MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

***News Flash* - Effective January 1, 2008, National Provider Identifiers (NPIs) will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.) You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until May 23, 2008, if you choose.**

MLN Matters Number: MM5865 Revised
Related Change Request (CR) #: 5865
Related CR Release Date: January 18, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1419CP
Implementation Date: January 7, 2008

January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0

Note: This article was revised on January 22, 2008, to reflect changes made to CR5865 as a result of legislation that required CMS to change the status indicator (SI) from K to H for brachytherapy and radiopharmaceutical codes for dates of service of January 1, 2008, through June 30, 2008. Relative changes were made in the table on pages 2-4 of this article. The CR release date, transmittal number and the Web address for accessing CR5865 were also changed.

Provider Types Affected

All providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5865 and notifies providers that the I/OCE Specifications Version 9.0, is effective January 1, 2008. Mote that claims

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with dates of service **prior to July 1, 2007** are routed through the non-integrated versions of the OCE software that **coincide with the versions in effect for the date of service on the claim.**

Background

This article is based on Change Request (CR) 5865 and informs providers that the I/OCE routes all institutional outpatient claims (including non-OPPS hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. **This integration does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software.** It expands the software usage to include non-OPPS hospitals.

There are numerous changes/additions/deletions to diagnosis codes, Ambulatory Payment Classification (APC) codes, and Health Care Common Procedure Codes (HCPCS) in January 2008. All of the changes will not be detailed in this article. Instead, please see CR5865 for those details. CR5865 is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1419CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

The key changes for the January 2008 I/OCE are as follows: (Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.)

Effective Date	Modification
1/1/08	Modify appendix D to prevent double discounting: 1. Replace discount formula #6 with formula #3 in applicable rows, to prevent application of both multiple procedures & terminated procedure discounting to the same procedure. 2. Create new discount formula #9 to replace discount formula #7 (to pay 100% of the APC rate, 50% x2, for a bilateral T procedure that is not the highest).
1/1/08	Discontinue use of discount formulae #6 and #7
1/1/08	Create new payment adjustment flag (PAF) 8: Item provided with partial credit to provider. 1. Assign to procedures subject to 50% of off-set, when modifier FC is present. 2. Reduce APC payment rate by 50% of offset amount before application of discounting logic.
1/1/08	Expand edit 75 to apply to modifier FC in addition to FB – to trigger if modifier FB or FC is appended to a code with status indicator (SI) other than S, T, X or V.
1/1/08	Expand use of SI of "Q" – to include other codes (not packaged services only) subject to SI change based on criteria.

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1/1/08	Implement new 'composite' APC assignment logic as specified in appendix K and Appendix H-c of the I/OCE specifications attached to CR5865.
1/1/08	Implement 2-character payment adjustment flags, 91-99; use for composite APCs (see appendix G of CR5865).
1/1/08	Deactivate observation logic that is based on payable G0378 (appendix H-a).
1/1/08	Remove criterion for 'payable G0378' from G0379 processing (appendix H-b).
1/1/08	Implement logic for assignment of new composite APCs which include observation (appendix K)
1/1/08	Bypass edit 48 for rev code 0948.
1/1/08	Apply wound care logic to all revenue codes in the therapy series: 042x, 043x and 044x (not 04x0 only).
1/1/08	Modify PHP and MH per-diem logic (appendix C)- • Replace APC numbers with specified lists of codes - PH services = list of codes that count toward Partial Hospitalization APC - MH services = list of codes that are included in the Daily Mental Health services cap • Assign SI of 'N' to all codes that are packaged into APC 33 & 34 • Count multiple occurrences of OT (G0129) as separate units in determining "3 or more" for PHP
1/1/08	Modify the current special packaged codes logic to package only in the presence of codes with SI of S,T,V or X on the same date of service = "STVX-packaged" codes.
1/1/08	Expand special packaged codes logic to add codes that will be packaged in the presence of a code with SI of T on the same date of service = "T-packaged" codes
8/1/00	Bypass edit 48 for rev codes 099x. Assign edit 9 (SI-E) if submitted without a HCPCS.
10/1/07	Rescind previous program modification - re-apply edit 71 to bill type 12x.
1/1/07	Modify the program to exclude bill type 12x from edit 77 (change effective date from 10/1 to **1/1/07**).
1/1/08	New edit 78 – Claim lacks required radiopharmaceutical **(RTP)**. Assign to specified nuclear medicine procedure if no specified radiopharmaceutical on the claim.
1/1/08	Make Non-OPPS bill type 83x invalid for the I/OCE – assign claim processed flag of "1" (claim could not be processed, invalid bill type).
7/1/07	Modify the program to bypass edit 17 for bill type 85x.

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7/1/07	Modify the processing flow such that no values are returned for the following OPPS-related flags on Non-OPPS claims (OPPS flag = 2). Return blank fields in the APC/ASC Return buffer. • status indicator, • payment indicator, • discounting formula number, • line item denial or rejection, • packaging, • payment adjustment, • payment method • line item action. Return "0" in the payment APC/ASC field.

	Make HCPCS/APC/SI changes as specified by CMS
	Implement version **13.3** of the NCCI file, removing all code pairs which include Anesthesia (00100-01999; 99143-99150), E&M (92002-92014, 99201-99499), or MH (90804-90911).
	Add new modifiers (FC, EA, EB, EC, KG, KK, KU, KW, KY,Q0, Q1) and delete modifiers QA, QR, and QV as specified by CMS.
	Modify description for edit 75: Incorrect billing of modifier FB or FC.
10/1/07	Add new revenue code 0948 to the valid revenue code list, no pre-assigned SI.
	Modify description for SI 'M' (Service not billable to the FI/MAC)… also modify descriptions for SI A, and K, and N, and Q, and V, and Y.
	Rename OCE Overview as appendix L; Rename Summary of Modifications as appendix M.

Readers should also read through the specifications attached to CR5865 and note the yellow highlighted sections, which indicate change from the prior release of the I/OCE software.

Additional Information

For complete details regarding CR5865, please see the official instruction (CR5865) issued to your Medicare A/B MAC, RHHI, or FI. To view the instruction, visit *http://www.cms.hhs.gov/Transmittals/downloads/R1419CP.pdf* on the CMS website.

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If you have questions, please contact your Medicare A/B MAC, RHHI, or FI at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

News Flash - **It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website.**

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