1/01/2017, v18.0 of the IOCE.
2.	Logic	1/1/2017	17	<u>Logic Modification:</u> For bill type 085x (CAH), when there are multiple occurrences of the same inherently bilateral procedure on the same date of service, modifier 76 or 77 are not present, and there is no professional services revenue code (096x, 097x, 098x) present on at least one of the multiple occurrences of the same inherently bilateral code, then edit 17 is applied. See Critical Access Hospital Processing for more information.
3.	Logic	1/1/2023		<u>Logic Correction:</u> For DMH and PHP claims (bill types 012x, 013x and 013x w/CC41), RMH add-on code, C7902 is no longer chosen for DMH APC assignment when requirements are met for designation of separately payable or composite-packaged RMH or DMH services. Additionally, C7902 does not count towards the DMH cap when requirements are met for eligible DMH claims. See Remote Mental Health Add-on Code Editing for more information.
4.	Logic	1/1/2017	89	<u>Logic Correction:</u> A correction was made for FQHC claims processing, bill type 077x, and edit 89; the line order processing was incorrectly evaluating qualifying visit pairs when the correct pairings were present.
5.	Logic	1/1/2017	27	<u>Logic Correction for edit 27:</u> When line item action flag (LIAF) values 1 or 5 are present, edit 27 does not get bypassed.
6.	Logic	1/1/2017	27	<u>Logic Modification for edit 27:</u> Edit 27 rejects the claim when all the claim's lines are any combination of the following: <ul style="list-style-type: none"> • Lines that are Packaged (SI=N) • Lines ignored by LIAF 2-4 • Invalid HCPCS Lines (Edit 6) • Blank HCPCS and Invalid Revenue Code Lines (Edit 41)
7.	Logic	1/1/2017	18, 45, 49	<u>Logic Correction:</u> The IOCE logic processing order is corrected to ensure that the identification of a primary comprehensive (SI=J1) procedure occurs prior to the execution of the Inpatient Expired and the Inpatient Day Denial logic associated with edits 18, 45 and 49.
8.	Logic	1/1/2017	60, 70	<u>Logic Correction:</u> Edits 60 (multiple modifier CAs not allowed) and 70 (modifier CA requires appropriate patient discharge status) are corrected to only apply for inpatient lines (SI=C).
9.	Logic	1/1/2017	25, 26	<u>Logic Modification:</u> For sex and age input fields, if the fields are blank, edits 25 (Invalid age) and/or 26 (Invalid sex) are returned on output.
10.	Logic	1/1/2017	48	<u>Logic Modification:</u> Removed edit 48 from both OPPTS and non-OPPTS Hospice bill types 081x and 082x.
				Documentation Changes:
11.	Documentation	10/1/2023		New section for Critical Access Hospital (CAH) Processing which discusses logic in the IOCE related to CAH processing.
12.	Documentation	10/1/2023		Included documentation for Diagnosis code validation processing which discusses validation editing related to diagnosis codes in the IOCE.
13.	Documentation	10/1/2023	21	Updated the Medical Visits and Procedure Processing on the Same Day section for clarification of codes applicable to edit 21.
14.	Documentation	10/1/2023		Modifications to the Edit Descriptions and Reason for Edit Generation table: <ul style="list-style-type: none"> • Updated the reason for edit generation for edit 17. • Updated the reason for edit generation for edit 27. • Updated the reason for edit generation for edit 21.
15.	Documentation	10/1/2023		Corrections to the Edits Applied by Bill Type tables: <u>OPPTS:</u> <ul style="list-style-type: none"> • 013x OPPTS: Added edits 60, 70 • 043x OPPTS: Removed edit 46 • 077x OPPTS: Added edit 68; Removed edit 84 • 081x OPPTS: Removed edit 48 • 082x OPPTS: Removed edit 48 • 087x OPPTS: Added edit 65 <u>Non-OPPTS:</u> <ul style="list-style-type: none"> • 071x Non-OPPTS: Added edit 68 • 077x Non-OPPTS: Removed edit 84

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Item #	Type	Effective Date	Edits Affected	Modification
				<ul style="list-style-type: none"> • 081x Non-OPPS: Removed edit 48 • 082x Non-OPPS: Removed edit 48 • 085x w/CC89 Non-OPPS: Removed edits 120 and 58
16.	Documentation	10/1/2023		Updated documentation in the Multiple Imaging Composite Logic with Assignment Rules & Criteria section to include that in the instance imaging composite services are reported for non-hospital outpatient bill types, no payment APC is provided.
17.	Documentation	10/1/2023		Out of Scope Documentation: <ul style="list-style-type: none"> • Status Indicator E (SI=E) ; Replaced by SI = E1
				Content Changes:
18.	Content	10/1/2023	1 , 2 , 3 , 5 , 86	Update diagnosis code editing for validity, age, gender, external cause of injury and manifestation based on the FY 2024 ICD-10-CM code revisions to the Medicare Code Editor (MCE). Note: CMS has chosen not to apply sex edits to the new maternity DX codes.
19.	Content	10/1/2023	113	Update the Unacceptable principal diagnosis list based on the FY 2024 ICD-10-CM code revision to the Medicare Code Editor (MCE) with any exclusions to that listing based on OPPS coding requirements and guidelines. Any diagnosis code flagged as being an exclusion to the Unacceptable Principal Diagnosis list does not return edit 113.
20.	Content	10/1/2023	110	Add mid-quarter edit 110 (initial marketing date) to the following HCPCS codes: <ul style="list-style-type: none"> • 0121A: 4/18/2023 • 0141A: 4/18/2023 • 0142A: 4/18/2023 • 0151A: 4/18/2023 • 0171A: 4/18/2023 • 0172A: 4/18/2023 • 90679: 5/3/2023 • J0174: 7/6/2023
21.	Content	5/31/2023	67	Add mid-quarter edit 67 (FDA approval) to the following HCPCS codes: <ul style="list-style-type: none"> • 90678: 5/31/2023
22.	Content	10/1/2023	69	Add mid-quarter edit 69 to return after the approval period for the following HCPCS codes: <ul style="list-style-type: none"> • 0001A: 12/11/2020 - 4/17/2023 • 0002A: 12/11/2020 - 4/17/2023 • 0003A: 8/12/2021 - 4/17/2023 • 0004A: 9/22/2021 - 4/17/2023 • 0011A: 12/18/2020 - 4/17/2023 • 0012A: 12/18/2020 - 4/17/2023 • 0013A: 8/12/2021 - 4/17/2023 • 0031A: 2/27/2021 - 6/1/2023 • 0034A: 10/20/2021 - 6/1/2023 • 0051A: 1/3/2022 - 4/17/2023 • 0052A: 1/3/2022 - 4/17/2023 • 0053A: 1/3/2022 - 4/17/2023 • 0054A: 1/3/2022 - 4/17/2023 • 0064A: 10/20/2021 - 4/17/2023 • 0071A: 10/29/2021 - 4/17/2023 • 0072A: 10/29/2021 - 4/17/2023 • 0073A: 1/3/2022 - 4/17/2023 • 0074A: 5/17/2022 - 4/17/2023 • 0081A: 6/17/2022 - 4/17/2023 • 0082A: 6/17/2022 - 4/17/2023 • 0083A: 6/17/2022 - 4/17/2023 • 0091A: 6/17/2022 - 4/17/2023 • 0092A: 6/17/2022 - 4/17/2023 • 0093A: 6/17/2022 - 4/17/2023 • 0094A: 3/29/2022 - 4/17/2023 • 0111A: 6/17/2022 - 4/17/2023 • 0112A: 6/17/2022 - 4/17/2023 • 0113A: 6/17/2022 - 4/17/2023 • 91300: 12/11/2020 - 4/17/2023 • 91301: 12/18/2020 - 4/17/2023 • 91303: 2/27/2021 - 6/1/2023 • 91305: 1/3/2022 - 4/17/2023 • 91306: 10/20/2021 - 4/17/2023 • 91307: 10/29/2021 - 4/17/2023 • 91308: 6/17/2022 - 4/17/2023 • 91309: 3/29/2022 - 4/17/2023 • 91311: 6/17/2022 - 4/17/2023

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Item #	Type	Effective Date	Edits Affected	Modification
23.	Content	10/1/2023	8	Removal of sex (female or male) designation from the following procedure codes: <ul style="list-style-type: none"> • 19300 • A4281 • A4282 • A4283 • A4284 • A4285 • A4286 • E0602 • E0603 • E0604 • G0101
				Data Content Changes:
24.	Content	10/1/2023		Make all Diagnosis, HCPCS, APC, SI and edit changes as specified by CMS. Updates were made to the following tables and lists: <p>DATA_DX10</p> <ul style="list-style-type: none"> • Diagnosis Age Conflict list (edit 2) • Diagnosis Sex Conflict (edit 3) • External Cause of Injury diagnosis list (edit 5) • Manifestation Diagnosis list (edit 86) • Unacceptable principal diagnosis list (edit 113) • Unacceptable principal diagnosis OPPS exclusion list (bypass edit 113) <p>DATA_APC</p> <ul style="list-style-type: none"> • Added new APCs <p>DATA_HCPCS</p> <ul style="list-style-type: none"> • Comprehensive APC exclusion list • Bypass Edit 92 list • Bypass Edit 99 list • Deductible Coinsurance N/A list • FQHC Flu PPV list • FQHC Non-covered list (edit 91) • Film_Xray list • Mid Quarter Edit list (edit 110)(edit 69)(edit 67) • Non-Billable MAC list (edit 72) • Non-covered Service List (edit 9) • Non-reportable site of services list (edit 55) • Passthrough Radiopharm (edit 99) • Procedure/Age Conflict (edit 7) • Procedure/Sex Conflict (edit 8) • Separate payment not provided by Medicare (edit 13) • Skin substitutes list (edit 87) • Telehealth (edit 126) • Vaccine (for HH Vaccine administration) <p>DSC_EDIT</p> <ul style="list-style-type: none"> • Description updates to applicable edits <p>DATA_REVENUE</p> <ul style="list-style-type: none"> • Revenue code SI changes (Retroactive) <p>OFFSET_CODEPAIR</p> <ul style="list-style-type: none"> • Pass-through Device Offset Code Pairs (Retroactive changes)
25.	Content	7/1/2023	124	<u>Clarification:</u> The following codes have a Mid-Quarter termination date determined by CMS as of 5/11/2023. <ul style="list-style-type: none"> • G2023 • G2024 • U0003 • U0004 • U0005 <p>The July 1, 2023 (v24.2) Summary of Data Changes documentation reflects that the above codes were officially deleted as of July 1, 2023 however, these codes apply to the CMS Mid-Quarter Termination List and receive edit 124 (RTP) when reported after the PHE end date of May 11, 2023. If they are reported on July 1, 2023 or after, they receive edit 6 (RTP) for the reporting of an invalid procedure code. See Public Health Emergency (PHE) Processing for additional information.</p>
26.	Content	10/1/2023	20, 40	Implement NCCI v29.3 for October 2023.
27.	Content	10/1/2023	106	Implement the Add-on code files for October 2023.
28.	Data Table Structure	10/1/2023		MAP_IMRT <ul style="list-style-type: none"> • Description update for Code 2 column <p>Please review the File Layout document for the descriptions of all Data Table Reports, associated fields and field values.</p>

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Item #	Type	Effective Date	Edits Affected	Modification
29.	Other	10/1/2023		Create 508-compliant versions of the Specifications, Summary of Data Changes and File Layout documents for publication on the CMS web site. Provide MF and PC IOCE software and supporting quarterly data file reports for publication on the CMS web site.

3 Introduction to the IOCE

3.1 IOCE Processing

This ‘integrated’ OCE (IOCE) program processes claims for outpatient institutional providers including hospitals that are subject to the Outpatient Prospective Payment System (OPPS) as well as hospitals that are not (Non-OPPS). The Medicare Administrative Contractor (MAC) identify the claim as ‘OPPS’ or ‘Non-OPPS’ by passing a flag to the IOCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

This version of the IOCE processes claims consisting of single or multiple days of service. The IOCE performs two major functions:

1. Edit the data to identify errors and return a series of edit flags.
2. Assign an Ambulatory Payment Classification (APC) number for each service covered under OPPS and return information to be used as input to an OPPS PRICER program. For Non-OPPS claims an APC is not assigned, instead a series of Non-OPPS applicable edits are returned.

Each claim is represented by a collection of data, which consists of all necessary demographic (header) data, plus all services provided (line items). It is the user’s responsibility to organize all applicable services into a single claim record and pass them as a unit to the IOCE. The IOCE only functions on a single claim and does not have any crossclaim capabilities. The IOCE accepts up to 450-line items per claim. The IOCE software is responsible for ordering line items by date of service.

The IOCE not only identifies individual errors but also indicates what actions should be taken and the reasons why these actions are necessary. To accommodate this functionality, the IOCE is structured to return lists of edit numbers. This structure facilitates the linkage between the actions being taken, the reasons for the actions and the information on the claim (e.g., a specific diagnosis) that caused the action.

In general, the IOCE performs all functions that require specific reference to HIPAA medical code sets, such as HCPCS codes, HCPCS modifiers and ICD-10-CM diagnosis codes. Since these coding systems are complex, the centralization of the direct reference to these codes and modifiers in a single program reduces effort and reduces the chance of inconsistent processing. HIPAA medical code sets are validated in the IOCE based on the claim From and Through dates as well as the line level Service date for items that are effective mid-quarter. Non-medical code sets such as revenue codes are validated in the IOCE effective with v22.2 (July 1, 2021) based on the date in which Medicare received the claim, otherwise known as the “Claim Receipt Date”. Please Reference the following CMS link to information on HIPAA defined Medical Code sets: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets>.

The span of time that a claim represents is controlled by the **From** and **Through** dates that are part of the input header information. If the claim spans more than one calendar day, the IOCE subdivides the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day.

Some edits are date driven. For example, a Bilateral Procedure is considered an error if a pair of procedures is coded with the same service date, but not if the service dates are different.

All institutional outpatient claims, regardless of facility type, process through the Integrated Outpatient Code Editor (IOCE); however, not all edits are performed for all sites of service or types of claim. [Table 6.3](#) contains IOCE edits that apply for each bill type under OPPS processing; [Table 6.4](#) contains OCE edits that apply to claims from hospitals not subject to OPPS.

3.2 Contractor (MAC) Actions Impacting IOCE Processing

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

3.2.1 Line Item Action Flag (LIAF) Processing

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

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

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

3.2.2 Contractor Bypass Processing

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

3.2.3 Payer Only Bypass of Deductible and/or Coinsurance on Part B Institutional Claims

Effective July 1, 2023 (v24.2), for both OPPS and Non-OPPS bill types 012x, 012x w/CC41, 013x, 013x w/CC41, 013x w/CC89, 014x, 014x w/CC41, 022x, 023x, 032x, 034x, 071x, 072x, 073x, 074x, 075x, 076x, 077x, 085x, 085x w/CC89, and 087x, new payer only modifiers and condition codes are allowed to be input by the MAC to allow systematic bypasses for coinsurance and/or deductible. Modifiers are reported at the line level and when a line is reported with an applicable modifier (see Payer Only Modifiers and Condition codes to bypass Deductible and/or Coinsurance table below), for OPPS claims, the IOCE assigns the appropriate payment adjustment flag (PAF) in the [priority order of 9, 4, or 10](#), for the line(s) to bypass either the deductible (PAF=4), the coinsurance (PAF=10) or both deductible and coinsurance (PAF=9).

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

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

3.2.3.1 Payer Only Modifiers and Condition codes to bypass Deductible and/or Coinsurance

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

3.2.4 Payer Only Value Code Z9 for CMS Mid-Quarter Termination Processing

Payer Value Code, Z9 (CMS determined mid-quarter termination date), is input by the MAC to identify claims in which CMS has determined there is a mid-quarter termination date. Z9 is reported with a date in the Value Code Amount field formatted as YYYYMMDD. When Z9 is input with a date and a code identified on the CMS Mid-Quarter Termination list in DATA_HCPCS is reported, the claim is returned to the provider with edit 124. Additionally, when a HCPCS modifier is reported that has been identified by CMS as applicable to the CMS Mid-Quarter Termination list and Payer Value code Z9 is present, the claim is returned to the provider with edit 123.

If Z9 is present and the Value Code Amount field is blank or has an invalid date, the From Date of the claim is used for processing. Note: If Z9 is not present, the default termination date is May 11, 2023. See the [Public Health Emergency \(PHE\) Processing](#) section for additional information.

3.3 Record Input

Information is passed to the IOCE by means of a control block of pointers which is described in the [IOCE Control Block Table](#). Multiple items are assumed to be in contiguous locations. The input for each line item contains the information described in the [Line Item Input Information Table](#)

3.3.1 Line Level Field Input Table

Field	UB-04 Form Locator	Number	Size (bytes)	Comments
HCPCS procedure code	44	1	5	May be blank
HCPCS modifier	44	5 x 2	10	May be blank; up to 5, 2-character contiguous modifiers allowed per single line item; validated in the order received
Service date	45	1	8	Required for all lines
Revenue code	42	1	4	Required for all lines
Service units	46	1	9	A blank or zero value is defaulted to 1
Charge	47	1	10	Used by PRICER to determine outlier payments
Contractor bypass edits	n/a	4	12	4 occurrences of 3-byte alphanumeric characters allowed per single line item (12 bytes total); right-justified, zero-filled, default value per occurrences is '000'
CB payment APC	n/a	1	5	Numeric; right-justified, zero-filled, default: '00000'
CB Status Indicator	n/a	1	2	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 ex. " bA " "_A"
CB Payment Indicator	n/a	1	2	Numeric; right-justified, zero-filled, default: '00'
CB Discounting Formula Number	n/a	1	1	Numeric; zero-filled, default: '0'
CB Line Item Denial or Rejection Flag	n/a	1	1	Numeric; zero-filled, default: '0'
CB Packaging Flag	n/a	1	1	Numeric; zero-filled, default: '0'
CB Payment Adjustment Flag 1	n/a	1	2	Numeric; right-justified, zero-filled, default: '00'
CB Payment Method Flag	n/a	1	1	Alphanumeric; zero-filled, default: '0'
CB Payment Adjustment Flag 2	n/a	1	2	Numeric; right-justified, zero-filled, default: '00'

3.3.2 Claim Level Field Input Table

Refer to the Component Input section of the Installation Manual for additional information.

Field Name	Description	UB-04 Form Locator	Number	Size (bytes)	Comment
Dx	ICD-10-CM diagnosis codes	70 a-c (Pt's rvdx) 67 (pdx) 67A-Q (sdx)	Up to 28	8 (7 for code, 1 for POA flag)	Diagnosis codes are left justified, and blank filled). First three listed diagnoses are considered 'patient's reasons for visit dx', fourth diagnosis is considered 'principal dx'.
Sg	Line item entries	42, 44-47	Up to 450	75	Table 3.3.1
Flag	Line item action flag set by MAC and passed by IOCE to Pricer	n/a	Up to 450	1	Optional field used to bypass editing
Age	Numeric age in years	n/a	1	3	0-124
Sex	Numeric sex code	11	1	1	0, 1, 2 (unknown, male, female)
Date	From and Through dates (YYYYMMDD)	6	2	8	Required to determine valid grouper version and for multi-day claim processing
CC	Condition codes	18-28	Up to 30	2	Reported for identifying special circumstances impacting grouping results.
Bill	Type of bill	4 (Pos 2-4)	1	3	Required to identify the site and type of service for processing and editing under the IOCE. It is presumed that bill type has been edited for validity by the Standard System before the claim is sent to IOCE.
NPI	National provider identifier (NPI)	56	1	13	Passed on to Pricer
CCN	CMS Certification Number (CCN)	57	1	6	Passed on to Pricer, previously known as OSCAR number.
Pstat	Patient status	17	1	2	UB-04 published values
Opps	Opps/Non-OPPS flag	n/a	1	1	1=OPPS, 2=Non-OPPS (A blank, zero or any other value is defaulted to 1)
Occ	Occurrence codes	31-34	Up to 30	2	For MAC use
VCAMT	Value codes and value code amounts	39-41	Up to 36	11	2-character Value Code, left-aligned, followed by a Value Code amount (nnnnnnnnn) zero-filled, right-justified.
CPRDate	Claims Processing Receipt Date (yyyymmdd)	n/a	1	8	Used for determining the effective date for items that are non-medical code sets (e.g., revenue codes). If field is left blank, the IOCE auto-fills the field based on the reported claim "Through date".
Dxedit	Diagnosis edit return buffer	n/a	Up to 28	Table 6.1.2	Diagnosis edits returned
Procedit	Procedure edit return buffer	n/a	Up to 450	Table 6.1.2	Procedure edits returned
Mdedit	Modifier edit return buffer	n/a	Up to 450	Table 6.1.2	Modifier edits returned
Dtedit	Date edit return buffer	n/a	Up to 450	Table 6.1.2	Date edits returned
Rcedit	Revenue code edit return buffer	n/a	Up to 450	Table 6.1.2	Revenue code edits returned
APC	APC return buffer	n/a	Up to 450	Table 7.1.2	APC detail returned
Claim	Claim return buffer	n/a	1	Table 7.1.1	Claim detail returned

3.4 Component Initialization

The following example references the required values needed to initialize the component. On the following page is a flowchart of the execution and processing of the IOCE component. **Note:** If the claim from/through dates span more than one day, subdivide the line items on the claim into separate days based on the calendar day of the line item service date.

1. Assign the default values to each line item in the APC return buffer. The default values for the APC return buffer for variables not transferred from input, or not pre-assigned, are as follows:

3.4.1 APC Return Buffer, Default Values

APC Return Buffer Item	Default Value
Payment APC	00000
HCPCS APC	00000
Status indicator	W
Payment indicator	3
Discounting formula number	1
Line item denial or rejection flag	0
Packaging flag	0
Payment adjustment flag 1	0
Payment method flag	0
Composite adjustment flag	00
Payment adjustment flag 2	0

2. If no HCPCS code is on a line and the revenue code is from one of four specific lists, then assign the following values to the line item in the APC return buffer.

3.4.2 Revenue Code with No HCPCS Code, Ex. 1

APC Return Buffer Item	Default list value	Default list value	Default list value	Default list value
Line item	N-list	E1-list	B-list	F-list
HCPCS APC	00000	00000	00000	00000
Payment APC:	00000	00000	00000	00000
Status Indicator:	N	E1	B	F
Payment Indicator	9	3	3	4
Packaging flag:	1	0	0	0

3. If there is no HCPCS code on a line, and the revenue center is not on any of the specified lists, assign default values as follows:

3.4.3 Revenue Code with No HCPCS Code, Ex. 2

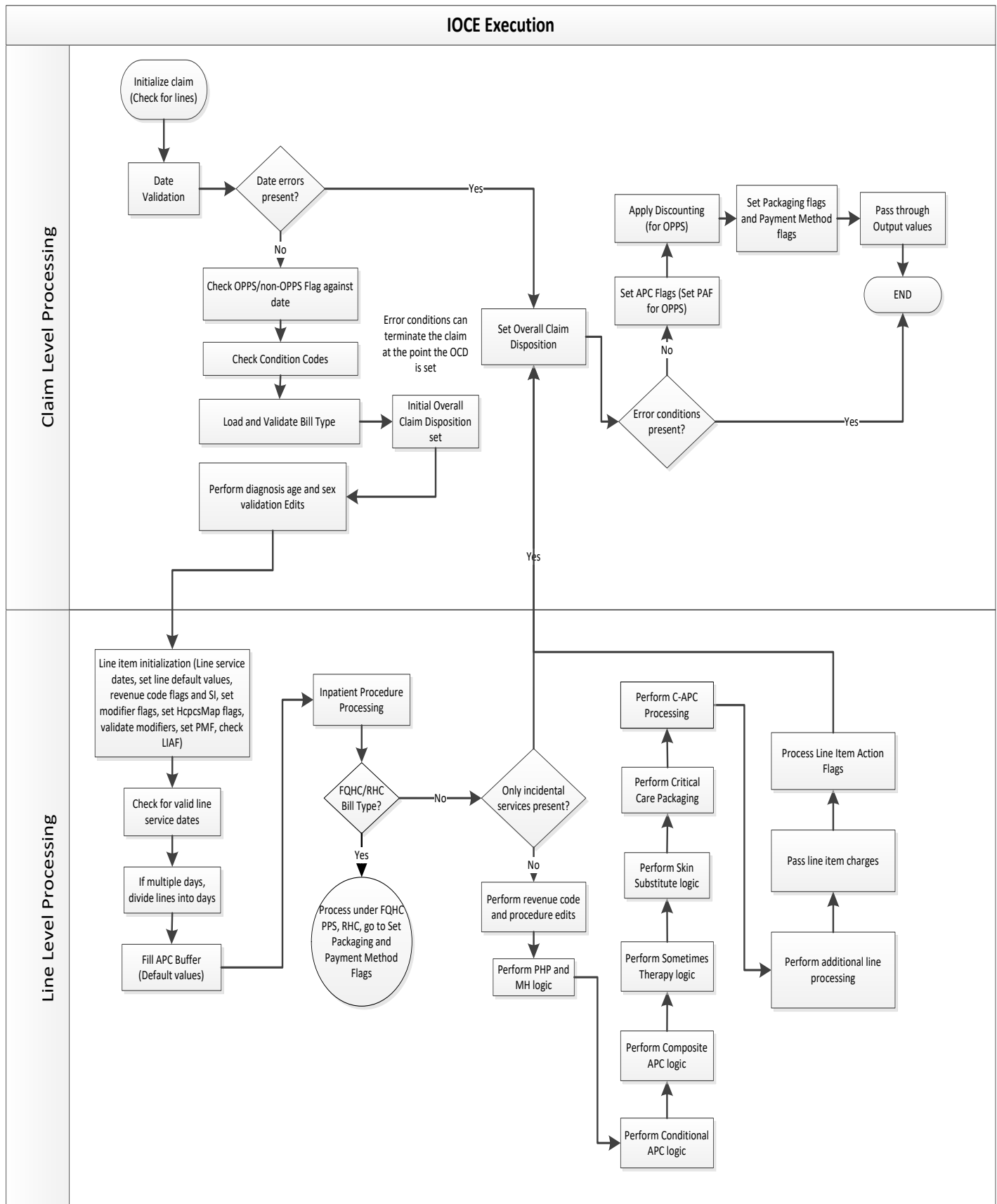
APC Return Buffer Item	Default Value
HCPCS APC	00000
Payment APC:	00000
Status Indicator:	Z
Payment Indicator	3
Packaging flag:	0

4. If the HCPCS code is invalid, or the revenue code is invalid and the HCPCS is blank, assign default values as follows:

3.4.4 Invalid HCPCS or Invalid Revenue Code

APC Return Buffer Item	Default Value
HCPCS APC	00000
Payment APC:	00000
Status Indicator:	W
Payment Indicator	3
Packaging flag:	0

3.4.5 IOCE Execution and Processing Flowchart



4 Processing that Applies to Both OPPS and Non-OPPS Claims

4.1 National Correct Coding Initiative (NCCI) Edits

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

Effective January 1, 2006, NCCI edits apply to ALL services billed under bill types 012x, 013x, 014x, 022x, 023x, 034x, 072x, 074x, 075x, 076x, and 085x by the following providers: Skilled Nursing Facilities (SNFs), ESRD facilities (ESRDs), Community Mental Health Clinics (CMHCs), Outpatient Physical Therapy and Speech-Language Pathology Providers (ORFs), CORFs, Home Health Agencies (HHAs), and Critical Access Hospitals (CAHs).

