CMS Manual System

Department of Health & Human Services

Pub 100-04 Medicare Claims Processing

Centers for Medicare & Medicaid Services

Transmittal 664

Date: August 30, 2005

Change Request 4007

SUBJECT: October 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.3

NOTE: Transmittal 660, dated August 26, 2005 is rescinded and replaced with Transmittal 664, dated August 30, 2005. Attachment B has been changed. All other information remains the same.

I. SUMMARY OF CHANGES: This instruction is to inform the Fiscal Intermediaries that the October 2005 Outpatient Prospective Payment System Outpatient Code Editor (OPPS OCE) specifications have been updated with new additions, deletions, and changes.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : October 01, 2005

IMPLEMENTATION DATE : October 03, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 664	Date: August 30, 2005	Change Request 4007

SUBJECT: October 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.3

NOTE: Transmittal 660, dated August 26, 2005 is rescinded and replaced with Transmittal 664, dated August 30, 2005. Attachment B has been changed. All other information remains the same.

I. GENERAL INFORMATION

A. Background: This notification reflects specifications that were issued for the July revision of the OPPS OCE (Version 6.2). All shaded material in Attachment A reflects changes that were incorporated into the October version of the revised OPPS OCE (Version 6.3).

B. Policy: This notification provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHC's) and for limited services as defined below when provided in a comprehensive outpatient rehabilitation facility (CORF), home health agency (HHS) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4007.1	The Shared System Maintainer shall install OPPS OCE Version 6.3 into their systems.	X				X				
4007.2	Intermediaries and RHHI's shall inform providers of the OPPS OCE changes for Version 6.3 detailed in this recurring change notification.	X	X			X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4007.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X				

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: OPPS OCE/ PRICER

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2005 **Implementation Date:** October 3, 2005 **Pre-Implementation Contact(s):** Diana Motsiopoulos at dmotsiopoulos@cms.hhs.gov., or Antoinette Johnson at ajohnson2@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

ATTACHMENT A

October Outpatient Code Editor (OCE) Specifications Version (V6.3)

This attachment contains specifications issued for the July OCE (Version 6.2). All shaded material reflects changes incorporated into the October version of the OPPS OCE (Version 6.3).

Introduction

This attachment provides OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for limited services as defined below when provided in a comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA) not under Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. Henceforth, this OCE will be referred to as the OPPS OCE. You are required, effective with unprocessed claims with dates of service on or after August 1, 2000, to send the following bills through the OPPS OCE:

- All outpatient hospital Part B bills (bill types 12X, 13X, or 14X) with the exception of critical access hospitals (CAHs), Indian Health Service Hospitals (IHS)/ Tribal hospitals including HIS/ Tribal CAHs, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan. In addition, claims from Virgin Island hospitals with dates of service January 1, 2002, and later, and claims from hospitals that furnish only inpatient Part B services with dates of service January 1, 2002, and later should not be sent through the OPPS OCE since they are also excluded from OPPS. (See below for more detail regarding these hospitals.);

- CMHC bills (bill type 76X);

- HHA and CORF bills containing certain Healthcare Common Procedure Coding System (HCPCS) codes as identified in the chart entitled "HCPCS Codes for Reporting Antigens, Hepatitis B Vaccines, Splints and Casts" below (bill types 34X or 75X); and

- Any bill containing a condition code 07, "treatment of non-terminal illness – hospice", with certain HCPCS codes as identified in the chart entitled "HCPCS Codes for Reporting Antigens, Hepatitis B Vaccines, Splints and Casts" below.

Send all other outpatient bill types (22X, 23X, 24X, 32X, 33X, 43X, 71X, 72X, 73X, 74X, 81X or 82X) through the OPPS OCE. Send Indian Health Service hospitals, CAHs, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan through the non-OPPS OCE (original OCE). Also send claims from Virgin Island hospitals with dates of service on or after January 1, 2002, and claims from hospitals that furnish only inpatient Part B services with dates of service on or after January 1, 2002, through the non-OPPS OCE. Refer to the IOM Chapter 100-04, Chapter 4, Section 150, for information regarding hospitals that provide Part B only services to their inpatients.

NOTE: For bill type 34X, only Hepatitis B vaccines and their administration, splints, casts, and antigens will be paid under OPPS. For bill type 75X, only Hepatitis B vaccines

and their administration are paid under OPPS. For bills containing condition code 07, only splints, casts and antigens will be paid under OPPS.