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

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

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

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

4.2 Add-On Code Edits

Effective April 1, 2018 (v19.1), claims with certain OPPS and Non-OPPS bill-types are subject to add-on code editing if the primary procedure for the add-on code is not present on the same day or day before. Add-on codes describe procedures or services that are always provided “in addition to” other, related services or procedures. Add-on procedure codes cannot be reported stand alone as separately reportable services. One add-on code may have multiple primary procedures for which it can be reported with. In addition, there may be circumstances where reporting multiple add-on procedure codes are necessary, and in this instance the primary procedure for both add-ons must be present on the day of or day before. There are three different types of add-on codes defined by CMS for which the IOCE returns an edit(s) if the conditions to satisfy the edit(s) are not met. Note: Although the source tables include historical add-on code pair editing content, the add-on edits are not applied until 4/1/2018. See the [Edits by Bill type table](#) for bill types applicable to add-on code edits.

1. Type I add-on codes have a defined list of primary procedure codes. If one or multiple Type I add-on codes are reported without their primary procedure [edit 106](#) is returned on the add-on procedure line(s) and line item denied (LID). See Map_Addon_Type1 table to review applicable code pairs.
2. Type II add-on codes do not have a defined list of primary procedures; individual contractors must define the list of primary procedure codes for Type II add-on codes. [Edit 107](#) is returned on all Type II add-on procedure line(s) for contractor review (LID). See Map_Addon_Type2 table to review applicable code pairs.
3. Type III add-on codes have defined primary procedures but there may be additional contractor defined primary procedures. Type III add-on codes act the same as Type I in how the edit is applied, with [edit 108](#) (LID). See Map_Addon_Type3 table to review applicable code pairs.

See [Edit Description and Reason for Edit Generation Table](#) for edit information as well as Edits by Bill Type Tables to view what bill types are applicable to Add on Editing.

For Critical Access Hospitals Add-on Code Editing, see [Critical Access Hospital Processing](#).

4.2.1 Drug Administration Add-on Code Editing

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

4.2.2 Software as a Service (SAAS) Add-on Code Editing

Software as a Service, SAAS, are algorithm-driven services that assist practitioners in making clinical assessments and can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). Effective January 1, 2023 (v24.0), Software as a service add-on codes reported on hospital outpatient claims with bill type 013x are subject to add-on code [edit 106](#) if the primary procedure is not present on the claim. Refer to Map_ADDON_SAAS for the list of impacted code pairs. Note: Additional add-on content associated with edit 106 applied to non-OPPS and other OPPS bill types is not included for bill type 013x (see section 4.2).

4.2.3 Remote Mental Health (RMH) Add-on Code Editing

Effective January 1, 2023 (v24.0), when Remote Mental Health add-on code, C7902, is reported on Partial Hospitalization claims (013x w/ CC41) or Daily Mental Health claims (012x, 013x) without a primary code on the same date of service, the line is line-item denied with edit 106. See the [Partial Hospitalization](#) and [Daily Mental Health](#) sections for more information.

4.2.4 COVID-19 Lab Add-on Code Editing: v22.0 - v24.2

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

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

4.3 Validation Editing

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

4.3.1 Diagnosis Code Validation

4.3.1.1 Invalid Diagnosis Editing

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

Prior to the July 1, 2021 (v22.2) release, the IOCE validates ICD-10-CM diagnosis codes based on the quarter that corresponds with the From date of the claim ([edit 1](#)). If a claim has From and Through dates that span a quarterly boundary, no cross-claim editing or validation is performed, except for Home Health claims (bill type 032x) where a bypass is applicable (see [Home Health Processing Logic](#)).

4.3.1.2 Diagnosis and Age/Sex Conflict Editing

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

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

4.3.1.3 Principal Diagnosis Code Editing

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

4.3.1.4 External Cause of Injury/Morbidity Code Editing

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

4.3.1.5 Manifestation Code Editing

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

4.3.1.6 Non-Mental Health Diagnosis and Code First Editing for Partial Hospitalization claims

Partial hospitalization (PHP) services are only allowed for mental health disorder diagnoses. The pdx for a PHP claim must be designated as Mental Health. When a PHP claim is submitted without a mental health diagnosis reported as the principal diagnosis the claim is returned to the provider with [edit 29](#). Note: Edit 29 is suppressed from being returned if a code first diagnosis is present in the pdx position.

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

4.3.1.7 Unacceptable Diagnosis Code Editing

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

4.3.2 Procedure Code Validation

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

4.3.2.1 Procedure and Age/Sex Conflict Editing

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

4.3.3 Revenue Code Validation

Effective with the July 1, 2021 (v22.2) release, all revenue codes are validated based on the claims processing receipt date. The claims processing receipt date is meant to be utilized by CMS for validation of non-medical code sets. Revenue Codes and their effective

dates are maintained by the NUBC and are implemented in the IOCE versioning, per the NUBC's revenue code reporting effective/deactivation dates. Providers are responsible for submitting claims with active revenue codes. If a claim contains a revenue code that is not yet effective as determined by the NUBC, providers must hold claims until that effective date.

[Edit 41](#) is applied, if a claim is submitted with a revenue code prior to/ exceeding the NUBC effective/deactivation date. Once a revenue code is effective for reporting, the held claims can be submitted to Medicare and the new revenue code is validated through the IOCE based on the "Claims processing receipt date". By using the claims processing receipt date, it allows these appropriately held claims to process through the IOCE successfully and according to the effective reporting date and timely filing requirements.

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

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

Of note, not all revenue codes are recognized by Medicare. There are certain revenue codes, while on the valid revenue code list, that are not recognized by Medicare and are therefore not appropriate for use on hospital outpatient department (HOPD) claims. If revenue codes are submitted on the specified bill types, without a HCPCS code, an SI of E1 is assigned and the line is rejected with [edit 65](#). Note: Edit 48 (rev code requires HCPCS) is not triggered. Refer to the Data_Revenue table for revenue codes flagged as "Not Recognized" for applicable codes.

4.3.4 Modifier Validation

The IOCE accepts all valid CPT® and HCPCS Level II modifiers on OPPS claims. For a list of valid modifiers, refer to the Data_MODIFIER reference table. In the instance a modifier is reported that is not on the valid modifiers list, the claim is returned to the provider with [edit 22](#). Note: Revenue code 0540 (Ambulance services) uses a different list of valid modifiers than OPPS; therefore, lines with revenue code 0540 are not checked for modifier validity to avoid conflict with the OPPS list.

4.3.5 Date Validation

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

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

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

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

4.3.6 Mid-Quarter Date Editing

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

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

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

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

Medicare is required to cover new services from the date that they receive NCD approval. Claims with lines for new services that are dated prior to NCD approval are not allowed. HCPCS codes for newly approved services need to be added to the valid code list at the beginning of the quarter; therefore, when the date of NCD approval occurs mid-quarter, any claims submitted for payment with lines reported prior to the NCD approval date must be identified and are line-item denied with [edit 68](#). Note: In the instance that services are reported after the date of NCD non-coverage determination, the lines are line-item denied with [edit 83](#).

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

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

4.3.6.4 Initial Marketing Date Coverage

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

4.4 Public Health Emergency (PHE) Processing

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

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

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

5 Processing Conditions Applied to OPPS Claims Only

5.1 Medical Visit Processing

5.1.1 Medical Visits and Procedure Processing on the Same Day

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

5.1.2 Multiple Medical Visit Conditions

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

5.1.2.1 Multiple Medical Visit Conditions

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

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

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

5.1.3 Medical Visit Processing and COVID-19 Related Services

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

Effective 03/18/2020 (v21.2), OPPS claims (bill type 013x w/o CC 41) with (E&M) visit code(s) reported with modifier CS apply a payment adjustment flag (PAF) of 9 if the SI is V or J2. Critical Care visit code 99291 and HOPD specimen collection code C9803 reported with modifier CS and SI= S, are also applicable for a PAF assignment of 9. In the circumstance the visit line with modifier CS is packaged (SI=N), the payment adjustment flag is not set to 9. The reporting of modifier CS indicates that the line(s) is a COVID-19 visit with testing-related services, deductible and coinsurance is not applicable for the visit. Additionally, modifier CS should only be reported when the item or service is identified by CMS as being eligible for a coinsurance and deductible waiver. If Modifier CS is reported on items or services not eligible for a coinsurance and deductible waiver, [edit 114](#) is returned (RTP). (Refer to the DATA_HCPSC table within the data files for services flagged as coinsurance_deductible_waiver_eligible. Refer to the [Observation Processing under C-APCs](#) as this logic also applies to Comprehensive Observation C-APCs (SI= J2).

5.2 Inpatient Procedure Processing

5.2.1 Inpatient-Only Procedures

Services designated as inpatient-only are only paid by Medicare when the services are furnished in the inpatient hospital setting. These types of services are typically, but not always, surgical services which require an inpatient level of care due to (1) the complexity and nature of the procedure, (2) the underlying physical condition of patients requiring the service, or (3) the need for at least 24 hours of postoperative recovery time and monitoring before the patient can be safely discharged. Inpatient-only procedures are recognized by SI = C. When a claim is reported with inpatient-only procedure(s), the IOCE denies the line(s) with [edit 18](#). If there are no SI=T procedure lines in addition to the inpatient-only procedure on the same day or there are no SI=J1 procedure lines for any of the claim days reported, the IOCE not only denies the SI =C line(s) with edit 18, but all other line items on the same day are edited with [edit 49](#).

Refer to the [Inpatient Procedure processing under Comprehensive APCs](#) section for CAPC processing.

5.2.2 Separate Inpatient Procedures

There are inpatient-only procedures that are defined by CPT® as separate procedures. The designation of a procedure as a “Separate procedure” refers to the procedure being identified as an essential component of a total service or procedure, the CPT® guidelines. Inpatient-only procedures on the ‘separate procedure’ list, when reported with other services that are SI=T or J1, are line-item rejected with [edit 45](#).

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

5.2.3 Part B Hospital Inpatient Processing

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

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

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

5.3 Computation of Discounting Fraction

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

D = Discounting Fraction (Currently 0.5)

U = Number of Units

T = Terminated Procedure Discount (Currently 0.5)

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

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

5.3.1 Type “T” Multiple and Terminated Procedure Discounting:

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

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

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

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

All line items for which the line-item denial or rejection indicator is 1 and the line item action flag is zero, or the line item action flag is 2, 3 or 4, are ignored in determining the discount; packaged line items (the packaging flag is not zero or 3) are also ignored in determining the discount. **Note:** Surgical procedures (SI= S or T and in CPT® code range 10000-69999) reported with charges less than \$1.01 but greater than \$0.00 where the packaging flag is 0 have the packaging flag reset to 3 when there are other surgical procedures on the claim with charges greater than \$1.00.

The discounting process utilizes the APC payment rate file (see the Data_APC table in the quarterly data files). The discounting factor for bilateral procedures is the same as the discounting factor for multiple type “T” procedures.

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

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

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

5.3.1.1 Discount Formulas Applied to Type "T" Procedures

Payment Amount	Modifier 52 or 73		Modifier 50	Conditional or Independent Bilateral	Inherent or Non-Bilateral
Highest	No		No	2	2
Highest	Yes		No	3	3
Highest	No		Yes	4	2
Highest	Yes		Yes	3	3
Not Highest	No		No	5	5
Not Highest	Yes		No	3	3
Not Highest	No		Yes	9	5
Not Highest	Yes		Yes	3	3

5.3.2 Non-Type T Procedure Discounting:

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

5.3.2.1 Discount formulas applied to non-type "T" procedures:

Payment Amount	Modifier 52 or 73	Modifier 50	Conditional or Independent Bilateral	Inherent or Non-Bilateral
Highest	No	No	1	1
Highest	Yes	No	3	3
Highest	No	Yes	8*	1
Highest	Yes	Yes	3	3
Not Highest	No	No	1	1
Not Highest	Yes	No	3	3
Not Highest	No	Yes	8*	1
Not Highest	Yes	Yes	3	3

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

5.4 Conditional APC Processing

5.4.1 Processing Procedures with Status Indicators of Q1 and Q2

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

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

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

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

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

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

5.4.2 Sometimes Therapy Processing for Wound Care Services

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

5.4.3 Critical Care Processing of Ancillary Services

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

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

Critical care-packaged ancillary service code 94762 is not subject to the modifier 59, XE, XP, XS, XU exception, and always packages when present with critical care code 99291. If reported in the absence of 99291, 94762 (SI = Q3) is subject to packaging under comprehensive APC processing, otherwise it is assigned its standard APC and SI for separate payment. Note: effective with version 18.3, critical care ancillary service code 36600 is no longer subject to the modifier exception.

5.4.4 Advance Care Planning

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

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

5.4.5 Conditional Processing for Laboratory Procedures

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

- For claims with bill type 013x: if the laboratory code(s) with SI Q4 is reported with modifier L1 (Separately payable lab test) and is present with other payable OPPS services that have SI = J1, J2, S, T, V, Q1, Q2, or Q3 on the same claim, the SI is changed to A; otherwise the laboratory code(s) is packaged with SI=N. If there are only laboratory codes present, all laboratory codes with SI=Q4 are changed to SI=A.

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

- Effective January 1, 2017 (v18.0), special conditions apply to OPPS services that have a final SI of Q1, Q3, S, T, or V and a line item action flag of 2 or 3 present. If the payable OPPS service(s) has the line item action flag of 2 or 3 present, the laboratory codes with SI = Q4 are processed for payment by having the SI changed from SI=Q4 to SI=A.
- For claims with bill type 012x without condition code W2, and for claims with bill type 014x: if a laboratory code(s) is present with SI Q4, the SI is changed to A. Laboratory services on claims with bill type 012x that do contain condition code W2 remain packaged (SI = N).

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

5.5 Composite APC Processing

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

5.5.1 Partial Hospitalization and Community Mental Health Center Processing: Effective through v17.3

For PHP claims processing after January 1, 2017 (v18.0) please refer to the [Partial Hospitalization and CMHC Processing](#) section.

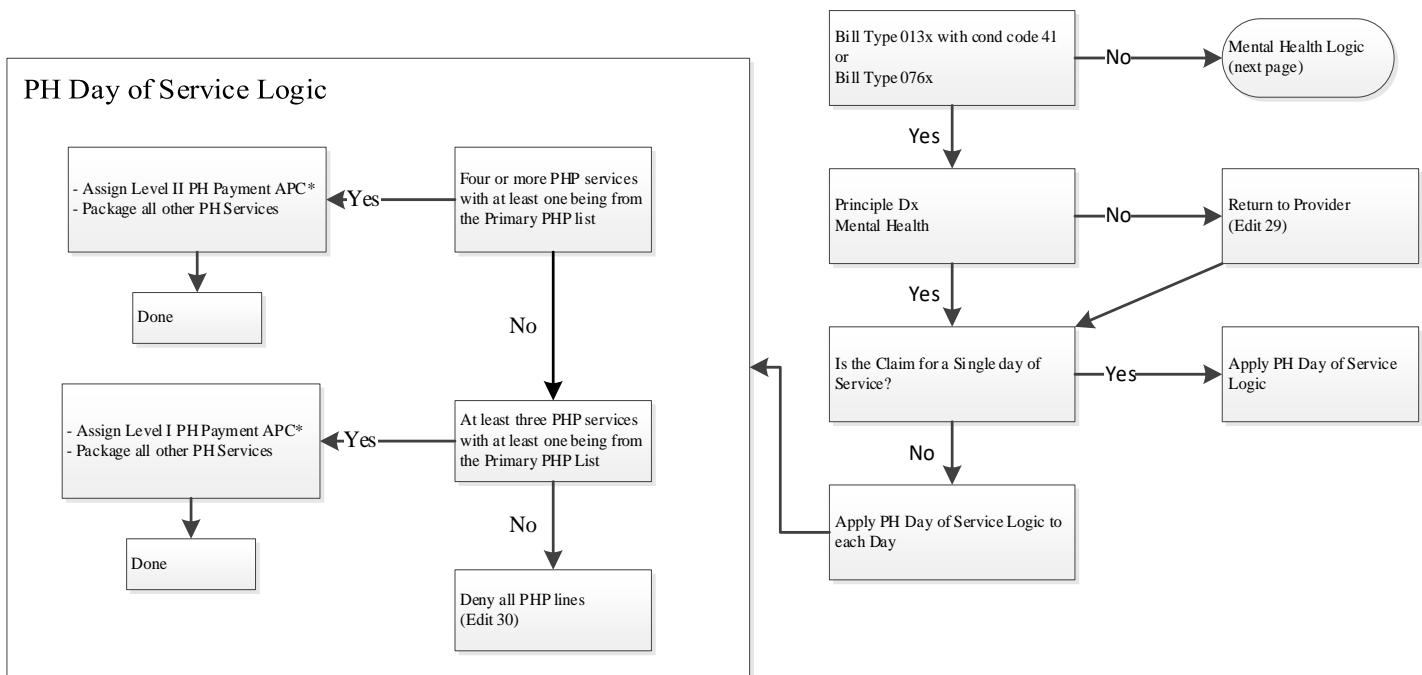
A partial hospitalization program (PHP) is a daily outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness or substance use disorder. Partial hospitalizations are identified by means of the bill type, (Hospital-based: TOB 13x with condition code 41 or CMHC: TOB 76x) condition codes and HCPCS codes specifying the individual services that represent a partial hospitalization. Partial hospitalizations are paid on a per diem basis according to the number of services reported. In order to assign the partial hospitalization APC (PHP APC), certain criteria for the amount of services provided and types of services provided must be met or the partial hospitalization day is denied ([edit 30](#)). When the criteria is met, the IOCE assigns the first listed line item with a Primary PHP service, the PHP payment APC, a final status indicator of P, a payment indicator of 8, a discounting factor of 1, a line-item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value. For all other PHP services reported for the day, the SI is changed to N, the packaging flag is set to 1, and the same composite adjustment flag value as for the PHP APC is assigned for those packaged lines. If mental health services, that are not approved for the partial hospitalization program, are submitted on a 013x TOB with CC41, or on a 076x TOB, the claim is returned to the provider ([Edit 80](#)).

Previously effective, 1/1/2011 (v12.0-v17.2), different PHP APCs, Level I and Level II, are assigned for hospital-based and Community Mental Health Center (CMHC) partial hospitalization programs according to the number of services provided. In obtaining the level II PHP APC a minimum of 4 or more services is provided, with at least one of those services being from the PH_PRIMARY list. To obtain the level I PH APC a minimum of 3 or more services is provided, with at least one of those services also being from the PHP Primary list. As mentioned above, the line item that obtains the PH APC is the first reported Primary PHP HCPCS reported (SI=P), and all other services on the claim are packaged with an SI of N. Note that the program logic determining level I or level II APCs is no longer required effective January 1, 2017 (v18.0).

Effective 7/1/2016 (v17.2), additional editing is implemented for PHP claims to monitor weekly claim submission of at least 20 hours of PHP services. PHP claims with a From and Through date greater than 7 days are returned to the provider ([edit 97](#)). Interim PHP claims, identified by bill type 0133 with condition code 41 or bill type 0763 for CMHC, that have a From and Through date span of less than 5 days are returned to the provider ([edit 96](#)). PHP claims with less than 20 hours of PH services per week are returned to the provider ([edit 95](#)). Hours of service for PHP services that result in packaging (SI = N) due to PHP APC processing are included in the total count of hours per week. If the PHP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week.

Note: Edits 95, 96 and 97 are deactivated with the October 2016 (v17.3) release, retroactively to 7/1/2016. Edit 95 is reactivated effective October 1, 2017 as an information only edit with no impact to payment.

5.5.1.1 Partial Hospitalization Logic Flowchart (Effective through v17.3)

**Notes:****Assign Partial Hospitalization Payment APC according to Bill Type**

For bill type 013xw/cc41: Level I (3 services) or Level II (4 or more services) Partial Hospitalization for Hospital-Based PHPs

For bill type 076x: Level I (3 services) or Level II (4 or more services) Partial Hospitalization for CMHCs

For any day that meets the criteria for Level I PHP APC, the first listed line item with a Primary PHP service is assigned the PHP payment APC, a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the PHP APC, assign units of service = 1 and payment adjustment flag = 11.

For all other PHP services reported for the day, the SI is changed to N, the packaging flag is set to 1, and the same composite adjustment flag value as for the PHP APC is assigned.

For ALL lines with a partial hospital service the HCPCS APC is set to 0 (effective 1/1/08).

Note: If mental health services, that are not approved for the partial hospitalization program, are submitted on a 013x TOB with CC41, or on a 076x TOB, the claim is returned to the provider (Edit 80).

5.5.2 Partial Hospitalization and CMHC Processing: v18.0- v23.3

For processing PHP claims with DMH services, or PHP claims after January 1, 2023 (v24.0), refer to the [Partial Hospitalization and Daily Mental Health Processing](#) section.

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

If there is an inpatient only procedure (SI = C) on the same claim as PHP or Daily Mental Health services, no Partial Hospitalization or Daily Mental Health processing logic is performed.

If less than the minimum amount (number and type) of services required for PHP are reported for any day, the PHP day is denied, i.e., all PHP services on the day are denied and no PHP APC is assigned (edit 30). Note that certain PHP services that are add-on codes are not included in the count of number of services for the day (Please reference the DATA_HCPCS table within the data files for list of PH_ADDON services). Any non-PHP services on the same day are processed per the usual OPPS rules. Lines that are denied or rejected are ignored in PHP processing. If mental health services that are not approved for partial hospitalization are submitted on a PHP claim (013x TOB with condition code 41 or TOB 076x), the claim is returned to the provider (edit 80).

Effective October 1, 2017 (v18.3), edit 95 is reactivated for informational purposes only, with no impact on payment. Edit 95 is returned if a PHP claim contains weekly services with less than 20 hours of PHP services per week. Hours of service for PHP services that result in packaging (SI = N) due to PHP APC processing are included in the total count of hours per week; however, certain PHP services that are add-on codes are not included towards the weekly count of hours. If the PHP service indicates a fractional time-based requirement in the procedure code description (e.g. 30 minutes), the fractional amount and the service units are utilized in the calculation of total hours per week. If conditions are present for edit 95, an informational only line item denial or rejection flag value of 3 is returned, indicating that although the conditions for edit 95 exist, payment is not impacted, and the line item rejection disposition flag in the claim return buffer is not set. The IOCE continues to process lines with edit 95 for payment by the OPPS Pricer. The IOCE does not apply edit 95 on the admission week submitted on an admission PHP claim (0761, 0762, 0131 w CC 41, or 0132 w CC41); instead, if the admission week has less than 20 hours of PHP services, Payer condition code MP is provided. The IOCE also does not apply edit 95 on the discharge week when submitted on a PHP discharge claim (0761, 0764, 0131 w CC 41, or 0134 w CC41); instead, Payer condition code MQ is provided if the discharge week contains less than 20 hours of PHP services. Effective July 1, 2019 (v20.2), the discharge week is identified as the last full (7 days) week on the claim and is never edited with 95 nor any partial days that follow; instead, MQ is returned if the last full week contains less than 20 hours of PHP services.

Effective July 1, 2019 (v20.2), the IOCE returns Payer Value Code and Value Code Amount QW on Interim PHP claims that have a partial last week present. The last 5 values of the Value Code Amount provided with QW represents the count of days and hours in which PHP services are provided for the partial week (first portion of week). For example, if the last week on an interim PHP claim is not 7 days but instead only 3 days, and in those 3 days 15 ½ hours of PHP services are provided, the last 5 values in the Value Code Amount is 000031550. Note that the partial week represented by the QW output is not edited with 95. The IOCE receives the next claim with Value Code QA and the associated value code amount from the QW output which was on the previous claim (first portion). Note that the Shared System Maintainer (SSM) may only supply this information on input. The IOCE then combines the partial week information from the previous claim and the claim being processed into one full week (7 days), if the full week does not contain up to 20 hours of PHP services, the lines on the second portion used in calculating the full week are edited with 95 and Payer Value Code MV is output. The output of MV requires the SSM to adjust the claim containing the first portion of the partial week, as the partial weeks after combining is not 20 hours. The SSM submits condition code MW on input for the PHP adjustment claim, indicating that the IOCE needs to edit the partial (last) week present on the claim. The IOCE edits with 95 on the line items associated with the partial week and outputs QW with the value code amount applicable.

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

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

health diagnosis reported as the principal diagnosis are RTP (edit 29), except in the instance of a code first diagnosis condition present.

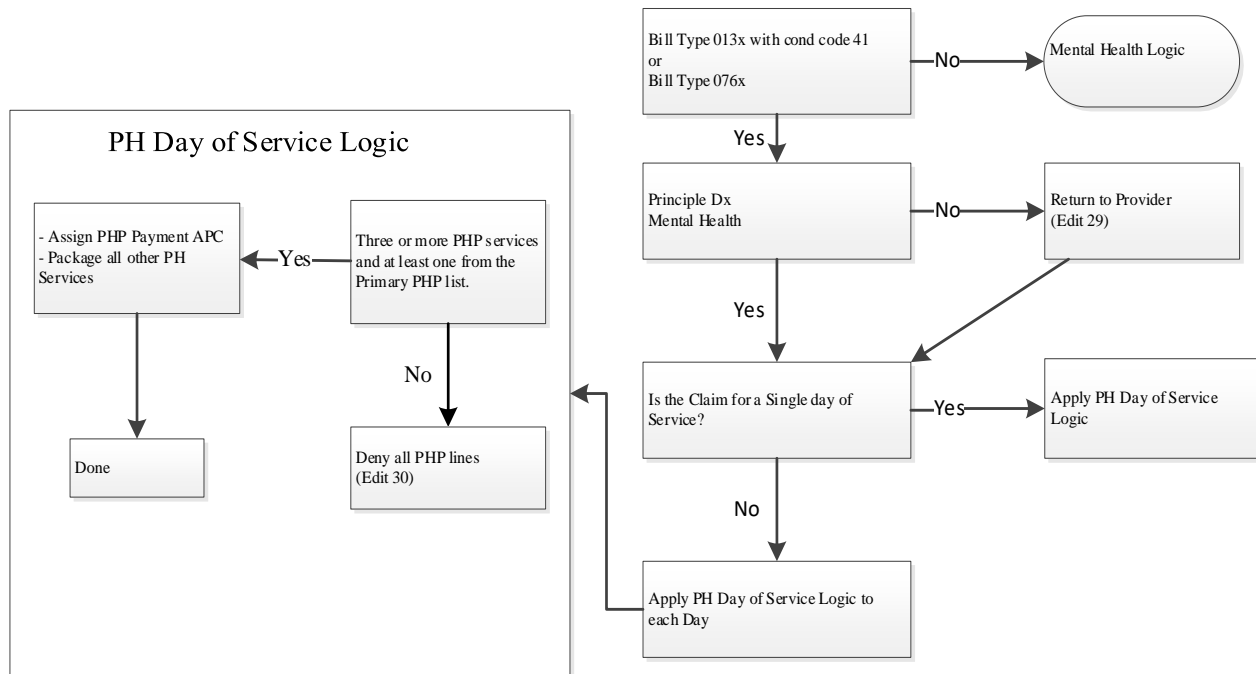
5.5.2.1 Payer Value Codes for Partial Hospitalization

Value Code	Description	Note	Dates Effective
QW	Partial week present on interim PHP claim	<p>Provided on output from the IOCE.</p> <p>The value code amount following Payer Value Code QW, zero-fill the first 4 values, the next 5 values represent an IOCE calculated amount for total days and hours of PHP services. One byte for days and 4 bytes to record full and partial hours. For example, 2 days and 8 and ½ hours converts to the following value code amount 000020850. QA is a copy of QW to be supplied on input to the IOCE.</p> <p>Note: If offset conditions do not exist, the value code label (QN-QW) is blank; the amount is zero-filled.</p>	July 1, 2019- to present
QA	Offset for combining partial PHP week on interim PHP claim	<p>Provided on input to the IOCE.</p> <p>Value Code QA is provided on input and the value code amount provided should zero-fill the first 4 values, the next 5 values represent an IOCE calculated amount for total days and hours of PHP services. One byte for days and 4 bytes to record full and partial hours. For example, 2 days and 8 and ½ hours converts to the following value code amount 000020850.</p>	July 1, 2019- to present

5.5.2.2 Payer Condition Codes for Partial Hospitalization

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

5.5.2.3 Partial Hospitalization Logic Flowchart (effective v18.0-23.3)

**Notes:****Assign Partial Hospitalization Payment APC according to Bill Type**

For bill type 013xw/cc41: Partial Hospitalization for Hospital-Based PHPs

For bill type 076x: Partial Hospitalization for CMHCs

For any day that meets the criteria for PHP APC, the first listed line item containing a Primary PHP service is assigned the PHP payment APC, a status indicator of P, a payment indicator of 8, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the PHP APC, assign units of service = 1 and payment adjustment flag = 11.

For all other PH service lines with a PH service on that day, the SI is changed to N, the packaging flag is set to 1, and the same composite adjustment flag value as for the PHP APC is assigned.

For ALL lines with a partial hospital service, the HCPCS APC is set to 0 (effective 1/1/08).

If mental health services that are not approved for the partial hospitalization program are submitted on a 013x TOB with CC41, or on a 076x TOB, the claim is returned to the provider (Edit 80).

Effective 10/1/2017 (v18.3), PHP claims containing weeks with less than 20 hours of PH services are line item rejected with edit 95, however line item denial rejection flag 3 is returned indicating no impact to payment.

5.5.3 Daily Mental Health Processing : v18.0 - Current

Prior to January 1, 2017, reimbursement for a day of outpatient mental health services in a non-PH (bill types 012x or 013x) program was capped at the amount of the level II hospital-based partial hospital per diem. This cap was performed due to limiting the costs associated with administering a partial hospitalization program representing the most resource intensive of all outpatient mental health treatment.

Effective January 1, 2017 (v18.0), the comparison for summing the payment of the individual MH services to the level II partial hospital-based per diem APC payment rate is changed to compare the sum to the single level PHP hospital-based per diem APC payment rate. Refer to [the Partial Hospitalization and Daily Mental APC](#) table for the applicable APC(s). On a non-PH claim, the IOCE totals the payments for all the designated DMH services with the same date of service; if the sum of the payments for the individual MH services exceeds the partial hospitalization single level hospital-based per-diem (PHP APC) payment rate, the IOCE assigns a special “Mental Health Service” composite payment APC (DMH APC) to one of the line items that represent DMH services.

Effective 4/1/2015 (v16.1), [payment adjustment flag value 11](#) is assigned to the Mental Health payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing. All other MH services for that day are packaged; SI changed from Q3 to N. A composite adjustment flag (CAF) identifies the Mental Health Service composite APC and all the packaged MH services on the day that are related to that composite. Additionally, lines that are denied or rejected are ignored in the Daily Mental Health logic processing. Note: The payment rate for the Mental Health Services composite APC is the same as that for the single level hospital-based partial hospitalization APC.

Some DMH services are specific to partial hospitalization and are not payable outside of a PH program; if any of these codes is submitted on a bill types 012x, or 013x without condition code 41, the claim is returned to the provider ([edit 81](#)).

5.5.3.1 Daily Mental Health Education and Training

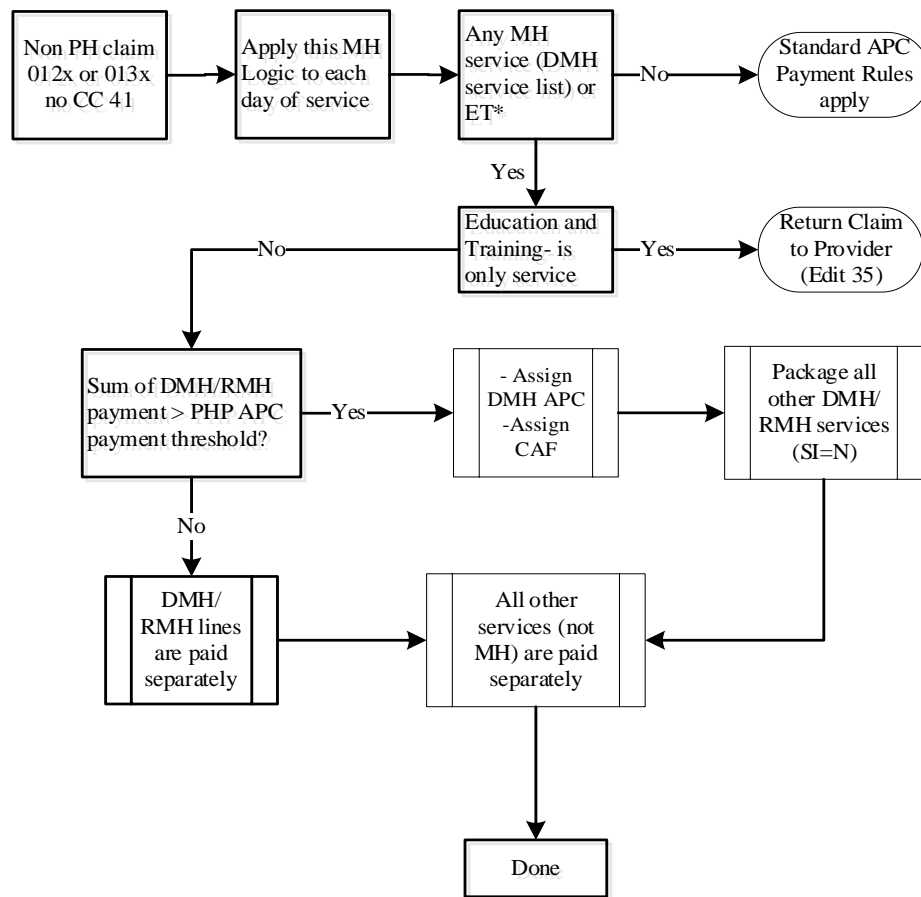
The use of code G0177 (Education and Training) is allowed on MH claims that are not billed as Partial Hospitalization. If Education and Training is the only service reported for the day, the claim is returned to the provider with [edit 35](#). Note: For a multi-day claim, if Education and Training is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

5.5.3.2 Daily Mental Health and Remote Mental Health Processing: v24.0- Current

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

The Flowchart for Daily Mental Health Processing is located on the next page.

5.5.3.3 Daily Mental Health Logic Flowchart v24.0

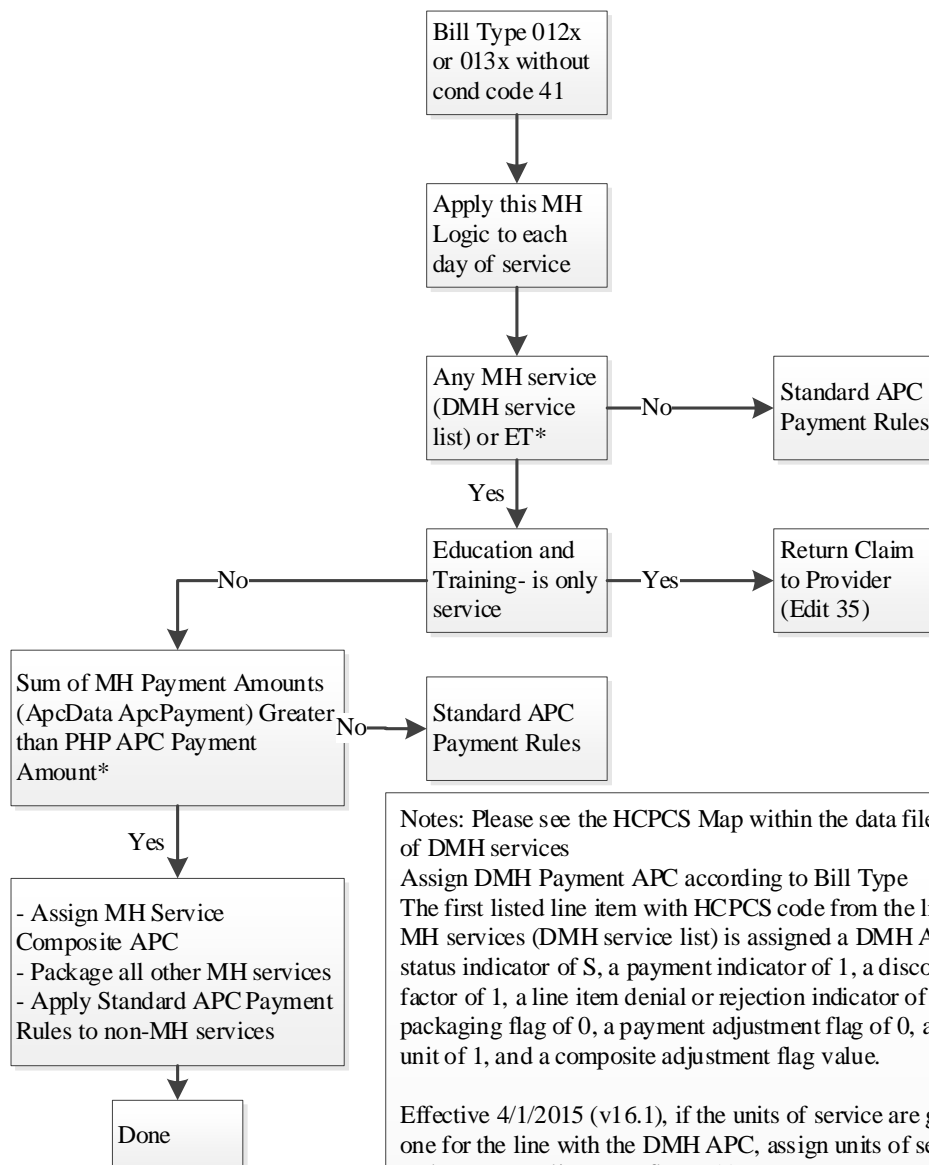


PH = Partial Hospitalization
 MH = Mental Health
 RMH= Remote Mental Health

Notes:

- The first listed line item with HCPCS code from the list of Daily MH services (DMH service list) is assigned a DMH APC, a status indicator of S, a payment indicator of 1, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value. **Note: If a qualifying RMH service is listed prior to the DMH service, the RMH service will receive the DMH APC.**
- The use of code G0177 (Education and Training (ET*)) is allowed on MH claims that are not billed as Partial Hospitalization.
- **Effective 1/1/2023 (v24.0),** the use of Remote Mental Health (RMH) codes are allowed on MH claims and count towards the DMH cap. **If RMH is reported by an add-on code only, the line is denied.**

5.5.3.4 Daily Mental Health Logic Flowchart (Prior to v24.0)



PH = Partial Hospitalization
MH = Mental Health

Notes: Please see the HCPCS Map within the data files for a list of DMH services

Assign DMH Payment APC according to Bill Type
The first listed line item with HCPCS code from the list of Daily MH services (DMH service list) is assigned a DMH APC, a status indicator of S, a payment indicator of 1, a discounting factor of 1, a line item denial or rejection indicator of 0, a packaging flag of 0, a payment adjustment flag of 0, a service unit of 1, and a composite adjustment flag value.

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the DMH APC, assign units of service = 1 and payment adjustment flag = 11.

For all other line items with a daily mental health service (DMH list), the SI is changed to N, the packaging flag is set to 1, and the same composite adjustment flag value as for the DMH APC line is assigned.

The use of code G0177 (Education and Training) is allowed on MH claims that are not billed as Partial Hospitalization

If mental health services, that are not payable outside the PH program, are submitted on a 012x or 013x TOB without CC41, the claim is returned to the provider (Edit 81).

*Effective 1/1/2017 (v18.0), the sum of MH payment amounts are compared to the single Partial Hospital-Based APC payment rate (no longer Level I/Level II PHP APCs).

5.5.4 Partial Hospitalization and Daily Mental Health Processing: v24.0 - Current

Effective January 1, 2023 (v24.0), the IOCE allows daily mental health (DMH) services to be reported on a PHP claim (13x w/ CC41) along with PHP services, edit 80 is no longer returned.

When a Partial Hospitalization composite is met and a PHP APC is obtained, the first line item containing the HCPCS code from the PH_PRIMARY list is assigned the PHP APC and a final SI = P. All other partial hospitalization services on the same day are packaged, SI is changed to N. A composite adjustment flag (CAF) is assigned by the IOCE to identify the PHP APC and all the packaged PHP services on the day. (Note: A different composite adjustment flag is assigned for each PHP day on the claim). Additionally, the payment adjustment flag value of 11 is assigned to the PHP payment APC line when the service units are greater than one, indicating the service units are reduced to one by IOCE processing. In the instance that DMH services are also reported in the presence of a PHP APC, the IOCE assigns the first DMH service line item to the DMH composite APC (DMH APC) with a payment method flag =1, and all other DMH services package (SI=N) into the DMH APC. (Note: The DMH APC is assigned even if the DMH composite cap threshold has not been exceeded when the PHP composite APC has been assigned for the day). The IOCE assigns a unique CAF to the DMH services, different from the PHP APC CAF, to identify the line with the DMH APC and any other DMH packaged services. This further indicates to the OPSS Pricer program that there is no additional payment for the DMH composite lines on the same date of service.

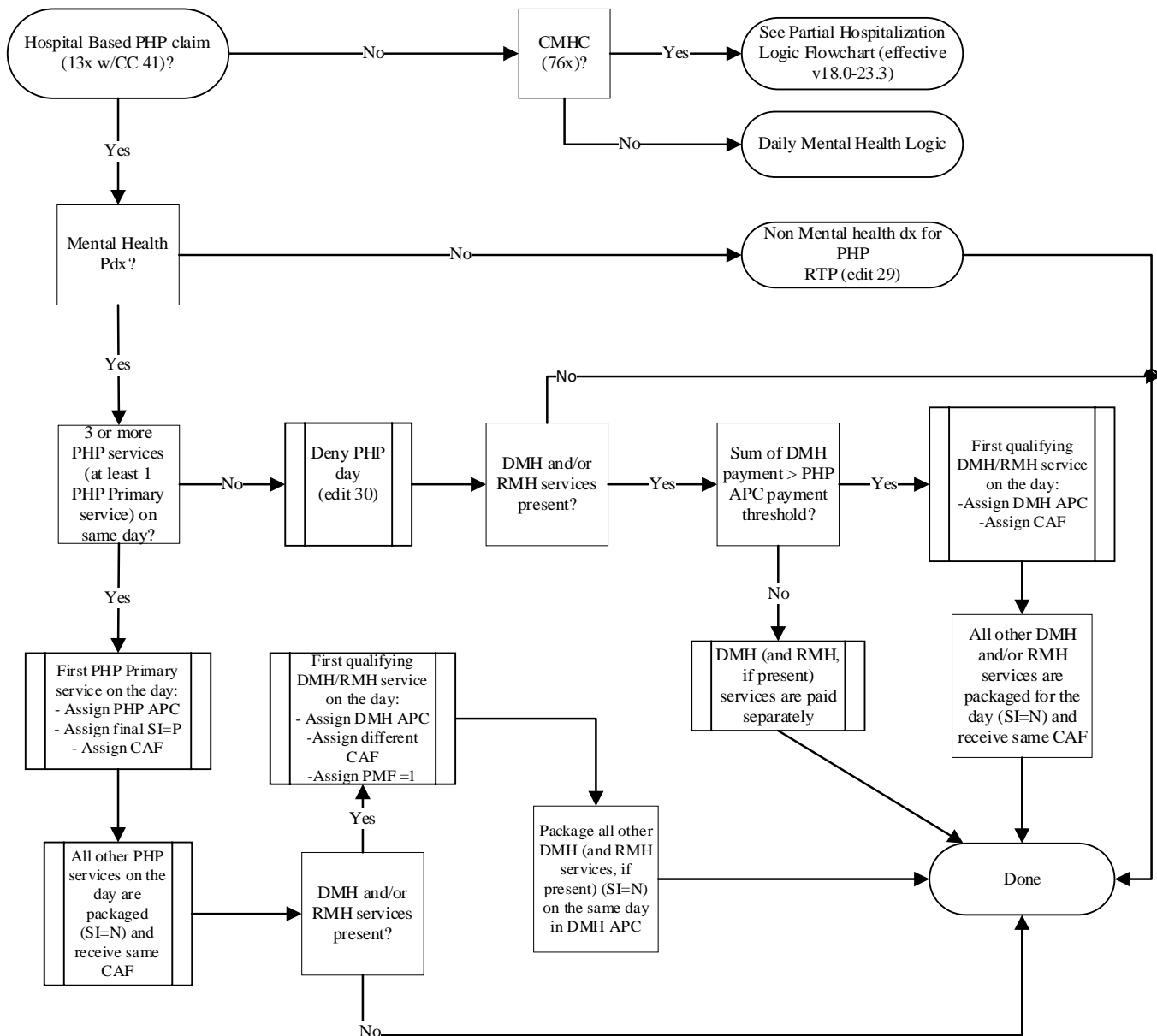
The processing of Remote Mental Health (RMH) services is also allowable on PHP claims. These services are provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder and furnished to beneficiaries in their homes by clinical staff of the hospital using communications technology.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

If less than the minimum amount (number and type) of services required for PHP are reported for any day, the PHP day is denied, i.e., all PHP services on the day are denied ([edit 30](#)) and no PHP APC is assigned. In the instance that MH services are reported and there is no PHP APC assigned, and the sum of payments for those DMH services exceed the Daily Mental Health composite cap (single level PHP hospital-based APC payment rate), the IOCE assigns the DMH APC, as a payable APC, to the first mental health service line, and all other DMH services for that day are packaged; SI is changed to N. A CAF is assigned by the IOCE to identify the DMH APC and all other packaged MH services on the day related to the DMH composite.

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

Note: There are services that are identified as both PHP (PH_Primary or PH_Service in the DATA_HCPCS table) and DMH (Daily_Mental_Health in the Data_HCPCS table). In the instance that PHP service lines are denied for the day with one or more of those service lines identified as also DMH, the denied line(s) are not processed within the DMH logic.

5.5.4.1 Partial Hospitalization and Daily Mental Health Processing Logic Flowchart v24.0

**Notes:**

- Effective v24.0, edit 80 no longer returns if DMH services are reported on a TOB 13x w/CC 41.
- In the presence of a PHP APC, DMH services package into DMH composite APC with no additional payment, PMF=1.
 - Remote Mental Health services (RMH) also package into DMH APC, when present.
- If no PHP APC is assigned, PHP lines are denied. DMH services reported continue standard DMH processing to determine if DMH composite is met.

Note: RMH services also count toward the DMH composite cap, when present.
- If no PHP APC or DMH APC are assigned, DMH and RMH services (when present) are paid separately via standard APC processing.

5.5.4.2 Partial Hospitalization and Daily Mental Health APC Table

APCs that are no longer effective are shaded in light gray.

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

5.5.5 CMHC Partial Hospitalization Processing: v24.0 - Current

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

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

5.5.6 LDR Prostate Brachytherapy Composite APC Processing and Assignment Criteria: [v9.0-v18.3]

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

Prime/Group A code	Non-prime/Group B code	Composite APC
55875	77778	08001

- A. If a ‘prime’ code is present with at least one non-prime code from the same composite on the same date of service, assign the composite APC and related status indicator to the prime code; assign status indicator N to the non-primary code(s) present.
- B. Assign units of service = 1 to the line with the composite APC.
- C. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.
- D. If there is more than one prime code present, assign the composite APC to the prime code with the lowest numerical value and assign status indicator N to the additional prime code(s) on the same day.
- E. Assign the indicated composite adjustment flag to the composite and all component codes present.
- F. If the composite APC assignment criterion is not met, assign the standard APC and related SI to any/all component codes present.
- G. Terminated codes (modifier 52 or 73 present) are ignored in composite APC assignment.
- H. Procedures that are packaged (SI changed to ‘N’ in an earlier processing step) are not included in the composite assignment logic.
- I. Effective 1/1/2017 (v18.0), prime code 55875 may be subject to comprehensive APC processing when reported without non-prime code 77778.

5.5.7 Multiple Imaging Composite Logic with Assignment Rules & Criteria:

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

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

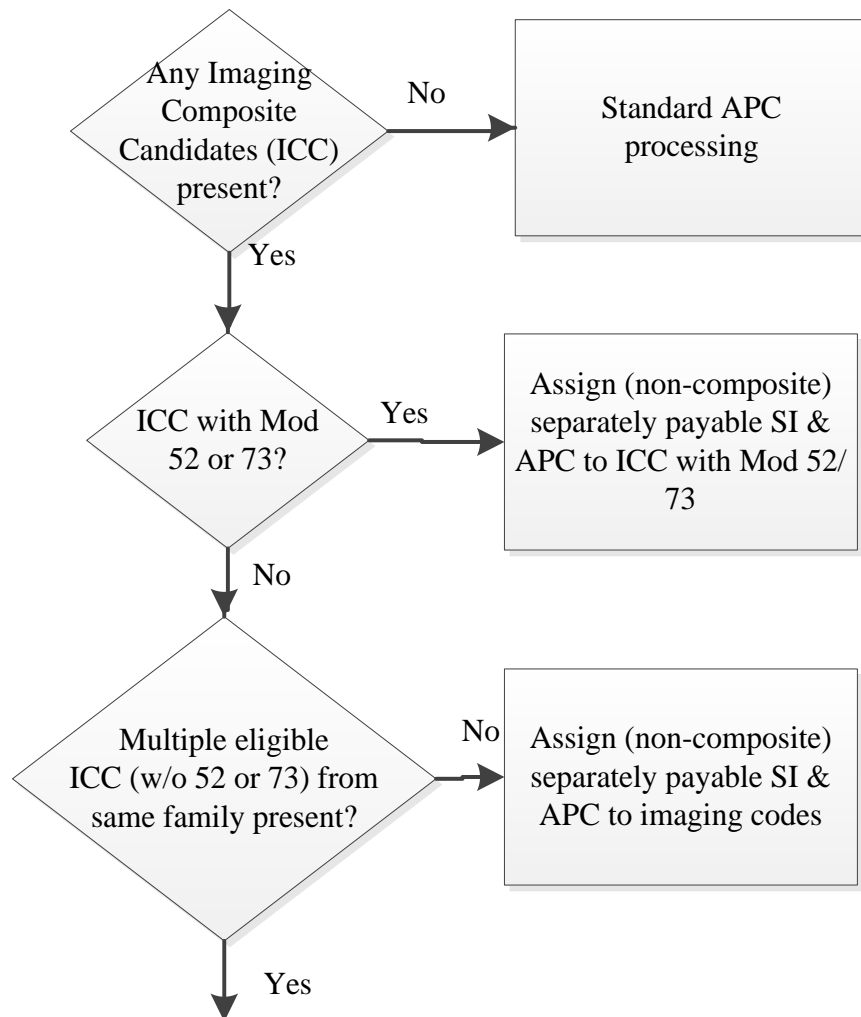
Note that when a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the “with contrast” composite APC (either APC 8006 or 8008) is assigned.

- A. Within two of the imaging families (i.e., CT/CTA and MRI/MRA), imaging composite APCs are further assigned based on procedures performed with contrast and procedures performed without contrast. There is currently a total of five multiple imaging composite APCs (08004, 08005, 08006, 08007, and 08008). For a list of procedures eligible for the composite assignment, refer to the MAP_COMPOSITE table within the data files.
- B. If multiple imaging procedures from the same family are performed on the same DOS, a multiple imaging composite APC is assigned to the first eligible code encountered; all other eligible imaging procedures from the same family on the same day are packaged (the status indicator is changed to N).
- C. Multiple lines or multiple units of the same imaging procedure count to assign the composite APC; independent or conditional bilateral imaging procedures with modifier 50 count as 2 units.
- D. If multiple imaging procedures within the CT/CTA family, or the MRI/MRA family are performed with contrast and without contrast during the same session (same DOS), the ‘with contrast’ composite APC is assigned.
- E. Imaging procedures that are terminated (modifier 52 or 73 present), are not included in the multiple imaging composite assignment logic; standard imaging APC is assigned to the line(s) with modifier 52 or 73 (SI changed from Q3 to separately payable SI and APC).
- F. Imaging procedures that are packaged (SI changed from Q# to N in an earlier processing step) are not included in the multiple imaging composite assignment logic.
- G. If the imaging composite APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.
- H. Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, the OCE re-assigns units of service = 1 and returns a payment adjustment flag = 11.
- I. Effective 1/1/2016 (v17.0), certain CT scan codes performed on equipment not meeting NEMA standards are reported with modifier CT. If multiple CT scan codes reported with modifier CT are present, and contribute to the assignment of a composite APC, the first eligible line assigned to the composite APC receives payment adjustment flag 14, whether or not modifier CT is reported on the line. All other CT scan codes reported with modifier CT that are included for composite APC assignment are packaged (SI = N), and do not have payment adjustment flag 14 assigned.
- J. Lines that are candidates for composite APC assignment that are present on a comprehensive APC claim do not have the composite adjustment flag applied; composite candidates are packaged with SI = N under comprehensive APCs.
- K. Special consideration is given to code 75635, which is a current composite candidate under ultrasound with SI = Q2 which makes it eligible for conditional APC processing. If 75635 is present, consideration of separate payment under conditional APC processing is evaluated prior to composite candidate consideration. If composite conditions are not present, then 75635 is processed for separate payment or packaging under conditional APC processing.

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

The flowchart for Multiple Imaging Composite Logic is located on the next page.

5.5.7.1 Multiple Imaging Composite Flowchart

**Assign Multiple Imaging Composite APC**

(see multiple imaging composite APC report within the data files for the lists of eligible candidates for each imaging family/composite APC):

For the first code encountered in the composite family – assign the composite APC, SI, PI, packaging flag = 0, composite adjustment flag = (01-xx), discount factor = 1, units output = 1

Effective 4/1/2015 (v16.1), if the units of service are greater than one for the line with the composite APC, assign units of service = 1 and payment adjustment flag = 11.

For all other eligible codes from the same family present – change the SI from Q3 to N, assign packaging flag = 1, same composite adjustment flag

Note: If there are a mix of eligible imaging candidates with & without contrast from the same imaging family, the “with contrast” composite APC is assigned.

5.6 Comprehensive APC Processing

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

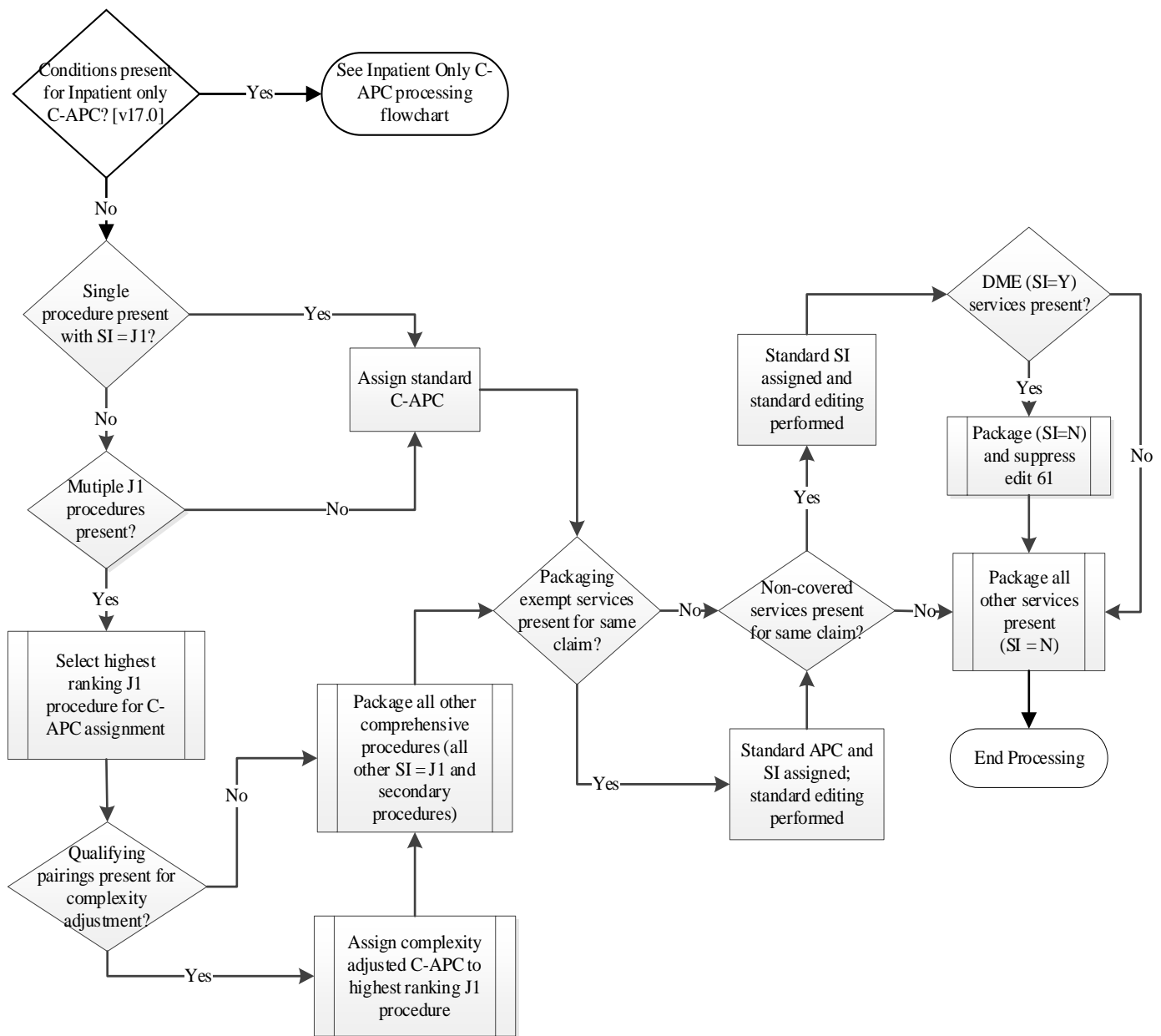
5.6.1 General Comprehensive APC Assignment Rules and Criteria: V16.0- Current

- A. Comprehensive APC processing is performed only for OPPS claims with bill type 013x or claims with bill type 012x with condition code W2.
- B. Comprehensive APCs are assigned using the following hierarchy:
 1. Inpatient-Only Patient Expired (SI = J1)
 2. High-Cost Procedures (SI = J1)
 3. Comprehensive Observation (SI = J2)
- C. If there are multiple comprehensive APC procedures existing on the same claim from the different categories listed above, the comprehensive APC procedures are packaged (SI = N) according to the hierarchy of services present; the procedure or service highest in the hierarchy is assigned the comprehensive APC for the claim. Additional processing conditions for each of the different categories is listed separately below.
- D. Multiple service units reported on a comprehensive APC line are reduced to one for processing payment based on a single comprehensive APC payment rate; payment adjustment flag 11 is assigned.
- E. Services that are excluded from comprehensive APC packaging include; ambulance, brachytherapy (SI=U), mammography, physical therapy, speech-language pathology, occupational therapy services, pass-through drugs, biologicals and devices (SI= G or H), preventive care including influenza, Hepatitis B, COVID-19 and pneumococcal vaccines (SI=L), self-administered drugs (SADs), corneal tissue acquisition, certain CRNA services, monoclonal antibody administration for COVID-19, services assigned to New Technology APCs (1491-1599 and 1901-1908) with SI = S or T and FDA-authorized or approved drugs and biologicals (including blood products (i.e. packed red cells or whole blood) reported with the appropriate revenue code) that are authorized or approved to treat or prevent COVID-19.

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

The flowchart for Comprehensive APC Processing is located on the next page.

5.6.1.1 Comprehensive APC Processing Flowchart (SI= J1) (v17.0)

Notes:

1. C-APC = Comprehensive APC.
2. Units of service greater than one for a comprehensive APC procedure line are reduced to one. Payment adjustment flag = 11 is assigned indicating to Pricer that only a single comprehensive APC payment rate is calculated for lines reporting multiple units of service.
3. The highest ranked J1 procedure is where the C-APC is assigned; all other services are packaged with SI = N, except for non-covered services and services excluded from C-APC packaging logic.
4. Complexity adjusted comprehensive APC assignment occurs when there is a qualifying pair of comprehensive procedures with SI = J1, or a comprehensive procedure with a qualifying add-on procedure code with SI = N, or may be multiple occurrences or service units of the same comprehensive procedure.
5. Effective v17.0, if SRS planning and preparation codes are present on the same claim with the SRS C-APC, the planning and preparation codes are excluded from the C-APC packaging logic.

5.6.2 Inpatient Procedure Processing under Comprehensive APCs

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

Effective January 1, 2016 (v17.0), if an inpatient-only procedure is present with modifier CA for a patient who expires or transfers to another hospital (patient status code is 2, 5, 20, 62, 63, 65, 66, 82, 85, 90, 91, 93 or 94), the inpatient procedure is assigned under a comprehensive APC (SI = J1), and all other services reported on the claim are packaged (SI= N), except for those items excluded under comprehensive APC processing. Excluded items with non-covered SI = B, E1, E2, C or M return line-item denial [edit 121](#) (non-covered service reported with an inpatient only procedure in which the patient expired or transferred) in addition to the payment indicator 3 and payment method flag 1.

If modifier CA is reported for an inpatient-only procedure and the discharge status does not indicate the patient expired or transferred, the claim is returned to the provider ([edit 70](#)). Additional comprehensive APC procedures (SI = J1 or J2) reported on the same claim as the inpatient-only procedure where the patient expired or transferred are packaged (SI = N). If multiple lines, or one line with multiple units, have SI = C and modifier CA, generate [edit 60](#) for all lines with SI = C and modifier CA. Note: When the specific edit criteria are met, inpatient-only procedure lines that result in being assigned to the Inpatient-Only Expired Comprehensive APC (SI = J1), that may or may not be reported with modifier CA, also generate edits 60 and/or 70.

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

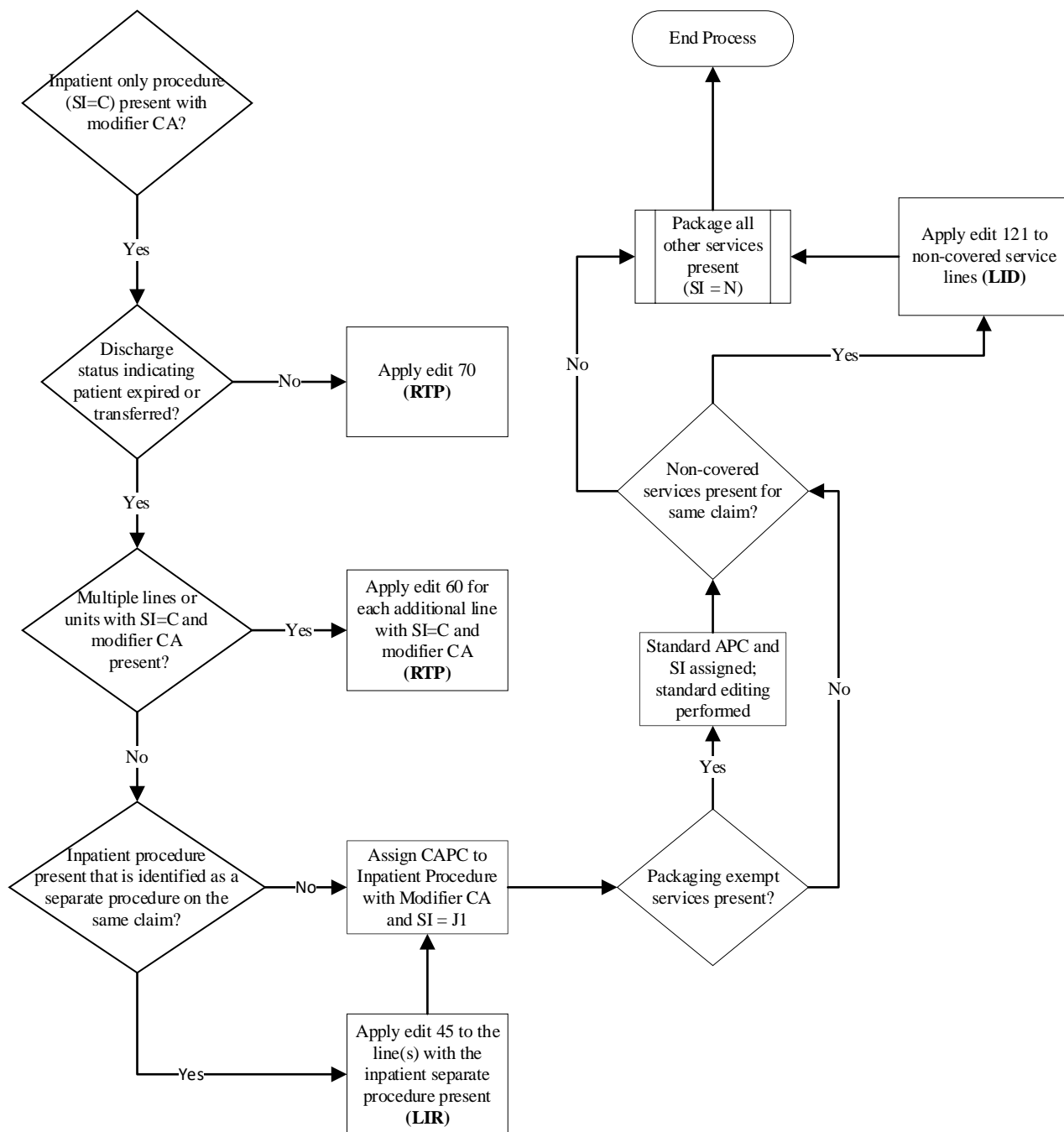
Effective January 1, 2018, if procedure code 01402 (Anesthesia for TKA) is reported on the same claim as procedure code 27447 (Total Knee Arthroplasty) the SI of procedure code 01402 changes from C to N and will always package. If procedure code 01402 is reported with any other procedure code without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

5.6.2.1 Patient Discharge Status Codes for use with CAPC Inpatient Procedure Processing Logic

Discharge Code	Description
02	Short Term Hosp
05	Canc/Child hosp
20	Died
62	Rehab facility/rehab unit
63	Long term care
65	Psych hosp/ unit
66	Critical Access hospital
82	Short Term Hospital w/ Planned Readmission
85	Canc/ child hosp w/Planned readmission
90	Discharged/transferred to an inpatient rehabilitation facility (IRF)
91	Discharged/transferred to a medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

The flowchart for Inpatient Procedure Processing under Comprehensive APCs is located on the next page.

5.6.2.2 Inpatient Procedure Processing under Comprehensive APCs Flowchart (v23.3)



Notes:

1. C-APC = Comprehensive APC.
2. Effective v17.0, conditions for inpatient-only procedures when the patient expires or transfers are assigned a C-APC with SI = J1. If this condition exists, no other C-APC is assigned for the claim.
3. If an inpatient-only procedure is present with modifier CA, the inpatient procedure is assigned under a comprehensive APC (SI = J1), and all other services not excluded that are reported on the same claim are packaged (SI = N).
4. Non-covered services with SI = B, E, E1, E2, C or M have edit 121 applied.

5.6.3 Comprehensive APC Assignment for High-Cost Procedures (v16.0 - Current)

- A. If a single comprehensive procedure (SI = J1) is present on a claim, assign the standard comprehensive APC for all-inclusive claim payment.
- B. If multiple comprehensive APC procedures are present, select the highest ranked comprehensive procedure for standard comprehensive APC assignment.
- C. Once the highest ranked comprehensive procedure is determined, if there are multiple comprehensive procedures present with SI=J1 or there are qualifying add-on procedure codes present (SI = N), determine if there are any pairings that may qualify for a complexity adjustment. Multiple occurrences or service units of the same comprehensive procedure, or the reporting of modifier 50, may qualify for complexity adjustment. If there is a qualifying pair present associated with the highest ranked comprehensive procedure, assign the complexity-adjusted comprehensive APC.
- D. If the highest ranked comprehensive procedure has service units greater than one, reduce the service units to one and assign [payment adjustment flag 11](#).
- E. If a comprehensive APC procedure is terminated by the reporting of modifier 52, 73 or 74, no complexity adjustment is performed for the claim; the standard comprehensive APC is assigned to the comprehensive procedure with the highest rank. Usual terminated procedure discounting is applied if modifiers 52 or 73 are reported (modifier 74 does not apply the terminated procedure discount).
- F. If the comprehensive APC is assigned to an independent or conditional bilateral code with modifier 50, the modifier is ignored in assigning the discount formula.
- G. Effective 1/1/2016 (v17.0), when SRS (stereotactic radiosurgery) planning and preparation codes are reported on the same claim as the comprehensive APC for SRS (APC 05627), the planning and preparation codes are excluded from packaging; the standard SI and APC, or the composite APC and SI (if criteria is met for multiple CT scan imaging procedures) are assigned. If the SRS planning and preparation codes are reported on a claim with any other comprehensive APC procedure, the codes are packaged under the comprehensive APC packaging criteria.
- H. Effective 1/1/2016 (v17.0), if conditions are present for pass-through device offset, a single device offset is provided for comprehensive APC claims only if the comprehensive APC procedure is paired with the pass-through device. Otherwise, no device offset is provided for device offset conditions that may be present for procedures that are packaged (SI = N) because of comprehensive APC processing.
- I. Effective 1/1/2019 (v20.0), procedure codes assigned to New Technology APC's are excluded from packaging under comprehensive APC processing logic for J1 or J2 services; standard SI and APC are assigned. Note: Procedure codes assigned to New Technology APC's which have a standard SI = T, prevent a J2 comprehensive observation APC from being assigned, due to standard [Observation C-APC assignment criteria](#).

5.6.4 Observation Processing under C-APCs

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

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

Effective 03/18/2020 (v21.2), OPPS claims (bill type 013x w/o CC 41) with E&M visit code(s) reported with modifier CS that meet the criteria for Observation C-APC assignment (SI = J2) or are assigned standard SI=V, return a [payment adjustment flag](#) of 9. Critical care code 99291 reported with modifier CS with an SI = S instead of SI=J2, is also applicable for a PAF assignment of 9. If the final status indicator for a visit line(s) with modifier CS is packaged (SI=N), the payment adjustment flag is not set to 9. The reporting of modifier CS indicates that the line(s) is a COVID-19 visit with testing-related services, deductible and coinsurance is not applicable for the visit. Additionally, modifier CS should only be reported when the item or service is identified by CMS as being eligible for a coinsurance and deductible waiver. If Modifier CS is reported on items or services not eligible for a coinsurance and deductible waiver, [edit 114](#) is returned (RTP). (Refer to the DATA_HCPCS table within the data files for services flagged as [coinsurance_deductible_waiver_eligible](#). Refer also to the [Medical Visit Processing and COVID-19 Testing-Related Services](#) as this logic is applicable to the medical visit processing logic.

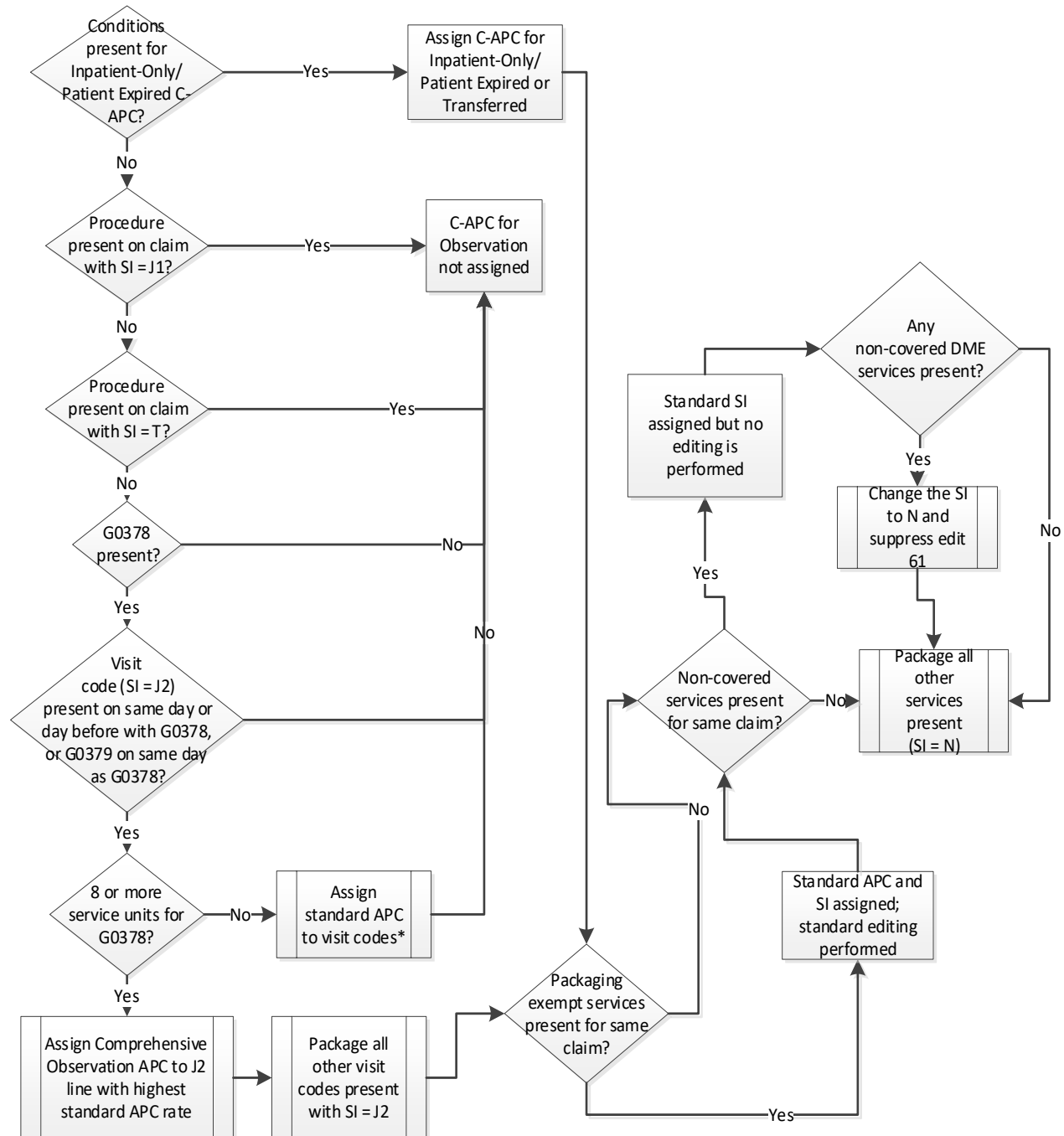
5.6.4.1 Comprehensive Observation APC Assignment Criteria:

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

The flowchart for Comprehensive APC for Observation processing is located on the next page.

5.6.4.2 Comprehensive APC for Observation Processing Flowchart (SI = J2) (v17.0)

Standard SI assigned and standard editing performed

**Notes:**

1. C-APC = Comprehensive APC.

2. The visit code with SI = J2 and the highest standard APC rate is where the C-APC is assigned; all other services are packaged with SI = N, except for non-covered services and services excluded from C-APC packaging logic.

Note: Edits are returned for excluded codes, or codes with SI values that are excluded, under inpatient only CAPC processing,

3. Conditions for inpatient-only procedures when the patient expires or transfers are assigned a C-APC with J1. If this condition exists, no other C-APC is assigned for the claim.

4. Observation claims not meeting the conditions for C-APC assignment are processed as visits under standard APC assignment (SI = V). *If G0379 is present and there is also a procedure present with SI = T or another SI = V procedure present, G0379 is packaged (SI = N).

5. HCPCS G0378 may only be reported once on the claim, if reported more than once, edit 51 is applied and the secondary occurrence is ignored from C-APC assignment.

5.7 Device-Intensive Procedure Editing and Processing

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

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

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

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

5.7.1 Device Credit Conditional Processing

Effective 1/1/2016 (v17.0), if conditions exist for full or partial device credit for a device-intensive APC represented by the presence of condition code 49, 50 or 53, the device credit amount is output by the IOCE with Payer Value Code [QU](#), which is used by the OPPS Pricer program to reduce the device-intensive APC payment rate by the device credit amount. A unique [payment adjustment flag value](#) of 17 identifies the device-intensive procedure for which the device credit applies. In the event there are multiple device intensive APCs present for device credit, the credits are summed, and the total is provided in the value code amount field; the payment adjustment flag of 17 is assigned for each device intensive procedure associated with the device credit. Device-intensive procedures that are packaged (SI = N) do not contribute to the device credit amount, and a payment adjustment flag is not returned. If the device-intensive procedure is a comprehensive APC procedure and is also eligible for complexity-adjusted APC assignment under comprehensive APCs, the device credit amount for the complexity-adjusted comprehensive APC is provided.

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

5.7.2 Pass-through Device Processing

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

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

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

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

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

5.7.3 Payer Value Codes for Device Intensive Procedure Processing

Value Code	Description	Note	Dates Effective
QN	First APC device offset	<p>Provided on output by the IOCE.</p> <p>Assigned with a value Code amount representing the payment offset when claims with pass-through device HCPCS codes (SI = H) furnished with certain device-intensive procedures require a payment offset to the APC payment rate for the procedure.</p>	1/1/2016-to present
QO	Second APC device offset	<p>Provided on output by the IOCE.</p> <p>Assigned if there is an additional condition present for a separate device offset.</p>	1/1/2016-to present
QQ	Terminated procedure with pass-through device	<p>Provided on output by the IOCE.</p> <p>Assigned with the device portion cost amount when there is a procedure identified in the Data_HCPCS table as a terminated device-intensive procedure and is reported with modifier 73.</p>	1/1/2016-to present
QU	Condition for device credit present	<p>Provided on output by the IOCE.</p> <p>Assigned when conditions exist for a full or partial device credit for a device-intensive APC represented by the presence of condition code 49, 50 or 53, the device credit amount is output.</p>	1/1/2016-to present

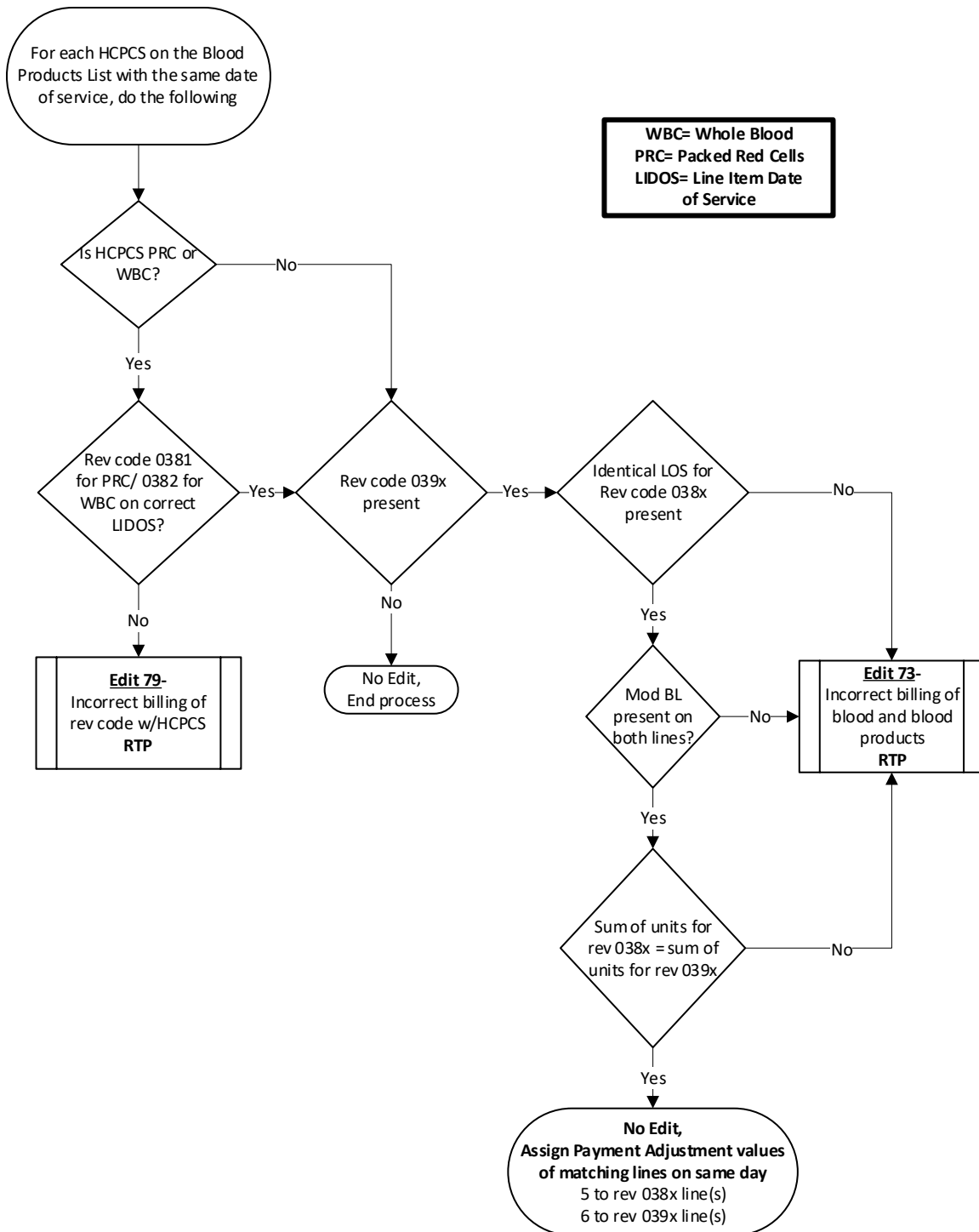
5.8 Blood and Blood Storage Processing

In order for Medicare to correctly allocate payment for blood processing and storage, providers are required to submit two lines with different revenue codes for the same service when blood products are billed. One line is required with revenue code 039x and an identical line (same HCPCS, modifier BL and units) with revenue code 038x. Modifier BL, special acquisition of blood and blood products, is required to be present on each line for the specified revenue codes or the claim is returned the provider ([edit 73](#)). Revenue code 0381 is reserved for billing packed red cells and revenue code 0382 is reserved for billing whole blood; if packed red cells and whole blood are not reported correctly, the claim is returned to the provider ([edit 79](#)). If both lines match (same HCPCS, modifier BL and units) edit 73 is not applicable and payment adjustment flag values 5 and 6 are applied (5 to revenue code 038x and 6 to revenue code 039x). Note: Payment Adjustment Flag values are not assigned to packaged blood lines.

Effective 1/1/2015, packed red cells reported with revenue code 0381 and whole blood reported with revenue code 0382 that appear on a claim with a comprehensive APC procedure (SI = J1) are excluded from packaging; the standard SI is retained.

The blood and blood storage processing flowchart is located on the next page..

5.8.1 Billing for Blood/ Blood Products Flowchart



5.9 Managed Care Processing

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

5.10 Preventive Services and Deductible/Coinsurance Waiver Processing

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

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

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

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

5.11 Opioid Treatment Program Processing

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

5.12 Opioid Use Disorder Model Processing

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

For additional criteria for reporting OUD office-based HCPCS for FQHC claims under the OUD demonstration model, please refer to the [FQHC PPS processing section](#).

5.13 Special Processing for Drugs and Biologicals

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

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

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

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

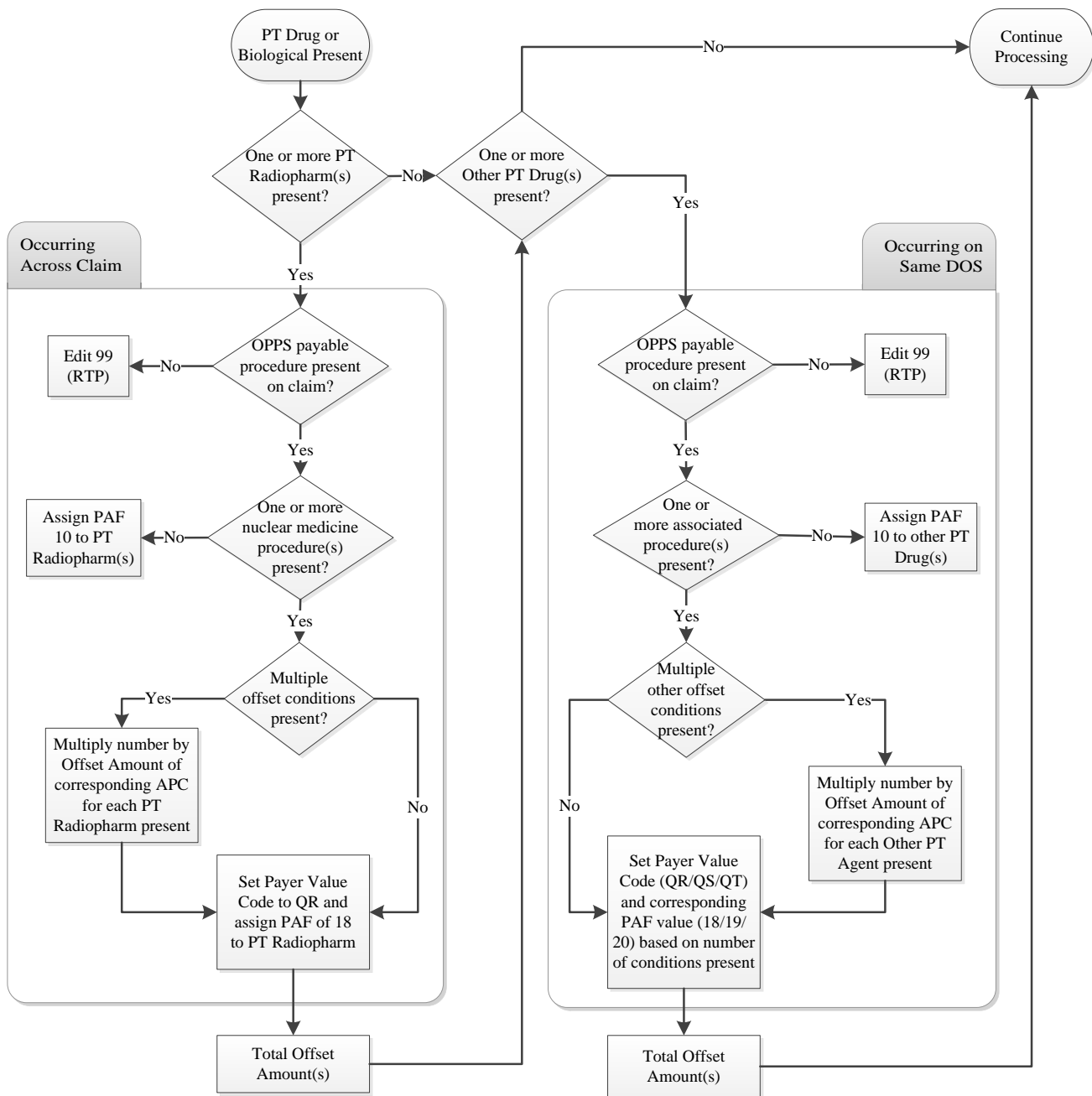
Effective July 1, 2021 (v22.2), drug HCPCS with final SI= G or K that are reported with token charges less than \$1.01 and at least \$0.01 are line item rejected ([edit 117](#)), unless a LIAF of 2, 3, or 4 is present. Note: Token charges are greater than \$0.00 and less than \$1.01.

Effective January 1, 2018 (v19.0), any service that is identified as a method used in manufacturing a drug or biological are not paid separately; these services are bundled into the total cost of the drug or biological. Claims submitted using these bundled services (HCPCS) are line item rejected with [edit 111](#), indicating that the service cost is duplicative. If the service identified as being bundled into the cost of the biological has a SI=B, edit 62 is not returned and instead edit 111 is applied. Additionally, if revenue code 0870, 0871, 0872, or 0873 (Cell/Gene Therapy) are reported with blank HCPCS, [edit 111](#) is returned (LIR) to identify that the charges associated with the revenue center are bundled into the cost of a drug or biological.

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

The flowchart for Pass-through Drugs and Biologicals Processing is located on the next page.

5.13.1 Pass-through Drugs and Biologicals Processing

**Notes:**

- 1) PT = Pass-through; PAF = Payment Adjustment Flag
- 2) Pass-through drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents.
- 3) Radiopharmaceutical (radiopharm) pass-through processing occurs across the claim. "Other" PT drugs refers to contrast, skin substitute products and stress agents, which are processed across each day of service for a multiple day claim.
- 4) Each PT drug present must be paired with an associated procedure (APC) in order to complete processing (edit 98).
- 5) The setting of the Payer Value Code is dependent upon the type and number of PT conditions present. PT radiopharms are processed first if present, and occupy the first QR position with PAF 18 assigned to the radiopharm. "Other" PT drug conditions occupy the subsequent Payer Value Code positions and PAF 19 and 20 depending upon the number of conditions present.
- 6) OPPS payable procedures include those with SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V.
- 7) If the PAF is set to 10, the payment offset is not applicable.
- 8) Note: Edit 99 is also applicable for non-pass-through drugs and biologicals (SI = K).

5.13.2 Payer Value Codes for Pass-through Drugs and Biological Processing

Value Code	Description	Note	Dates Effective
QR	First APC pass-through drug or biological offset	<p>Provided on output by the IOCE.</p> <p>Assigned with a value Code amount representing the payment offset when claims with pass-through drug HCPCS codes (SI = G) furnished with certain procedures require a payment offset to the APC payment rate for the procedure.</p>	4/1/2016-to present
QS	Second APC pass-through drug or biological offset	<p>Provided on output by the IOCE.</p> <p>Assigned if there is an additional condition present for a separate payment offset to the APC payment rate for the procedure.</p>	4/1/2016-to present
QT	Third APC pass-through drug or biological offset	<p>Provided on output by the IOCE.</p> <p>Assigned if there is an additional condition present for a separate payment offset to the APC payment rate for the procedure in addition to the second offset.</p>	4/1/2016-to present

5.14 Skin Substitute Editing and Processing

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

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

5.15 Biosimilar HCPCS Processing

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

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

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

5.16 HSCT and Donor Acquisition Services Processing

Effective January 1, 2017 (v18.0), claims containing HSCT (hematopoietic stem cell transplantation) allogeneic transplantation procedure 38240 require the reporting of a separate line representing donor acquisition costs with revenue code 0815. If the separate line with revenue code 0815 is not present, the claim is returned to the provider ([edit 100](#)).

5.17 Radiological Processing

5.17.1 CT Scan Equipment Not Meeting NEMA Standards

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

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

Note: Modifier CT should not be reported on the same HCPCS line with X-ray modifiers FX or FY as they are conflicting modifiers, [edit 102](#) is returned to the provider.

5.17.2 Film X-Ray HCPCS Processing

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

5.17.3 Computed Radiography Technology HCPCS Processing

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

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

5.18 Intensity-Modulated Radiotherapy (IMRT) Planning

Intensity Modulated Radiotherapy planning (IMRT) is a computer-based method of planning for and delivery of radiation to solid tumors. IMRT planning and delivery uses an approach for obtaining the dose distributions needed to irradiate complex targets positioned near, or invaginated by, sensitive normal tissues, thus improving the therapeutic ratios. Effective 1/1/2017, payment for the services identified by CPT® codes 77014, 77295, 77306, 77307, 77316, 77317, 77318, 77321, 77331, and 77370 are included in the APC payment for CPT® code 77301 (IMRT planning). These codes are not to be reported on the same claim as CPT® code 77301 when provided prior to or as part of the development of the IMRT plan. In addition, CPT® codes 77280, 77285 and 77290 (simulation-aided field settings) are not to be reported for verification of the treatment field during a course of IMRT. In the instance that the above codes are reported on the same claim as 77301, the claim is returned to the provider ([edit 125](#)).

5.19 Radiation Oncology Model (ROM) Processing Logic

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

5.20 Hospice Processing Logic

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

Per the Medicare Claims Processing Manual, any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider using institutional claims for non-hospice Medicare payment. On institutional claims, these services are coded with condition code 07 “Treatment of Non-terminal Condition for Hospice”. If condition code 07 is submitted on a claim bill type 022x, 023x, 032x, 072x, 074x, 075x, 081x, or 082x (OPPS=1) with an antigen, splint, or cast service, these services are paid by APC under OPPS. Please refer to the [Edits by Bill Type Table \(OPPS\)](#) to reference the editing that is performed if condition code 07 is present on an applicable bill type with antigen, splint or cast.

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

5.21 Home Health Processing Logic

Home health claims (032x) are episode-based with dates of service that can span a maximum of 30 days (January 1, 2020) or 60 days (Claims prior to January 1, 2020). Prior to v22.2, to allow for home health claims to be processed through the IOCE, diagnosis codes reported on a claim with dates of service that span the annual October diagnosis update and the previous quarter, bypass [edit 1](#). Effective with v22.2, all claims (including 032x) that have From and Through dates that span any quarterly boundary (e.g., 09/29-10/29) bypass edit 1 if the diagnosis reported is valid in at least one of the two quarters. If the diagnosis code reported is not valid in either of the two quarters, [edit 1](#) is applied.

Effective 1/1/2015, diagnosis codes considered to be manifestation codes (per the Medicare Code Editor [MCE]) are not allowed as the principal diagnosis for home health claims submitted with bill type 032x. Home Health claims submitted with a manifestation code as principal diagnosis are returned to the provider with [\(edit 86\)](#).

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

Effective with the July 2018 release (v19.2), home health claims (bill type 032x) are subject to procedure based edits [6 \(Invalid Procedure\)](#) and [22 \(Invalid Modifier\)](#); except in the instance of reporting a HIPPS code with revenue code 0023. Effective with the April 2019 release (v20.1), HHA’s (032x) submitting claims with dates of service that span the annual (January) release and the previous quarter do not return edit 6 if the service provided is effective for the reported line item date of service.

Effective with the April 2021 release (v22.1), home health claims (bill type 032x) reporting a HIPPS code with revenue code 0023 do not have edit 23 applied if the line item date of service is outside the claim From Date and Through Date.

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

5.22 Non-Excepted Items or Services in Off-Campus Provider-Based Hospitals (Section 603)

Effective January 1, 2017 (v18.0), certain items and services, when provided in an off-campus provider-based hospital outpatient department, may be considered non-excepted under Section 603 of the Bipartisan Budget Act of 2015. Non-excepted services are reported with modifier PN (Non-excepted off-campus svc) and are subject to special processing in the IOCE for determination of whether payment is to be made or reduced under an alternative method (i.e. Physician Fee Schedule (PFS)). Claims containing certain services that are not allowable with modifier PN are returned to the provider ([edit 101](#)). Line items that are reported with two of the following conflicting modifiers (PO, PN, or ER) are returned to the provider, ([edit 102](#)).

5.22.1 Criteria for Non-Excepted Services Reported with Modifier PN:

- Special processing occurs only for hospital outpatient claims with bill type 013x with and without condition code 41, and bill type 076x (CMHC).
- Non-excepted processing logic occurs after all other IOCE processing.
- Services reported with modifier PN are identified using the [Payment Method Flag](#) for determination of payment method or reduction by the OPPS Pricer. ([PMF 7 or PMF 8](#))

5.22.1.1 Hospital outpatient claims with bill type 013x without condition code 41 Reporting Modifier PN:

1. Emergency department visits and critical care encounters that have standard assignment under SI = V or S (critical care) are not allowed with modifier PN. Edit 101 is applied (RTP) and the Payment Method Flag is not set to a value of 7 or 8.
2. Payment Method Flag Value 7 is applied for the following:
 - Services with SI = F, H, L, R and U that are excepted under Section 603
 - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T and V that have [Payment Adjustment Flag Value](#) 4, 9, 10 or 25 assigned (preventive services)
 - Certain HCPCS codes for radiation treatment with SI = B when reported with modifier PN have the SI changed to S and are assigned a special APC (see quarterly data file reports for the list of radiation procedure codes)
3. Payment Method Flag Value 8 is applied for the following:
 - Services with SI = J1, J2, Q1, Q2, Q3, Q4, S, T, and V, except for emergency department visits with SI = V and critical care encounters with SI = S.
 - HCPCS G0463 for clinic visit with SI = J2 (for comprehensive observation APC) or standard SI = V is always assigned Payment Method Flag 8, regardless of the payment adjustment flag value being 4, 9, or 10. HCPCS G0463 is not included in the list of emergency department visit codes or critical care encounters that are subject to [edit 101](#).
 - Services with SI = A, G, K and N have no impact; Payment Method Flag values 7 and 8 are not applicable.

5.22.1.2 Hospital outpatient claims with bill type 013x with condition code 41 (PHP) Reporting Modifier PN:

1. PHP services with SI = P have a change in APC assignment to the CMHC PHP APC, with Payment Method Flag 7 applied.
2. **Note:** Non-PHP services reported with modifier PN that may be present on a hospital PHP claim are subject to the logic listed above for claims with bill type 013x without condition code 41.

5.22.1.3 CMHC PHP outpatient claims with bill type 076x Reporting Modifier PN:

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

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

1. Effective January 1, 2015, modifier PO (Excepted off-campus service) is added as a valid modifier to voluntarily report items or services furnished in an off-campus provider-based outpatient department of a hospital (bill type 013x w/ or w/o CC 41). Effective January 1, 2016, reporting modifier PO is required to be reported for items or services performed in a hospital off-campus provider-based outpatient department.
2. Effective January 1, 2019, off-campus provider-based outpatient departments submitting clinic visit HCPCS code G0463 with modifier PO have [payment method flag A](#) returned to apply a payment reduction in the OPPS Pricer. Note: Modifiers PO, PN, or ER cannot be submitted on the same HCPCS line item, [edit 102](#) is returned to the provider.

5.23 FQHC Processing Under FQHC PPS

Effective for claims with From Dates on or after October 1, 2014, claims submitted through the IOCE with bill type 077x, and without condition code 65, for Federally Qualified Health Centers (FQHC) are processed under FQHC PPS. Effective October 1, 2020, claims submitted through the IOCE for bill type 077x (FQHC) with condition code 65, which indicated the claim was not subject to FQHC PPS, are processed under the FQHC PPS. Processing occurs for each date of service if the claim contains multiple dates. FQHC claims are paid on a per encounter basis for qualified clinic visits. Any supporting ancillary services provided on the day of the FQHC visit are packaged into the encounter payment. If the FQHC claim contains multiple dates of service, each day is processed separately through the IOCE. Special output flag values are assigned during FQHC processing under the IOCE to facilitate identification of FQHC payment processing by the Pricer program.

5.23.1 Criteria for FQHC Encounters/ Visit Processing Logic

FQHC encounters require the reporting of both a unique FQHC payment HCPCS code indicating the type of visit (New or established medical visit, new or established mental health visit, or Initial Preventive Physical Exam/Annual Wellness Visit), and a qualifying visit HCPCS related to the services performed. FQHC claims that do not contain a required FQHC payment HCPCS code are returned to the provider ([edit 88](#)). The FQHC HCPCS payment code must be reported with revenue code 0519, 052x or 0900. The FQHC HCPCS payment code must be reported with revenue code 0519, 052x or 0900. FQHC payment HCPCS codes reporting revenue codes other than those listed are returned to the provider ([edit 90](#)). FQHC claims that do not contain both the FQHC payment HCPCS code and a qualifying visit code are also returned to the provider ([edit 89](#)). The FQHC payment HCPCS code identifies the line where the Pricer program applies the FQHC encounter payment. (For a list of paired qualifying visit codes, reference the MAP_FQHC_VISIT table within the data files.)

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

- a. Medical visit codes require revenue code 052x or 0519
- b. Mental health visit codes require revenue code 0900 or 0519

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

Payable FQHC payment code lines are flagged with a [Payment Indicator](#) (PI) = 10 unless there is a new patient or IPPE/AWV visit present. If there is a new patient visit or IPPE/AWV reported, PI= 13 is assigned to the FQHC payment code representing the new patient/IPPE/AWV visit. If multiple visits are reported, only one new patient FQHC payment HCPCS is assigned PI=13 per day. Any additional FQHC payment codes present for the same day are assigned PI=10. Qualifying visit codes that accompany the FQHC payment code are flagged with PI=12 and are packaged with Packaging Flag =5.

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

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

A composite adjustment flag is assigned for lines reporting FQHC payment codes, identifying the type of FQHC visit(s) present for a date of service, whether for: 01) medical visit or IPPE/AWV, 02) mental health visit, or 03) a subsequent visit reported with modifier 59. The composite adjustment flag is used by the Pricer program to identify line item charges associated with each type of FQHC encounter. All FQHC payment codes are assigned a composite adjustment flag by the IOCE; the assignment of the composite adjustment flag has no bearing on whether the visit is eligible for separate FQHC encounter payment.

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

5.23.2 FQHC PPS – Grandfathered Tribal Providers

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

5.23.3 FQHC PPS – Preventive Services

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

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

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

5.23.4 FQHC PPS – Non-Covered Services

Items or services that are not covered under the FQHC are line item rejected PPS (DME, ambulance, laboratory, and other non-covered services). Non-covered lines are assigned Line Item Action Flag 5 and PI=3, and although SI is ignored under FQHC, all non-covered lines are assigned to SI=E1. If line items with non-covered charges are passed into the IOCE with Line Item Action Flag 5 previously assigned, these lines are not line item rejected. **Note:** All line items submitted on a claim with bill type 0770 (No payment claim) are submitted to the IOCE with Line Item Action Flag 5 assigned; edit 91 is not returned for claims with bill type 0770, nor is any other FQHC editing performed.

FQHC non-covered items or services include durable medical equipment submitted with revenue code 029X, ambulance services submitted with revenue code 054X, laboratory services paid under the Clinical Lab Fee Schedule (excluding venipuncture, 36415, which is packaged), hospital-based care, group services and non-face-to-face services.

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

5.23.5 FQHC PPS – Chronic Care Management Services

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

5.23.6 FQHC PPS – Telehealth Services

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

5.23.7 FQHC PPS – COVID-19 Services

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

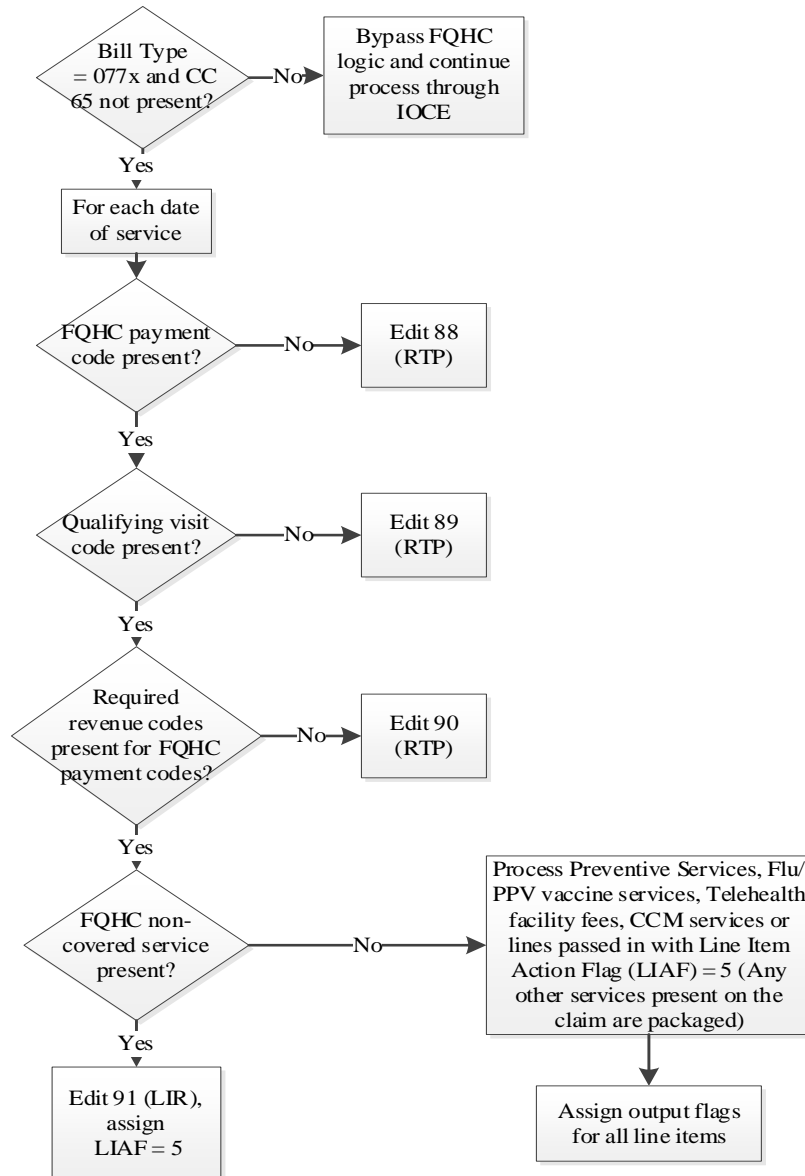
Effective March 18, 2020 (v21.2), FQHC claims with a HCPCS line item(s) reported with modifier CS return payment method flag (PMF) value C. A [PMF of C](#) indicates that payment is made by the FQHC PPS and coinsurance is not applicable as the item is a COVID-19 testing-related service. Additionally,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

5.23.8 FQHC PPS – Opioid Use Disorder Treatment Demonstration Model

Effective April 1, 2021 (v22.1), Opioid use disorder (OUD) treatment demonstration code G2172 is paid by the Medicare physician fee schedule (payment indicator =2) and is not packaged into the FQHC encounter payment (packaging flag =0). OUD treatment demonstration code G2172 if reported without an FQHC payment code or qualifying visit code bypasses edits 88 and 89. Note: If office-based OUD treatment codes are reported with OUD treatment demonstration code, G2172, without an FQHC payment code or qualifying visit code, edits 88 and 89 are not bypassed.

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

5.24 FQHC PPS Processing Logic Flowchart (v23.3)

Notes:

1. Effective v16.2, if only Telehealth services are reported, edits 88 and 89 are not returned.
2. Effective v16.3, if only FQHC non-covered services are present, edits 88 and 89 are not returned.
3. Effective v17.0, if condition code MG is present for Grandfathered Tribal FQHC provider, only a single FQHC encounter is eligible for payment.
4. Effective v17.0, Advanced Care Planning services may be treated as a qualifying visit code or if reported with an annual wellness visit, is treated as a packaged preventive service.
5. Effective v22.1, if OUD treatment demo code is reported, edits 88 and 89 are bypassed.
6. Effective v23.1, if OUD treatment demo code is reported without qualifying visit code and OUD office based HCPCS, edits 88 and 89 are not bypassed.

5.25 Rural Health Clinic Visit Processing

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

Effective 4/1/2016 (v17.1), the non-covered services list for FQHC is applied to RHC (Rural Health Clinic) claims with bill type 071x. Program logic associated with the execution of [edit 91](#) and the return of line item action flag 5 is included for RHC claims (Note: RHC claims are not subject to any additional FQHC PPS logic.)

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

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

6 Special logic information

6.1 Critical Access Hospital Processing

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

6.1.1 NCCI and Add-on Code Editing for Critical Access Hospitals

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

6.1.2 Bilateral Procedure processing for Critical Access Hospitals

Procedures identified as inherent bilateral are codes in which the procedure in and of itself is bilateral. Inherent bilateral procedures are treated as non-bilateral procedures since the bilateralism of the procedure is encompassed in the code. In the instance that the same inherent bilateral procedure code is reported two or more times on the same service date, and there is no professional service revenue code (096x, 097x, 098x) present on at least one of the same inherently bilateral code lines, then all applicable bilateral procedure lines are line-item rejected with [edit 17](#).

6.1.3 Critical Access Hospital and Opioid Treatment Program Processing

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

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

6.1.4 Colorectal Screening Services for Critical Access Hospitals

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

6.1.5 Telehealth Claims Processing

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

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

7 Edit Application within the IOCE**7.1 Introduction to Edits**

As specified in the introduction to the IOCE, one of the three major functions provided by the IOCE is the application of edit(s) to identify errors. Each edit is unique, as it directly links the reason the edit is returned, any related information at the line or claim level, and the action required indicated by the edit disposition. For example, an edit can cause a line item rejection or return the claim to the provider. It is possible for a claim to have one or more edits in all 6 dispositions. The table below lists and describes each edit disposition.

7.1.1 Edit Dispositions Table

Disposition	Description
Claim Rejection	There are one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.
Claim Denial	There are one or more edits present that cause the whole claim to be denied. A claim denial means that the provider cannot resubmit the claim but can appeal the claim denial.
Claim Return to Provider (RTP)	There are one or more edits present that cause the whole claim to be returned to the provider. A claim returned to the provider means that the provider can resubmit the claim once the problems are corrected.
Claim Suspension	There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not returned to the provider but is not processed for payment until the MAC decides or obtains further information.
Line Item Rejection (LIR)	There are one or more edits present that cause one or more individual line items to be rejected. A line item rejection means that the claim can be processed for payment with some line items rejected for payment. The line item can be corrected and resubmitted but cannot be appealed.
Line Item Denial (LID)	There are one or more edits present that cause one or more individual line items to be denied. A line item denial means that the claim can be processed for payment with some line items denied for payment. The line item cannot be resubmitted but can be appealed.

Six dispositions are contained in the claim return buffer that indicate the presence or absence of edits in each of the six dispositions. In addition, there are six lists of reasons in the claim return buffer that contain the edit numbers that are associated with each disposition. For example, if there were three edits that caused the claim to have a disposition of return to provider, the edit numbers of the three edits would be contained in the claim return to provider reason list.

In addition to the six individual dispositions, there is also an overall claim disposition within the [Claim return buffer](#), which summarizes the status of the claim.

7.1.2 Edit Return Buffer Table

The Edit Return buffer table contains edit values for applicable items that are within the 28 prior quarters (7 years) for each release.

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	1, 2, 3, 5, 86, 113	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 28 diagnoses.
Procedure edit return buffer	3	30	6, 7, 8, 9, 11, 12, 13, 17, 18, 20, 21, 28, 30, 35, 37, 38, 40, 42, 43, 44, 45, 47, 49, 50, 51, 53, 55, 57, 58, 60, 61, 62, 63, 64, 66, 67, 68, 69, 70, 71, 72, 73, 74, 76, 79, 80, 81, 82, 83, 84, 87, 88, 89, 91, 92, 93, 94, 95, 98, 99, 100, 101, 102, 104, 105, 106, 107, 108, 110, 112, 114, 115 116, 117, 120, 121,122, 124, 125, 126	Three-digit code specifying the edits that applied to the procedure.	There is one 30x3 buffer for each of up to 450-line items.
Modifier edit return buffer	3	4	0, 22, 75, 103, 123	Three-digit code specifying the edits that applied to the modifier.	There is one 4x3 buffer <u>for each of the five modifiers</u> for each of up to 450-line items.
Date edit return buffer	3	4	0, 23	Three-digit code specifying the edits that applied to <u>line item</u> dates.	There is one 4x3 buffer for each of up to 450-line items.
Revenue center edit return buffer	3	5	0, 9, 41, 48, 50, 65, 90, 111, 127	Three-digit code specifying the edits that applied to revenue centers.	There is one 5x3 buffer for each of up to 450-line items

The edit return buffers consist of a list of the edit numbers that occurred for each diagnosis, procedure, modifier, date, or revenue code. For example, if a 75-year-old male had a diagnosis related to pregnancy it would create a conflict between the diagnosis, age, and sex. Therefore, the diagnosis edit return buffer for the pregnancy diagnosis would contain the edit numbers 2 and 3. There is more space allocated in the edit return buffers than is necessary for the current edits to allow future expansion of the number of edits.

Each of the edit return buffers is positionally representative of the source that it contains information for, in the order in which that source was passed to the OCE.

Some of the IOCE edits are inactive for the current version of the program. Each edit is assigned a number and description which can be found in the [Edit Description and Reason for Edit Generation Table](#). The [Claim Return Buffer](#) summarizes the edits that occurred on the claim.

7.2 Edit Descriptions and Reason for Edit Generation Table

Edits that are no longer effective are shaded in light gray. Edits that are *italicized*, *shaded in light gray*, and labeled as **(inactive)** are edits that are no longer effective and that have fallen out of scope within the 7 years' worth of contained logic in the IOCE.

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
1	Invalid diagnosis code	The principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid. Effective with v22.2, edit 1 is bypassed, if a claim with a From-Through date spanning the quarter boundary (e.g., 09/29/-10/01) reports a diagnosis code that is valid in at least one quarter. If the diagnosis code is not valid in either of the quarters edit 1 is applied.	1.0 – present	8/1/00 - present	Y	RTP	
2	Diagnosis and age conflict	The diagnosis code includes an age range, and the age reported is outside that range.	1.0 – present	8/1/00 - present	Y	RTP	
3	Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match. This edit is bypassed if condition code 45 is present on the claim.	1.0 – present	8/1/00 - present	Y	RTP	
4	Medicare secondary payer alert	<i>The procedure code has an MSP alert warning indicator. This edit applies to v1.0 and v1.1 only and is not applicable for reason for visit diagnosis. (inactive)</i>	1.0 – 1.1	8/1/00 -12/31/00	N	Suspend	
5	External cause of morbidity code cannot be used as principal diagnosis	The diagnoses reported is considered a morbidity code and cannot be used as the principal diagnoses	1.0 – present	8/1/00 - present	Y	RTP	
6	Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.	1.0 – present	8/1/00 - present	Y	RTP	
7	Procedure and age conflict	The age of the patient does not fall within the age range(s) designated for the procedure code reported. Note: Ages are based on published CMS/AMA information. This is an information only edit that sets the Line Item Denial Rejection flag = 3.	23.3-present	1/1/2016	Y	LIR (Information only edit)	Y
8	Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure code reported. This edit is bypassed if condition code 45 is present on the claim.	1.0 – present	8/1/00 - present	Y	RTP	Y
9	Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	The procedure code is flagged as Non-covered for reasons other than statute exclusion or Revenue code is 099x with SI of E1 and is submitted without a HCPCS code. This edit is bypassed when code G0428 is present with E1.	1.0 – present	8/1/00 - present	Y	LID	Y
10	Service submitted for denial	The claim submitted has condition code 21 present. Prior to the implementation of v22.0, edit 10 terminated processing early and returned Claim Processed Flag value 3 (Claim could not be processed (edit 10 condition code 21 is present)), and Return Code 20 (Claim was not processed, condition code 21 exists). Effective with v22.0, edit 10 no longer terminates processing but instead just returns the edit and all other edits if present on the claim.	1.0 – present	8/1/00 - present	Y	Claim Denial	
11	Service submitted for MAC review	The claim has condition code 20 present.	1.0 – present	8/1/00 - present	Y	Suspend	
12	Questionable covered service	The procedure reported is flagged as a Questionable covered service.	1.0 – present	8/1/00 - present	Y	Suspend	
13	Separate payment for services is not provided by Medicare	The claim is OPPS and the HCPCS code has status indicator E2.	18.0- Present	1/1/17 - present	Y	LIR	Y
14	Code indicates a site of service not included in OPPS	<i>This procedure code has a Not included in OPPS indicator. This edit applies to v1.0-v6.3 only. (inactive)</i>	1.0 – 6.3	8/1/00- 12/31/05	N	RTP	
15	Service unit out of range for procedure	<i>The maximum units allowed is greater than zero and the sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure and Modifier 91 is not present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. (inactive)</i>	1.0 – 9.1	8/1/00 – 6/30/08	Y	RTP	
16	Multiple bilateral procedures without modifier 50	<i>The same bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant procedure lines for dates of service prior to 10/01/05 only. (inactive)</i>	1.0 – 6.2	8/1/00 – 6/30/05	N	RTP	

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
17	Inappropriate specification of bilateral procedure	The same inherent bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant bilateral procedure lines, except when modifier 76 or 77 is submitted on the second or subsequent line or units of an inherently bilateral code. Exception: For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17. For CAHs (085x), a professional service revenue code (096x, 097x, 098x) must be present on at least one of the multiple occurrences of the same inherently bilateral code to bypass editing.	1.0 – present	8/1/00 – present	Y	LIR	Y
18	Inpatient procedure	A line has a C status indicator and is not on the 'separate procedure' list or A line has a C status indicator and is on the 'separate procedure' list, but there are no type T lines on the same day. All other line items on the same day as the line with a C status indicator are line-item denied (line item denial/rejection flag = 1, APC return buffer) with edit 49. This is the only edit that can cause one or more days of a multiple day claim to be denied, or single day claim with all lines denied.	1.0 – present	8/1/00 – present	N	LID	
19	<i>Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present</i>	<i>A pair of procedures reported on a claim in which one of the procedures is identified by NCCI to be mutually exclusive and cannot be reported together on the same day. The second procedure within the NCCI pair will obtain edit 19. (inactive)</i>	1.0 – 13.1	8/1/00 – 6/30/12	N	LIR	
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The second procedure reported is part of an NCCI pair, which will cause the generation of edit 20 to LIR even in the presence of a modifier.	1.0 – present	8/1/00 – present	Y	LIR	Y
21	Medical visit on the same day as a type T or S procedure without modifier 25	One or more type T or S procedures occur on the same day as a medical visit line item with SI of V, without modifier 25. See Medical Visit Processing logic for more information.	1.0 – present	8/1/00 – present	N	RTP	Y
22	Invalid modifier	The modifier is not in the list of valid modifier entries and the revenue code is not 0540.	1.0 – present	8/1/00 – present	Y	RTP	Y
23	Invalid date	The service date and/or the from and through dates are invalid (or blank). Or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. Edits 23 and 24 for from/through dates, are IOCE program errors that are applicable to each bill type. Exception: Home Health claims (032x) reporting a HIPPS code with revenue code 0023 do not have edit 23 applied if the line item date of service is outside the claim From Date and Through Dates. Home Health adjustment claims (032G) do not have edit 23 applied to any line items that report a service date outside the claim From-Through dates. Note: If edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates and processing continues.	1.0 – present	8/1/00 – present	Y	RTP	
24	Date out of OCE range	The From/Through date falls outside the date range of any version of the program. Presence of this edit condition terminates processing for the claim. Edits 23 and 24 for from /through dates, are IOCE program errors that are applicable to each bill type.	1.0 – present	8/1/00 – present	Y	Suspend	
25	Invalid age	The age field is blank, non-numeric or outside the range of 0-124 years.	1.0 – present	8/1/00 – present	Y	RTP	
26	Invalid sex	The sex field is blank, non-numeric or outside the range of 0-2. This edit is bypassed if condition code 45 is present on the claim.	1.0 – present	8/1/00 – present	Y	RTP	
27	Only incidental services reported	All line items are incidental (SI= N) or all lines on the claim are a combination of the following conditions: <ul style="list-style-type: none"> • Lines that are Packaged (SI=N) • Lines ignored by LIAF 2-4 • Invalid HCPCS Lines (Edit 6) • Invalid Revenue Code Lines (Edit 41) 	1.0 – present	8/1/00 – present	N	Claim Rejection	
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare' indicator.	1.0 – present	8/1/00 – present	Y	LIR	Y

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
29	Partial hospitalization service for non-mental health diagnosis	The principal diagnosis is not related to mental health.	1.0 – present	8/1/00 – present	N	RTP	
30	Insufficient services on day of partial hospitalization	If less than 3 PHP services are reported for any one day, the day is denied, and the lines return edit 30. See Partial Hospitalization Processing logic for more information.	1.0 – present	8/1/00 – present	N	LID	Y
31	<i>Partial hospitalization on same day as ECT or type T procedure</i>	<i>Electroconvulsive therapy or a significant procedure (SI=T) occurs on the same day as partial hospitalization, and APC 00033 partial hospitalization) is assigned to a mental health service on the same day. (inactive)</i>	1.0 – 6.3	8/1/00- 12/31/05	N	Suspend	
32	<i>Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days</i>	<i>A claim suspended for medical review (edit 30) does not span more than three days. (inactive)</i>	1.0 – 9.3	8/1/00- 12/31/08	N	Suspend	
33	<i>Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services</i>	<i>A claim suspended for medical review (edit 30) spans more than three days. However, partial hospitalization services were not provided on at least 57% 4/7) of the days. (inactive)</i>	1.0 – 9.3	8/1/00- 12/31/08	N	Suspend	
34	<i>Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria</i>	<i>A claim suspended for medical review (edit 30) spans more than three days and partial hospitalization services were provided on at least 57% 4/7) of the days. However, on the days when partial hospitalization services were provided, less than 75% of the days met the partial hospitalization day of service criteria i.e., edit 30 occurred on the line item). (inactive)</i>	1.0 – 9.3	8/1/00- 12/31/08	N	Suspend	
35	Only Mental Health education and training services provided	Only education and training services are present without a mental health service(s); the claim fails mental health status. Effective with v21.2, edit 35 logic is revised retroactively to be returned if education and training services are the only service(s) reported on the claim. Note: edit 27 is suppressed from being returned if conditions for edit 35 are present.	1.0 – present	8/1/00 – present	N	RTP	Y
36	<i>Extensive mental health services provided on day of type T procedure</i>	<i>Electroconvulsive therapy or a non-mental health type T procedure APC is present on the same day as extensive mental health service. (inactive)</i>	1.0 – 6.3	8/1/00- 12/31/05	N	Suspend	
37	Terminated bilateral procedure or terminated procedure with units greater than one	A modifier 52 or 73 is present, as well as: an independent or conditional bilateral procedure with modifier 50 or a procedure with units greater than 1.	1.0 – present	8/1/00 – present	N	RTP	Y
38	Inconsistency between implanted device or administered substance and implantation or associated procedure	There is a code with status indicator H or U present, but no type S, T, or J1 procedures are present on the same claim. See Device Intensive Procedure Editing and Processing for more information.	1.0 – present	8/1/00 – present	N	RTP	Y
39	<i>Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present (deleted, combined with edit 40 retroactive to earliest included version)</i>	<i>The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit. (inactive)</i>	1.0 – 13.1	8/1/00 – 6/30/12	N	LIR	
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.	1.0 – present	8/1/00 – present	Y	LIR	Y
41	Invalid revenue code	The revenue code is not in the list of valid revenue codes or the revenue code is reported prior to/exceeding its NUBC effective date. Effective with the July 1, 2021 (v22.2) release, revenue codes are validated based on the claims processing receipt date, as revenue codes are considered a non-medical code set and should be validated not based on claim From-through dates but per the date in which CMS received the claim. See Revenue Code Editing for more information on revenue code editing or IOCE Processing for reference to non-medical code set validation.	1.0 – present	8/1/00- present	Y	RTP	Y
42	Multiple medical visits on same day with same revenue code without condition code G0	Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other. See Medical Visit Processing for more information	1.0 – present	8/1/00- present	N	RTP	Y

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
43	Transfusion or blood product exchange without specification of blood product	A blood transfusion or exchange is coded but no blood product is reported.	1.1 – present	10/1/00 - present	N	RTP	Y
44	Observation revenue code on line item with non-observation HCPCS code	A 0762 (observation) revenue code is used with a HCPCS other than G0378 or G0379.	2.0 – present	1/1/01 - present	Y	RTP	Y
45	Inpatient separate procedures not paid	On the same day, all lines with status indicator C are on the ‘separate procedure’ list, and there is at least one type T or J1 line. Note: Lines with SI=C if reported on a claim with a C-APC procedure SI=J1, the lines with the inpatient-separate procedure return edit 45.	2.3 – present	8/1/00 - present	N	LIR	Y
46	Partial hospitalization condition code 41 not approved for type of bill	Bill type 012x or 014x is present with condition code 41. Edit 46 terminates processing only for those bill types where no other edits are applied	2.0 – present	1/1/01 – present	Y	RTP	
47	Service is not separately payable	The claim consists entirely of a combination of lines that: are denied or rejected or have a status indicator N. Edit 47 is assigned to all lines with status indicator N, or that change from Q to N, that are not already denied or rejected and have no other service on the claim.	2.2 – present	8/1/00 - present	N	LIR	Y
48	Revenue center requires HCPCS	The HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed if the revenue code is flagged as “Bypass_E48” in the Data_Revenue table.	2.2 – present	8/1/00 – present	Y	RTP	Y
49	Service on same day as inpatient procedure	A service is reported on the same day of an inpatient only procedure (SI=C) that is denied with edit 18.	3.0 - present	8/1/00 – present	N	LID	
50	Non-covered under any Medicare outpatient benefit, based on statutory exclusion	The HCPCS reported is on ‘statutory exclusion’ list or the revenue code center reported is on the “statutory exclusion” list with status indicator E/E1 and submitted without a HCPCS code.	3.0 - present	8/1/00 – present	Y	RTP	Y
51	Observation code G0378 not allowed to be reported more than once per claim	HCPCS code G0378 is reported more than once on a 013x or 085x claim/bill type. The edit is applicable to the subsequent lines of G0378 only. Edit 51 is bypassed if the subsequent G0378 line(s) has a line item action flag of 2, 3, or 4.	22.2 - present	1/1/16 - present	Y	RTP	Y
52	<i>Observation does not meet minimum hours, qualifying diagnoses, and/or ‘T’ procedure conditions</i>	<i>The observation period is less than 8 hours or there is no diagnosis of CHF, chest pain or asthma or there is a T procedure (except 90780) on the same or previous day. (inactive)</i>	3.0 – 6.3	4/1/02- 12/31/05	N	RTP	
53	Codes G0378 and G0379 only allowed with bill type 013x or 085x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 013x or 085x.	3.0 – present	4/1/02 – present	Y	LIR	Y
54	<i>Multiple codes for the same service</i>	<i>Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035. (inactive)</i>	3.0 – 4.1	4/1/02 – 4/1/03	Y	RTP	
55	Non-reportable for site of service	The procedures reported are non-reportable for the site of service indicated.	3.0 – present	8/1/00 – present	Y	RTP	
56	<i>E/M condition not met and line item date for obs code G0378 is not 12/31/ or 1/1</i>	<i>There is no specified E/M code the day of or the day preceding the observation and the date of observation is not 12/31/yyyy or 1/1/yyyy. (inactive)</i>	4.0 – 6.3	1/1/03- 12/31/05	N	RTP	
57	E/M condition not met for observation and line item date for code G0378 is 1/1	There is no specified E/M or critical care visit the day of or the day preceding the observation and the date of observation is 01/01/yyyy.	4.0 – present	1/1/03 – present	N	Suspend	
58	G0379 only allowed with G0378	Code G0379 is present without code G0378 for the same line item date.	4.1 – present	4/1/03 – present	N	RTP	Y
59	<i>Clinical trial requires diagnosis code V707 as other than primary diagnosis</i>	<i>Code G0292, G0293 or G0294 is present and Diagnosis code V70.7 is not present as admit or secondary diagnosis. (Inactive - Deleted, retroactive to the earliest included version.)</i>	4.1 – 11.1	1/1/03 – 6/30/10	N	RTP	
60	Use of modifier CA with more than one procedure not allowed	Modifier CA is present on more than one line or Modifier CA is submitted on a line with multiple units. (see Inpatient Procedure Processing)	4.1 – present	1/1/03 – present	N	RTP	
61	Service can only be billed to the DMERC	The procedure code has a ‘DMERC billable only’ flag indicator set and SI=Y.	5.0 – present	8/1/00 – present	Y	RTP	Y
62	Code not recognized by OPPS; alternate code for same service may be available	The procedure code has a ‘Not recognized by Medicare for OPPS’ indicator. Services with a status indicator of B always return edit 62.	5.0 – present	1/1/04 – present	Y	RTP	

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
		Note: Edit 62 is bypassed if the bill type is 022x or 023x with or without condition code 07.					
63	<i>This OT code only billed on partial hospitalization claims</i>	<i>Occupational therapy services are present, and the bill type is 012x or 013x without condition code 41. (inactive)</i>	1.0 – 13.3	8/1/00- 12/31/12	N	RTP	
64	<i>AT service not payable outside the partial hospitalization program</i>	<i>Activity therapy services are present, and the bill type is 012x or 013x without condition code 41. (inactive)</i>	1.0 – 13.3	8/1/00- 12/31/12	N	LIR	
65	Revenue code not recognized by Medicare	The revenue code is flagged as “Not_ Recognized” by Medicare in the Data_Revenue table.	5.2 – present	8/1/00 – present	Y	LIR	Y
66	Code requires manual pricing	The HCPCS code is an unclassified drug code.	5.2 – present	1/1/04 – present	N	Suspend	
67	Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.	5.2 – present	1/1/04 – present	Y	LID	Y
68	Service provided prior to date of National Coverage Determination (NCD) or Demonstration approval	The line item date of service of a code is prior to the code activation date as determined by National Coverage Determination (NCD) or approval of a Demonstration.	6.0 – present	7/1/04 – present	Y	LID	Y
69	Service provided outside approval period	The service was provided outside the period approved by CMS.	6.0 – present	10/1/04 – present	Y	LID	Y
70	CA modifier requires patient discharge status indicating expired or transferred	CA modifier requires patient discharge status indicating expired or transferred. (See Inpatient Procedure Processing)	6.1 – present	4/1/05 – present	N	RTP	
71	<i>Claim lacks required device code</i>	<i>A specified procedure is submitted on a claim without the code (s) for the required devices. This edit is bypassed if the procedure is terminated and reported with modifier 52, 73, or 74. (inactive)</i>	6.1 – 15.3	4/1/05 –12/31/14	N	RTP	
72	Service not billable to the Medicare Administrative Contractor	A code has a status indicator M. This edit is bypassed when the bill type is 085x and revenue code is 096x, 097x, or 098x. This edit is also bypassed on FQHC and RHC bill types if the code reported is flagged as “BYPASS E72 FQHC RHC”.	6.1 – present	1/1/05 – present	Y	RTP	
73	Incorrect billing of blood and blood products	Blood product claims lack two identical lines (of HCPCS code, units, and modifier BL), one line with revenue code 038x and the other line with revenue code 039x. See Blood and Blood Storage Processing for more information.	6.2 – present	7/1/05 – present	N	RTP	Y
74	Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same line. If bill type is 085x and revenue code is 096x, 097x, or 098x, the units are summed if multiple lines of the same HCPCS and same revenue code on the same day, if some or all the lines have modifier 50. Note: Exclude any lines that have any other modifier, other than 50, present.	7.3 – present	10/1/06 – present	Y	RTP	Y
75	<i>Incorrect billing of modifier FB or FC</i>	<i>Modifier FB or FC is present, and SI is not S, T, V or X. (inactive)</i>	8.0 – 15.3	1/1/07 –12/31/14	N	RTP	
76	Trauma response critical care code without revenue code 068x and CPT® 99291	Trauma response critical care code is present without revenue code 068x and CPT® code 99291 on the same date of service.	8.0 – present	1/1/07 - present	N	LIR	Y
77	<i>Claim lacks allowed procedure code</i>	<i>A specified device is submitted on a claim without a code for an allowed procedure, and the bill type is not 012x. (inactive)</i>	8.1 – 15.3	1/1/07 –12/31/14	N	RTP	
78	<i>Claim lacks required radiolabeled product</i>	<i>A specified nuclear medicine procedure is submitted on a claim without the code for a required radiopharmaceutical. (inactive)</i>	9.0 – 14.3	1/1/08 –12/31/13	N	RTP	
79	Incorrect billing of revenue code with HCPCS code	The revenue code is 0381 with a HCPCS code other than packed red cells or the revenue code is 0382 with a HCPCS code other than whole blood. See Blood and Blood Storage Processing for more information. Refer to the Data_HCPCS table for codes flagged as Packed_Red_Cells or Whole_Blood.	9.3 – present	10/1/08 – present	N	RTP	Y
80	Mental health code not approved for partial hospitalization	Mental health HCPCS codes that are not approved for partial hospitalization program submitted on bill type 076x.	9.3 – present	1/1/08 – present	N	RTP	Y

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
81	Mental health service not payable outside the partial hospitalization program	Mental health HCPCS codes that are not payable outside the partial hospital program submitted on bill type 012x or 013x without condition code 41.	10.0 – present	1/1/09 – present	N	RTP	Y
82	Charge exceeds token charge (\$1.00)	Code C9898 is billed with charges greater than \$1.00.	10.0 – present	1/1/09 – present	N	RTP	Y
83	Service provided on or after effective date of NCD	The line item date of service of a code is after the date of non-coverage determination.	10.0 – present	1/1/09 – present	Y	LID	Y
84	Claim lacks required primary code	A specified add-on code is submitted without its required primary procedure on the same date of service. PHP add-on codes apply edit 84 until version 18.1. For v15.3 – v16.0 only, FQHC claims reporting psychotherapy add-on codes without a primary service are edited with 84.	13.0 – 18.1	1/1/12- 6/30/17	Y	RTP	Y
85	<i>Claim lacks required device code or required procedure code</i>	<i>Code C9732 and C1840 not submitted together on the same day. (Code for insertion of ocular telescopic lens submitted without the code for the intraocular lens, or vice versa). Discontinued insertion procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing telescopic lens code. (inactive)</i>	<i>13.0 – 14.3</i>	<i>1/1/12 –12/31/13</i>	<i>N</i>	<i>RTP</i>	
86	Manifestation code not allowed as principal diagnosis	A diagnosis code considered to be a manifestation code from the Medicare Code Editor (MCE) manifestation diagnosis list is reported as the principal diagnosis code on a hospice (081x, 082x) or home health (032x) bill type	15.3 – present	10/1/14 – present	Y	RTP	
87	Skin substitute application procedure without appropriate skin substitute product code	A List A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service. See Skin Substitute Editing and Processing logic for more information.	15.0 – present	1/1/14 – present	N	RTP	Y
88	FQHC payment code not reported for FQHC claim	FQHC payment code not reported for a FQHC claim (bill type 077x without condition code 65). Note: If the bill type is 0770 (No payment claim), edit 88 is not applicable. Note: Edit 88 is bypassed on FQHC PPS claims that do not report the FQHC payment code for the following: Telehealth originating site services, Chronic Care Management and the Opioid Use Disorder (OUD) Demonstration Model; also edit 88 is bypassed for FQHC when only FQHC non-covered services are present with edit 91. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	Y	RTP	
89	FQHC claim lacks required qualifying visit code	FQHC payment code reported for FQHC claim (bill type is 077x without condition code 65) without a qualifying visit HCPCS code. Note: Edit 89 is bypassed on FQHC PPS claims that report the FQHC payment code and not the qualifying visit for the following: Telehealth originating site services, Chronic Care Management and the Opioid Use Disorder (OUD) Demonstration Model; also edit 89 is bypassed for FQHC when only FQHC non-covered services are present with edit 91. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	Y	RTP	
90	Incorrect revenue code reported for FQHC payment code	FQHC payment code not reported with revenue code 0519, 052x or 0900. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	Y	RTP	
91	Item or service not covered under FQHC PPS or for RHC	A service considered to be non-covered under FQHC PPS or for RHC is reported. See FQHC Processing for more information.	15.3 – present	10/1/14 – present	Y	LIR	Y
92	Device-intensive procedure reported without device code	A device-intensive procedure is reported without a device code. See Device-Intensive Procedure Editing and Processing for more information.	16.0 – present	1/1/15 – present	N	RTP	Y
93	Corneal tissue processing reported without cornea transplant procedure	Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date.	17.0 – present	1/1/16 - present	Y	LIR	Y
94	Biosimilar HCPCS reported without biosimilar modifier	A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier which represents the biosimilar manufacturer. See Biosimilar HCPCS processing for more information.	17.0 – 19.0	1/1/16 – 3/31/18	Y	RTP	Y
95	Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care	A PHP claim contains weekly PHP services that total less than 20 hours per 7-day span. This edit applies to v17.2 with a disposition of RTP, and effective v18.3- Present, with a disposition of LIR. See Partial Hospitalization Processing logic for more information. This is an information only edit that sets the Line Item Denial Rejection flag = 3.	17.2, 18.3-present	7/1/16 – 9/30/16, 10/1/17 - present	N	LIR (Information only edit)	

Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
96	Partial hospitalization interim claim from and through dates must span more than 4 days	An interim PHP claim (bill type 0763 or 0133 with condition code 41) From and Through date spans less than 5 days. See Partial Hospitalization Processing logic for more information. (inactive)	17.2 only	7/1/16 – 7/1/16	N	RTP	
97	Partial hospitalization services are required to be billed weekly	A PHP claim From and Through date spans more than 7 days. See Partial Hospitalization Processing logic for more information. (inactive)	17.2 only	7/1/16 – 7/1/16	N	RTP	
98	Claim with pass through device lacks required procedure	A pass-through device is present without an associated, required procedure. See Pass-Through Device Processing for more information.	17.2 – present	1/1/16 - present	N	RTP	Y
99	Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure	There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V. See Special Processing for Drugs and Biologicals for more information.	17.3 - present	1/1/16 – present	N	RTP	Y
100	Claim for HSCT allogeneic transplantation lacks required revenue code line for donor acquisition services	A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 0815 for donor acquisition service. See HSCT and Donor acquisition services processing.	18.0 – present	1/1/17 - present	Y	RTP	Y
101	Item or service with modifier PN not allowed under PFS	Modifier PN is reported for an item or service that is non-excepted for an off-campus provider-based hospital outpatient department under Section 603. See Section 603 Logic for more information.	18.0 – present	1/1/17 – present	N	RTP	Y
102	Modifier pairing not allowed on the same line	A line item is reported with a pair of modifiers that have conflicting meaning and should not be reported together. Please reference the data files for a report named Modifier Pairs, which contains an up to date list of modifiers not allowed to be reported on the same line. Note: Edit 102 is updated in v20.0 retroactively to inception (1/1/17), to not allow any conflicting modifiers to be reported on the same line item reporting HCPCS.	18.0 – present	1/1/17 – present	Y	RTP	Y
103	Modifier reported prior to FDA approval date	A modifier is reported before its activation date for reporting. See biosimilar HCPCS processing .	19.0 only	7/1/17 – 3/31/18	Y	LID	
104	Service not eligible for all-inclusive rate	An RHC claim (071x) is reported with a line containing the CG modifier.	19.1 – present	4/1/18 – present	Y	LIR	Y
105	Claim reported with pass-through device prior to FDA approval for the procedure	A procedure is reported with a device before the FDA approval date. The edit is returned on the line containing the device. See Device Pass-Through processing	19.1 – present	7/1/17 – present	N	LID	Y
106	Add-on code reported without required primary procedure code	A claim is submitted with a Type I add-on code(s) without the applicable defined primary procedure(s). The edit is returned on the add-on code line(s) when conditions of the edit are not met. See Add-on Code Edit Processing for more information. Note: Effective v.24.0 (1/1/23), for 013x and 013x w/CC41 bill types, Remote Mental Health (RMH) add-on codes, are subject to this edit if reported without the primary code. For 013x only, Software as a Service (SAAS) add-on codes, are subject to this edit if reported without the primary code.	19.1 – present	4/1/18 – present	Y	LID	Y
107	Add-on code reported without required contractor-defined primary procedure code	A claim is submitted with a Type II add-on code(s) reported with a professional services revenue code (096x, 097x or 098x), to allow for contractors to review and define the primary procedure on the claim. See Add-on Code Edit Processing for more information.	19.1 – present	4/1/18 – present	Y	LID	Y
108	Add-on code reported without required primary procedure or required contractor-defined primary procedure code	A claim is submitted with a Type III add-on code(s) without a defined primary(s) or contractor defined primary(s) procedure. This edit is returned on the add-on code line(s) when conditions are not met. See Add-on Code Edit Processing for more information.	19.1 – present	4/1/18 – present	Y	LID	Y
109	Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	A PHP claim is submitted with a Code First diagnosis without a mental health diagnosis in the first secondary diagnosis position. If the first secondary diagnosis position is blank edit 109 is still returned. Note: Edit 29 is suppressed from being returned if a code first diagnosis is present in the pdx position. See PHP processing section for more information.	20.0 - present	10/1/18 - present	N	RTP	
110	Service provided prior to initial marketing date	The reported line item date of service of a code is prior to the initial marketing date, for which it can be reported.	20.0 - present	7/1/18 - present	Y	LIR	Y

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
111	Service cost is duplicative; included in cost of associated biological.	The reported line item is considered duplicative as the routine costs of all steps in creating a biological are bundled into the covered benefit, the biological. Any procedure identified as being “bundled into biological” and reported as a line item are rejected. Additionally, this edit is returned if revenue codes 0870-0873 are submitted as line items with blank HCPCS.	20.2 - present	1/1/18 - present	Y	LIR	Y
112	Information only service(s)	The reported line item is a non-covered service as it is for informational reporting purposes only. Any HCPCS identified as being an information only service is assigned a non-covered status indicator and is line item rejected with no impact on payment.	21.0 - present	1/1/20 - present	Y	LIR	Y
113	Supplementary or additional code not allowed as principal diagnosis	The principal diagnosis code reported is considered supplementary or an additional code and cannot be used as the principal diagnoses. The unacceptable principal diagnosis list is defined by the Medicare Code Editor (MCE) but there are some exclusions to the MCE list due to current OPPS coding requirements and guidelines. Any diagnosis code flagged as being an OPPS exclusion to the Unacceptable Principal Diagnosis list does not return edit 113.	21.3- present	10/1/19 – present	Y	RTP	
114	Item or service not allowed with modifier CS	Modifier CS is reported on an item or service that is not on the coinsurance waiver eligible list. Modifier CS should only be reported on items that are identified by CMS as being eligible for a coinsurance deductible waiver. Refer to the DATA_HCPCS table and column for named coinsurance_deductible_waiver_eligible for the list of services that are appropriate to report with modifier CS. (inactive)	21.3- 23.2	3/18/20-6/30/23	Y	RTP	Y
115	COVID-19 lab add-on code reported without required primary procedure	HCPCS U0005 is reported on a claim without one of its primary procedures U0003 or U0004 on the same date of service. Note: U0005 may be considered a Type I add-on code but it has been given a separately distinct function from regular add-on code editing applicable for edit 106. This add-on code (U0005) is only subject to edit 115 in the IOCE. (inactive)	22.0-23.2	1/1/21- 6/30/23	Y	LID	Y
116	Opioid treatment program service not payable outside the opioid treatment program	Opioid Treatment Program HCPCS codes are reported on a bill type that is not approved for an Opioid Treatment Program provider. Opioid Treatment Program HCPCS codes should only be reported on claims with bill types 087x, 013x with condition code 89, or 085x with condition code 89.	22.0-present	1/1/20-present	Y	RTP	
117	Token charge less than \$1.01 billed by provider	A drug HCPCS with final SI= K or G is reported with charges that are less than \$1.01 and at least \$0.01. The edit is not applied if a line item action flag of 2, 3, or 4 is present on the drug line(s).	22.2-present	7/1/21-present	N	LIR	Y
118	Invalid bill type	A claim is submitted with a bill type that is not programmed to process in the IOCE. The presence of this edit terminates the processing of the claim, claim processed flag value 1 and return code 18 are provided. Edit 118 is not specified in the Edits by bill type table as this edit can only be applied to bill types that are not programmed in the IOCE.	22.2-present	10/1/14-present	Y	RTP	
119	Invalid claims processing receipt date	The claims processing receipt date is invalid (malformed) or the date falls outside the date range of any version of the IOCE program. This edit is an IOCE program error and is applicable to being returned on all programmed bill types. The claim processed flag value 1 and return code 29 are provided if edit 119 is applied.	22.2-present	10/1/14-present	Y	RTP	
120	Incorrect reporting of modifier PT	A single day claim or a single date of service on a multiple day claim is submitted with modifier PT present and no Colorectal procedure is reported for the same service date. This edit is returned at the line level. Refer to the DATA_HCPCS table and the column named Colorectal, for a list of procedures that are to be reported in the presence of modifier PT. See Preventive Services and Deductible/Coinsurance Waiver Processing for more information. This edit is also returned for Non-OPPS bill type 085x (Critical Access Hospitals). Note: A line item action flag of 1 overrides this edit when input by the MAC.	23.1-present	10/1/15-present	Y	RTP	Y
121	Non-covered service reported with inpatient only procedure where patient expired or transferred	Non-covered services, identified with status indicators B, E1, E2, C or M, should not be paid separately when reported on a claim with an inpatient-only procedure and modifier CA.	23.1-present	1/1/16-present	N	LID	Y

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAB 1 Bypassable?
122	340B-acquired drug modifier(s) reported inappropriately	Pass-through drug and biological (SI=G) incorrectly reported with 340B program modifier. This is an information only edit that sets the Line Item Denial Rejection flag = 3.	23.1-present	4/1/22-present	N	LIR (Information only edit)	Y
123	Modifier used after CMS termination date	The reported claim is submitted with a HCPCS and appended with a modifier designated as not reportable after the CMS determined termination date for the modifier (Example modifier(s) includes: CS). Note: A line item action flag of 1 overrides this edit when input by the MAC.	23.2-present	7/1/22-present	Y	RTP	Y
124	HCPCS reported after CMS termination date	The reported claim is submitted with a HCPCS on a date of service after the CMS determined termination date. Refer to the DATA_HCPCS table and the column named "CMS_Mid-Quarter Termination" for a list of codes applicable. Note: A line item action flag of 1 overrides this edit when input by the MAC.	23.2-present	7/1/22-present	Y	RTP	Y
125	Incorrect billing of IMRT planning and delivery	A code is present that should not be reported on the same claim as 77301 (Intensity Modulated Radiotherapy planning). Refer to the Map_IMRT table for the list of applicable codes. Note: The applicable codes are not separately reportable on the same claim since they are already included in the APC payment or should not be reported for verification of the treatment field during a course of IMRT.	24.1-present	1/1/17-present	N	RTP	Y
126	Incorrect reporting of telehealth modifier	A code not flagged as "Telehealth" is present with modifiers 95, GT or GQ. Refer to the Telehealth column in Data_HCPCS for allowable Telehealth service codes as designated by CMS.	24.2-present	7/1/23-present	Y	RTP	Y
127	Service not allowed for Part B Inpatient claim	The revenue code reported is not on the allowable list for the Part B Inpatient claim, bill type 12x. Note: Edit 127 is bypassed when there is an allowable HCPCS present without a Part B Inpatient billable revenue code. Additionally, this edit is bypassed when condition code W2 is present. For a list of allowable revenue codes, see the Part B Billable Inpatient Revenue list in Data_Revenue. For a list of allowable HCPCS codes, see the Part B Billable Inpatient HCPCS list in Data_HCPCS.	24.2-present	7/1/23-present	Y	LIR	Y
128	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
129	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
130	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
131	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
132	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
133	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
134	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
135	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
136	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
137	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
138	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
139	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
140	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
141	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
142	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
143	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
144	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
145	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
146	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
147	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
148	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
149	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
150	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
151	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
152	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
153	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
154	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
155	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
156	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
157	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
158	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
159	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
160	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
161	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
162	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
163	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
164	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
165	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
166	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
167	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
168	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
169	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
170	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
171	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
172	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
173	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
174	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	

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Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non-OPPS	Disposition	LIAF 1 Bypassable?
175	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
176	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
177	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
178	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
179	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
180	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
181	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
182	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
183	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
184	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
185	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
186	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
187	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
188	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
189	Reserved	Line level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
190	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
191	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
192	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
193	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
194	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
195	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
196	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
197	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
198	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	
199	Reserved	Claim level reserved edit	23.0-present	1/1/22-present	N/A	Suspend	

7.3 IOCE Edits Applied by OPPTS Hospital Bill Type Table [OPPS Flag = 1]

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 OPPTS flag is set 1 to indicate OPPTS 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.

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPTS Flag (1)	APC Return Buffer Completed
012x	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, 81, 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	Y
012x with condition code 41	Hospital Inpatient with Partial Hospitalization (Medicare Part B Only)	23, 24, 46, 119	N
013x	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, 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	Y
013x with condition code 41	Hospital Outpatient with Partial Hospitalization	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 35, 37, 38, 40, 41, 43, 47, 48, 50, 57, 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, 121, 122, 123, 124	Y
013x 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	Y
014x	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, 35, 37, 40, 41, 42, 47, 48, 50, 53, 55, 57, 61, 62, 65, 66, 67, 68, 69, 72, 74, 76, 83, 87, 94, 99, 102, 103, 110, 111, 112, 113, 116, 119, 120, 122, 123, 124	Y
014x with condition code 41	Hospital – Laboratory services Provided to Non-Patients with Partial Hospitalization	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, 57, 61, 62, 65, 67, 68, 69, 72, 74, 83, 94, 102, 103, 110, 112, 113, 115, 116, 119, 123, 124	N
022x	Skilled Nursing Inpatient (Medicare Part B Only)	23, 24, 46, 119	N
023x	Skilled Nursing – Outpatient		
032x	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, 28, 40, 41, 48, 50, 53, 55, 61, 65, 67, 68, 69, 72, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
034x	Home Health Services not under a plan of treatment with APC covered services on claim (i.e., Vaccine Administration, Antigenes, Splints, Casts, or v18.0 NPWT)	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, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	Y

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Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPTS Flag (1)	APC Return Buffer Completed
034x	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, 69, 72, 94, 106, 107, 108, 110, 111, 113, 119, 123, 124	N
043x	Religious Non-Medical Health Care Institutions – Outpatient Services	10, 23, 24, 25, 26, 41, 55, 65, 119	N
071x	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, 91, 94, 102, 104, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
072x	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, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
074x	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, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
075x	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	N
076x	Clinic- Community Mental Health Center (CMHC)	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 20, 22, 23, 24, 25, 26, 27, 29, 30, 40, 41, 43, 47, 48, 50, 53, 55, 61, 65, 67, 69, 72, 80, 84, 94, 95, 99, 101, 102, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 122, 123, 124	Y
077x	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, 88, 89, 90, 91, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
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, 67, 69, 72, 94, 106, 107, 108, 110, 112, 113, 119	N
081x	Hospice (Non-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, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
082x	Hospice (Hospital Based)		
087x	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	N
022x, 023x, 032x, 072x, 074x, 075x, 081x, 082x, with condition code 07, and Antigens, 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, 69, 68, 72, 74, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 119, 122, 123, 124	Y

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.

7.4 IOCE Edits Applied by Non-OPPS Hospital Bill Type Table [OPPS Flag = 2]

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.

Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPS Flag (2)	APC Return Buffer Completed
012x	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, 81, 82, 83, 87, 93, 94, 100, 102, 103, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 120, 123, 124, 127	N
012x with condition code 41	Hospital Inpatient with Partial Hospitalization (Medicare Part B only)	23, 24, 46, 119	N
013x	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	N
013x 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, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
013x 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	N
014x	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	N
014x with condition code 41	Hospital – Laboratory services Provided to Non-Patients with Partial Hospitalization	23, 24, 46, 119	N
022x 023x	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, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
032x	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, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
034x	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, 94, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
043x	Religious Non-Medical Health Care Institutions – Outpatient Services	10, 23, 24, 25, 26, 41, 55, 65, 119,	N
071x	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, 91, 94, 102, 104, 106, 107, 108, 110, 112, 111, 113, 114, 115, 116, 119, 123, 124	N

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Bill Type	Provider Type or Logic Condition	Edit(s) Applicable to Bill Type and OPPTS Flag (2)	APC Return Buffer Completed
072x	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, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
073x	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, 106, 107, 108, 110, 112, 113, 114, 115, 116, 119, 123, 124	N
074x	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, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
075x	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	N
077x	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, 88, 89, 90, 91, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
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, 50, 53, 55, 61, 65, 67, 68, 69, 72, 94, 106, 107, 108, 110, 112	N
078x	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, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
081x	Hospice (Non-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, 86, 94, 102, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
082x	Hospice (Hospital Based)		
083x	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	N
084x	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, 106, 107, 108, 110, 111, 112, 113, 114, 115, 116, 119, 123, 124	N
085x	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, 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	N
085x 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, 106, 107, 108, 110, 112, 113, 114, 115, 119, 123, 124	N
087x	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	N
089x	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, 106, 107, 108, 110, 112, 113, 114, 115, 116, 119, 123, 124	N

8 IOCE APC Processing

8.1 Standard APC Processing

As stated in the introduction the second main function of the IOCE is to assign an APC (Ambulatory Payment Classification) number for each service covered under OPPTS (the APC is only returned for claims from HOPDs that are subject to OPPTS), as well as return information within the APC return buffer to be used as input to the OPPTS PRICER program for payment. There are two types of APCs assigned within the IOCE output. The HCPCS APC is the default APC given to a HCPCS/ CPT® code. The Payment APC when assigned, is the APC given to the line(s) that determines payment for the line. The Payment APC may be different from the HCPCS APC based on additional processing logic that determines the final APC. Note that the final SI is inherited from the Payment APC.

[The APC Return Buffer](#) contains the APC output information for each line item along with the relevant information for computing OPPTS payment for OPPTS hospital claims. A series of flags and editing will affect which APC is assigned for the final payment APC. When all criteria within the APC return buffer is filled, the IOCE passes information to the OPPTS PRICER to apply the payment amount to any paying lines of service on the claim.

The OPPTS PRICER computes the standard APC payment for a line item as the product of the payment amount corresponds to the assigned payment APC, the discounting factor, and the number of units for all line items for which the following is true:

Criteria for applying standard APC payment calculations:

- APC value is not 00000
- Payment indicator has a value of 1
- Packaging flag has a value of zero or 3
- Line item denial or rejection flag is zero or the line item action flag is 1
- Line item action flag is not 2, 3 or 4
- Payment adjustment flag 1 and 2 is zero
- Payment method flag is zero
- Composite adjustment flag is zero

Lines receive a payment APC of '00000' if one of the following conditions are true:

- The line is on a non-OPPTS claim
- The line is packaged (SI=N)
- The line has an invalid CPT/HCPCS
- The line has a non-payable status indicator (E1, Q1, Q2, Q3, or C)
- The line has a valid CPT/HCPCS; however, it is not payable for the claim's provider bill type (FQHC, HH, CMHC, etc.)

If payment adjustments are applicable to a line item ([payment adjustment flag](#) is not 0 or 1) then nonstandard calculations are necessary to compute payment for a line item. The line item action flag if passed on input to the IOCE can override a line item denial or rejection or allow the line item to be denied or rejected for reasons outside IOCE editing. The LIAF also impacts the computation of the discounting factor. [The Payment Method flag](#) identifies which services are paid under OPPTS depending on the site of service. OPPTS payment for the claim is computed as the sum of the payments for each line item with the appropriate conversion factor, wage rate adjustment, outlier adjustment, etc. applied. [Component Initialization](#) summarizes the process of filling in the [APC return buffer](#).

The [Packaging flag](#) identifies line items that are packaged into other payable services present on the claim. Lines with a packaging flag value of 3 (Artificial charges for surgical procedure [submitted charges for surgical HCPCS < \$1.01, but greater than \$0.00]) are not treated the same as "packaged" (SI=N, PI=9) lines by the program. Additionally, line-items eligible for a packaging flag value of 1 always take precedence over a value of 3.

8.1.1 Multi-day Claims Processing

Multiple day claims are those with From and Through dates that span a range. The [overall claim disposition \(OCD\) value](#) returned by the IOCE is based on the number of days present. as well as any edits assigned to the claim.

When a claim spans more than one day, the IOCE subdivides the claim into separate days for the purpose of determining discounting and multiple visits on the same day. Multiple day claims are determined based on calendar day. The IOCE deals with all multiple day

claims issues by means of the return information. The PRICER does not need to be aware of the issues associated with multiple day claims. The PRICER simply applies the payment computation as described above and the result is the total OPPS payment for the claim regardless of whether the claim was for a single day or multiple days. If a multiple day claim has a subset of the days with a claim denial, RTP or suspend, the whole claim is denied, RTP or suspended.

8.2 Claim Return Buffer Table

The claim return buffer table contains edit values for applicable items that are within the 28 prior quarters (7 years) for each release.

Item	Bytes	Number	Values	Description
Claim processed flag	1	1	0-4, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, 46, 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
Num of line items	3	1	nnn	Up to 450 total line items
National provider identifier (NPI)	13	1	aaaaaaaaaaaaa	Transferred from input, for Pricer.
CMS certification number (CCN)	6	1	aaaaaa	Transferred from input, for Pricer. Previously known as the OSCAR number.
Overall claim disposition	1	1	0-5	0 - No edits present on claim. 1 - Only edits present are for line item denial or rejection. 2 - Multiple-day claim with one or more days with lines that are denied or rejected. 3 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only post payment edits. 4 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only pre-payment edits. 5 - Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w both post-payment and pre-payment edits.
Claim rejection disposition	1	1	0-2	0 - Claim not rejected. 1 - There are one or more edits present that cause the claim to be rejected. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be rejected.
Claim denial disposition	1	1	0-2	0 - Claim not denied. 1 - There are one or more edits present that cause the claim to be denied. 2 - There are one or more edits present that cause one or more days of a multiple-day claim to be denied, or single day claim with all lines denied
Claim returned to provider disposition	1	1	0-1	0 - Claim not returned to provider. 1 - There are one or more edits present that cause the claim to be returned to provider.
Claim suspension disposition	1	1	0-1	0 - Claim not suspended. 1 - There are one or more edits present that cause the claim to be suspended.
Line item rejection disposition	1	1	0-1	0 - There are no line item rejections. 1 - There are one or more edits present that cause one or more-line items to be rejected.
Line item denial disposition	1	1	0-1	0 - There are no line item denials. 1 - There are one or more edits present that cause one or more-line items to be denied.
Claim rejection reasons	3	4	27	Three-digit code specifying edits that caused the claim to be rejected. There is currently only one edit that causes a claim to be rejected
Claim denial reasons	3	8	10	Three-digit code specifying edits that caused the claim to be denied. There is currently one active edit that causes a claim to be denied.
Claim returned to provider reasons	3	30	1-3, 5, 6, 8, 21-23, 25, 26, 29, 35, 37, 38, 41-44, 46, 48, 50, 51, 55, 58, 60-62, 70, 72-74, 79-82, 84, 86-90, 92, 94, 98-102, 109, 113,114, 115, 116, 118, 119, 120, 123,124, 125, 126	Three-digit code specifying edits that caused the claim to be returned to provider. (Table 6.2)
Claim suspension reasons	3	16	11, 12, 24, 57, 66	Three-digit code specifying the edits that cause the line item to be suspended. .(Table 6.2)
Line item rejection reasons	3	12	7, 13, 17, 20, 28, 40, 45, 47, 53, 65, 76, 91, 93, 95, 104, 110-112, 117, 122, 127	Three-digit code specifying the edits that caused the line item to be rejected .(Table 6.2)

Item	Bytes	Number	Values	Description
Line item denied reasons	3	6	9, 18, 30, 49, 67-69, 83, 103, 105-108, 115, 121	Three-digit code specifying the edits that caused the line item to be denied. (Table 6.2)
APC return buffer flag	1	1	0-1	0 - No services paid under OPPTS. 1 - One or more services paid under OPPTS. APC return buffer filled in with APC.
Version Used	8	1	yy.vv.rr	Version ID of the version used for processing the claim (e.g., 2.1.0).
Patient Status	2	1		Patient status code - transferred from input.
OPPS Flag	1	1	1-2*	OPPS/Non-OPPS flag - transferred from input *A blank, zero or any other value is defaulted to 1
Non-OPPS bill type flag	1	1	2	2 = Bill type should not be 083x
Payer Value Code and Payer Value Code Amount	11	10	2-character Value Code (QN-QW) followed by amount (nnnnnnn.nn*)	<u>Assigned by IOCE based on criteria for APC payment offset.</u> QN – First APC device offset QO – Second APC device offset QP – Reserved for future use QQ – Terminated procedure with pass-through device QR – First APC pass-through drug or biological offset QS – Second APC pass-through drug or biological offset QT – Third APC pass-through drug or biological offset QU – Condition for device credit present QV – Reserved for future use <u>Assigned by IOCE based on PHP weekly processing criteria.</u> QW – Partial week present on interim PHP claim Note: If offset conditions do not exist, the value code label (QN-QW) is blank; the amount is zero-filled.
Payer Condition Code	2	10	2-character Condition Code	2-character Payer Only Condition Code assigned by IOCE based on PHP weekly processing criteria MP – PHP claim contains initial admit week MQ – PHP claim contains final discharge week MV – Second portion of combined PHP week is not 20 hours
Return Code	2	1	0-29	Two-digit code that describes how the claim processed successfully or if errors occurred which prevented further processing. 0 - Claim processed 1 - Memory allocation error 2 - Not used 3 - Run time environment setup failed, could not initialize run-time environment 4 - Could not open Read-Only Table file 5 - Could not determine Read-Only Table size 6 - No memory for Read-Only Table 7 - Could not read Read-Only Table file 8 - Read-Only Table file corrupted 9 - Read-Only Table version does not match component version 10 - Could not link Read-Only Tables to base object 11 – OCEInit not called before call to OCECLM 12 - Invalid number of line items 13 - Invalid From date 14 - Invalid Through date 15 - Invalid date sequence 16 - Invalid line date 17 - From date outside of OCE version range 18 - Invalid bill type 19 - (Reserved) 20 - (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 bypass edit is not able to be bypassed 27 – Invalid format used for contractor bypass input values 28 – Input format is incorrect for value code amount field 29 – Invalid claims processing receipt date

8.3 APC Return Buffer Table

** Indicates fields that are not activated or returned for Non-OPPS Bill Type (OPPS=2) claims.

Name	Size (bytes)	Values	Description
HCPCS procedure code	5	Alpha	For potential future use by Pricer; transfer from input.
Payment APC	5	00001-nnnnn	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	00001-nnnnn	APC assigned to HCPCS code
Status Indicator (SI)**	2	Alpha	<p>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)</p> <p>B – Non-allowed item or service for OPPS</p> <p>C – Inpatient procedure</p> <p>E1 – Non-allowed item or service</p> <p>E2 – Items and services for which pricing information and claims data are not available</p> <p>F – Corneal tissue acquisition; Certain CRNA services</p> <p>G – Drug/Biological Pass-through</p> <p>H – Pass-through device categories</p> <p>J1 – Hospital Part B services paid through a comprehensive APC</p> <p>J2 – Hospital Part B services that may be paid through a comprehensive APC</p> <p>K – Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals</p> <p>L – Influenza Vaccine; Pneumococcal Pneumonia Vaccine; Hepatitis B Vaccines; Covid-19 Vaccine; Monoclonal Antibody Therapy Product</p> <p>M – Service not billable to the MAC</p> <p>N – Items and Services packaged into APC rates</p> <p>P – Partial hospitalization service</p> <p>Q1 – STV-Packaged codes</p> <p>Q2 – T-Packaged codes</p> <p>Q3 – Codes that may be paid through a composite APC</p> <p>Q4 – Conditionally packaged laboratory services</p> <p>R – Blood and blood products</p> <p>S – Procedure or service, not discounted when multiple</p> <p>T – Procedure or service, multiple reduction applies</p> <p>U – Brachytherapy sources</p> <p>V – Clinic or emergency department visit</p> <p>W – Invalid HCPCS or Invalid revenue code with blank HCPCS</p> <p>Y – Non-implantable DME</p> <p>Z – Valid revenue code with blank HCPCS and no other SI assigned</p> <p>Note: * = No Longer Applicable</p>
Payment Indicator**	2	Numeric (1-nn)	<p>1 – Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V)</p> <p>2 – Services not paid by OPPS Pricer; paid under fee schedule or other payment system (SI of A, G, K)</p> <p>3 – Not paid (Q1, Q2, Q3, Q4, M, W, Y, E1, E2), or not paid under OPPS (B, C, Z)</p> <p>4 – Paid at reasonable cost (status indicator F, L)</p> <p>5 – Paid standard amount for pass-through drug or biological (status indicator G) *</p> <p>6 – Payment based on charge adjusted to cost (status indicator H)</p> <p>7 – Additional payment for new drug or new biological (status indicator J) *</p> <p>8 – Paid partial hospitalization per diem (status indicator P)</p> <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, G0177 or G0129)</p> <p>10 – Paid FQHC encounter payment</p> <p>11 – Not paid or not included under FQHC encounter payment</p> <p>12 – No additional payment, included in payment for FQHC encounter</p> <p>13 – Paid FQHC encounter payment for New patient or IPPE/AWV</p> <p>14 – Grandfathered tribal FQHC encounter payment</p>
Discounting Formula Number**	1	1-9	See Discounting formula for discounting fraction values 1-9
Line Item Denial or Rejection Flag**	1	0-3	<p>0 - Line item not denied or rejected</p> <p>1 - Line item denied or rejected</p> <p>2 – The line is not denied or rejected but occurs on a day that has been denied or rejected (not used as of 4/1/2002 - v3.0)</p> <p>3 - Line item not denied or rejected; identified for informational alert only</p> <p>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.</p>

Name	Size (bytes)	Values	Description
Packaging Flag**	1	0-6	0 – Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – <i>Packaged as part of PH per diem or daily mental health service per diem (v1.0-v9.3 only) *</i> 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < \$1.01) 4 – <i>Packaged as part of drug administration APC payment (v6.0 – v7.3 only) *</i> 5 – Packaged as part of FQHC encounter payment 6 – FQHC packaged preventive or other reported service not subject to coinsurance payment
Payment Adjustment Flag 1**	2	0-nn [Right justified, blank filled]	0 – No payment adjustment 1 – Paid standard amount for pass-through drug or biological 2 – Payment based on charge adjusted to cost 4 – Deductible not applicable (specific list of HCPCS codes) 5 – Blood/blood product used in blood deductible calculation 6 – Blood processing/storage not subject to blood deductible 9 – Deductible/coinsurance not applicable 10 – Coinsurance not applicable 11 – Multiple service units reduced to one by OCE processing; payment based on single payment rate 12 – Offset for first device pass-through 13 – Offset for second device pass-through 14 – PAMA Section 218 reduction on CT scan 15 – <i>Reserved for future use</i> 16 – Terminated procedure with pass-through device 17 – Condition for device credit present 18 – Offset for first pass-through drug or biological 19 – Offset for second pass-through drug or biological 20 – Offset for third pass-through drug or biological 21 – CAA Section 502(b) reduction on film X-ray 22 – CAA Section 502(b) reduction on computed radiography technology 23 – Coinsurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b) 24 – Coinsurance 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
Payment Method Flag**	1	0-x	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 (COVID-19) V - Contractor bypass applied to FQHC PPS service and coinsurance is n/a (COVID-19) W - Contractor bypass applied to off-campus clinic visit for payment reduction X - Contractor bypass applied to Section 603 service with no reduction applied in OPPS Pricer Y - Contractor bypass applied to Section 603 service with reduction applied in OPPS Pricer Z - Contractor bypass determines payment for services
Service Units	9	1-x	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 assigned a value of one by the IOCE even if the input service units were greater than one, and payment adjustment flag 11 is provided (v16.1). 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 (v16.2). Input service units also may be reduced for some Drug administration APCs (v6.0 – v7.3 only).
Charge	10	nnnnnnnnnn	Transferred from input for Pricer; COBOL pic 9(8)v99
Line Item Action Flag**	1	0-5	Transferred from input to Pricer and can impact selection of discounting formula. 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

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Name	Size (bytes)	Values	Description
Composite Adjustment Flag**	2	Alphanumeric	00 – Not a composite 01 – ZZ: First thru 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 077x) only, the following values are defined for composite adjustment flag: 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC medical clinic visit (modifier 59 reported)
HCPCS Modifier	4	Alphanumeric	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) Reserved for future use
Payment Adjustment Flag 2**	2	0-nn [Right justified, blank filled]	0 – No payment adjustment Reserved for future use*

8.4 Payment Method Flag (PMF) Value Table

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

8.4.1 Payment Method Flag (PMF) Value Condition Settings:

1. If the claim is not processed (claim processed flag is greater than 0), the PMF is not set and is left blank.
2. If the line-item denial or rejection flag is 1 or 2, and the PMF is set to 2 by the process above, the PMF is reset to 3.
3. If the line-item action flag is 2 or 3, the PMF is reset to 4.
4. If the line-item action flag is 4, the PMF is reset to 0.
5. If PMF is set to a value greater than 0, reset Payment APC to 00000; except for PMF values 6, 7, 8, 9 and effective 1/1/2016 if PMF of 2 is set to Drug HCPCS with SI of G or K.
6. PMF A is assigned only for HCPCS code G0463 reported with modifier PO for OPPS claims with bill type 013x w/ or w/o CC 41 and this is not represented in table 7.2.2.
7. PMF V, W, Y, and Z are assigned to identify line items that have a contractor defined bypass condition applied. PMF V, W, Y and Z are not represented in table 7.2.2., as the contractor bypass can be applicable to all Status Indicators and Bill Types. Note: PMF Z is not output when there is a possible error in contractor bypass field entry. The default PMF is assigned instead.
8. PMF C and 5 are not represented in table 7.2.2 as Status Indicators are not used for payment by the FQHC PPS.
9. PMF B is for Payer Only use, and is not represented in table 7.2.2.

8.4.2 Payment Method Flag Assignment by Status Indicator and Bill Type Table

Type of Bill	PMF = 0	PMF = 1	PMF = 2	PMF = 6	PMF = 7	PMF = 8	PMF = 9	Comments
HOPD 013x w or w/o Condition Code 41 or condition code 89	H, J1, J2, N, P, R, S, T, U, V	B, C, E, M, Q1, Q2, Q3, Q4, W, Y, Z	A, F, G, K, L	Not set	SI = F, H, L, R, U; SI = J1, J2, Q1, Q2, Q3, Q4, S, T and V if PAF set to 4, 9 or 10; SI = P w/ APC changed to CMHC APC	J1, J2, Q1, Q2, Q3, Q4, S, T and V	Not set	PMF 7 also applies to certain radiation treatment HCPCS
HOPD 012x, 014x with CC41	Not set	Not set	Not set	Not set	Not set	Not set	Not set	PMF not set, edit 46 generated, claim processed flag set to 1; no further processing occurs
HOPD 012x, 014x Without CC 41	H, J1, J2, N, P, R, S, T, U, V	B, C, E, M, Q1, Q2, Q3, Q4, W, Y, Z	A, F, G, K, L	Not set	Not set	Not set	Not set	N/A
CMHC 076x	PHP services and Non- PHP w/SI=N	Non-PHP, not Telehealth service: A, B, C, E, F, G, H, J1, J2, K, L, M, R, S, T, U, V, Q1, Q2, Q3, Q4, W, Y, Z	Telehealth (Q3014)	PHP services and Non- PHP w/SI = N that have reached the CMHC outlier payment limitation	Not set	Not set	PHP services and Non-PHP w/SI = N; MAC bypass of the CMHC outlier payment limitation	N/A
CORF 075x	Vaccine [v1- 6.3]	C, E, M, W, Y, Z	A, B, F, G, H, J1, J2, K, L, N, P, Q1, Q2, Q3, Q4, R, S, T, U, V	Not set	Not set	Not set	Not set	N/A
Home Health 034x	Vaccine, Antigen, Splint, Cast or NPWT	Not vaccine, Antigen, splint, cast or NPWT: C, E, M, W, Y, Z	Not vaccine, Antigen, splint, cast or NPWT: A, B, F, G, H, J1, J2, K, L, N, P, Q1, Q2, Q3, Q4, R, S, T, U, V	Not set	Not set	Not set	Not set	N/A
RNHC (043x) RHC (071x) FQHC (073x/077x)	Not set	C, E, M, W, Y, Z	A, B, F, G, H, J1, J2, K, L, N, P, Q1, Q2, Q3, Q4, R, S, T, U, V	Not set	Not set	Not set	Not set	N/A
022x, 023x, 032x, 072x, 074x, 075x, 081x, 082x, with condition code 07, and Antigen, Cast, or Splint	Antigen, Splint, Cast:	Not Antigen, Splint, Cast: C, E, M, W, Y, Z	Not Antigen, Splint, Cast: A, B, F, G, H, J1, J2, K, L, N, P, Q1, Q2, Q3, Q4, R, S, T, U, V	Not set	Not set	Not set	Not set	N/A
OTP 087x	Not set	C, E, M, W, Y, Z	A, B, F, G, H, J1, J2, K, L, N, P, Q1, Q2, Q3, Q4, R, S, T, U, V	Not set	Not set	Not set	Not set	N/A

8.5 Payment Adjustment Flag Values Table

*Note: values italicized and * are deleted, values just italicized indicate the value is reserved for future use*

Criteria/Description	Value	Applicable Versions
No payment adjustment (all others)	0	v1.0-current
<i>Paid standard amount for pass-through drug or biological (SI=G)</i>	<i>1</i>	v3.0-v17.2*
<i>Payment based on charge adjusted to cost (SI=H)</i>	<i>2</i>	v1.0-v17.2*
Code is flagged as 'deductible not applicable' or condition code "MA" is present on the claim or modifier "PT" is reported on an applicable procedure	4	v1.0-current
Blood product with modifier BL on RC 038x line	5	v6.2-current
Blood product with modifier BL on RC 039x line	6	v6.2-current
Code is flagged as "Deductible/coinsurance not applicable" or Q3 modifier is reported or CS modifier is reported on applicable visit codes	9	v12.0-current
Coinsurance not applicable	10	v12.0-current
Multiple service units reduced to one by OCE processing; payment based on single payment rate	11	v16.0-current
Offset for first device pass-through	12	v17.0-current
Offset for second device pass-through	13	v17.0-current
PAMA Section 218 reduction on CT scan	14	v17.0-current
<i>Placeholder reserved for future use</i>	<i>15</i>	n/a
Terminated procedure with pass-through device	16	v17.0-current
Condition for device credit present	17	v17.0-current
Offset for first pass-through drug or biological	18	v17.0-current
Offset for second pass-through drug or biological	19	v17.0-current
Offset for third pass-through drug or biological	20	v17.0-current
CAA Section 502b reduction on film x-ray	21	v18.0-current
CAA Section 502b reduction on computed radiography technology	22	v19.0-current
Coinsurance deductible not applicable, as well as subject to a reduction due to film x-ray (CAA Section 502b)	23	v18.0-current
Coinsurance deductible not applicable, as well as subject to a reduction due to computed radiography technology (CAA Section 502b)	24	v19.0-current
Deductible not applicable and coinsurance reduced when modifier PT reported on applicable procedure	25	v23.0-current

8.5.1 Payment Adjustment Flag (PAF) Value Condition Settings/Notes:

Note: The payment adjustment flag for a line item is set based on the criteria in the description and is defined within the specific processing logic sections or notated below.

1. PAF values are assigned in the priority sequence of 9, 4, and 10 when an applicable payer only condition code or modifier have been applied to applicable bill types. Note: The logic for Payer Only Bypass of Deductible and/or Coinsurance takes priority of any other PAF logic. See [Payer Only Bypass of Deductible and/or Coinsurance on Part B Institutional Claims](#) for additional information.
2. PAF values 1 and 2 are discontinued effective October 2016 (v17.3).
3. PAF value 4 is assigned when codes are flagged in the database as “deductible_na” or by program logic regarding the reporting of mod or payer condition code MA.
4. PAF value 9 is assigned when codes are flagged in the database as “deductible_coins_na” or by program logic regarding the reporting of modifier Q3, or modifier CS on applicable visit codes.
5. Effective v23.0, PAF 25 is assigned to the line(s) when modifier PT is reported on the claim with the same service date as a code flagged in the database as “Colorectal” in addition to other applicable procedures with SI = J1, T, or Q1, Q2, Q3 that resolve to J1 or T. PAF 4, is overridden, if present and PAF 9 continues to be assigned over payment adjustment flag 25, if applicable.
6. If services applicable for a PAF of 4, 9, 10 or 25 are packaged with SI = N and the line item charges = 0.00, no PAF is assigned.
7. Effective with v22.3, PAF 9 is assigned over values 4, 10 or 25 in instances where more than one of these payment adjustment flag values is applicable.
8. Description for PAF 11 modified 4/1/2015 (v16.1). PAF 11 is not assigned if another PAF value has been set previously during processing.
 - a. For line items assigned to APCs for daily mental health, PHP, composite APC or comprehensive APC, the service units are assigned a value of one by the IOCE even if the input service units were greater than one, and payment adjustment flag 11 is provided (v16.1).
 - b. 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 (v16.2).
9. PAF 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 PAF 12 and 13.
10. PAF 14 is assigned to a specific list of CT scan procedure codes if reported with modifier CT; if there is a CT scan code reported with modifier CT that is packaged with SI = N as a result of composite APC or comprehensive APC processing, PAF 14 is not assigned to the packaged code.
 - a. If conditions for PAF 9 and PAF 14, PAF 9 is assigned to the line item.
11. PAF 16 is assigned to a terminated device intensive procedure reported with modifier 73.
12. PAF 17 is assigned to a device intensive procedure if condition code 49, 50 or 53 is reported.
13. PAF 18-20 is assigned for conditions that may be present for pass-through drugs or biologicals requiring payment offset.
14. PAF 21 and 22 is assigned to a list of radiology HCPCS codes that are subject to payment reduction if modifiers FX or FY are reported.
15. PAF 23 and 24 is assigned when coinsurance and deductible is not applicable as well as subject to a radiology payment reduction (PAF 21/22).