You are also required to notify your providers of the OPPS OCE claim outputs.

The following information provides you with the OPPS OCE edit specifications that will be utilized to make appropriate payments under the OPPS system, which was effective August 1, 2000.

General Functions of the OCEs

The OPPS OCE performs the following two major functions:

- Edit claims data to identify errors and return a series of edit flags; and
- Assign an ambulatory payment classification (APC) number for each service covered under OPPS and return information to be used as input to the PRICER program.

A major change in processing was required to handle claims with service dates that span more than 1 calendar day. Each claim is represented by a collection of data, which consists of all necessary demographic (header) data, plus all services provided (line items). You are responsible for organizing all applicable services into a single claim record, and passing them as a unit to the OPPS OCE. OPPS OCE functions only on a single claim and does not have any cross-claim capabilities. OPPS OCE will accept up to 450 line items per claim. The OPPS OCE software is responsible for ordering line items by date of service.

The non-OPPS OCE focused solely on the presence or absence of specific edits and did not specify action that should be taken when an edit occurred (e.g., deny claim, suspend claim). Further, it did not compute any information that would be used for payment purposes. Therefore, it was structured to return a set of flags for each diagnosis and procedure that indicated the presence or absence of individual edits. The OPPS OCE not only identifies individual errors but also indicates actions to take and the reasons why these actions are necessary. In order to accommodate this expanded functionality, the OPPS OCE is structured to return lists of edit numbers instead of zero/one flags. This new structure facilitates the linkage between the action being taken, the reasons for the action, and the information on the claim (e.g., a specific diagnosis) that caused the action.

In general, the OPPS OCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes. Since these coding systems are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program will reduce effort for you and reduce the chance of inconsistent processing.

The span of time that a claim represents will be controlled by the from and through dates that will be part of the input header information. If the claim spans more than 1 calendar day, the OPPS OCE will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day.

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

Information Sent to OPPS OCE

Header and line item information is passed to the OPPS OCE by means of a control block of pointers. Table 1 contains the structure of the "OPPS OCE Control Block". The shaded area separates input from return information. Multiple items are assumed to be in contiguous locations.

The header information must relate to the entire claim and must include the following:

- From date;
- Through date;
- Condition code;
- List of ICD-9-CM diagnosis codes;
- Age;
- Sex;
- Type of bill; and
- Medicare provider number.

The from and through dates will be used to determine if the claim spans more than 1 day and therefore represents multiple visits. The condition code (e.g., 41) specifies special claim conditions such as a claim for partial hospitalization, which is paid on a per diem basis. The diagnosis codes apply to the entire claim and are not specific to a line item. Each line item contains the following information:

- HCPCS code with up to 4 modifiers;
- Revenue code;
- Service date;
- Service units; and
- Charge.

The HCPCS codes and modifiers are used as the basis of assigning the APCs. Not all line items will contain a HCPCS code. The line item service dates are used to subdivide a claim that spans more than 1 day into individual visits. The service units indicate the number of times a HCPCS code was provided (e.g., a lab test with a service unit of 2 means the lab test was performed twice).

Information Returned From OPPS OCE

The following is an overview of the information that will be returned from OPPS OCE and used as input into the PRICER program.

Field	UB-92 Form Locator	Number	Size (bytes)	Comments
HCPCS procedure code	44	1	5	May be blank
HCPCS modifier	44	5 x 2	10	

Service date	45	1	8	Required for all lines
Revenue code	42	1	4	
Service units	46	1	7	A blank or zero value is defaulted to 1
Charge	47	1	10	Used by Pricer to determine outlier payments

Line item input information

There are currently (73) different edits in the OCE, two of which are currently inactive. Each edit is assigned a number. A description of the edits is contained in the "Claim Return Buffer" Table 4. 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 and 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 in order to allow future expansion of the number of edits. Table 3 describes the Edit Return Buffers.

The "Claim Return Buffer" described in the Table 4 summarizes the edits that occurred on the claim. The occurrence of an edit can result in one of six different dispositions.

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 FI makes a determination or obtains further information.
Line Item Rejection	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 Denials	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 can not be resubmitted but can be appealed.

In the OPPS OCE, many of the edits had a disposition of RTP in order to give providers time to adapt to OPPS. In subsequent releases of OPPS OCE, the disposition of some edits was changed to other more automatic dispositions such as a line item denial. A single claim can have one or more edits in all six dispositions. Six 0/1 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 RTP, the edit numbers of the three edits would be contained in the claim RTP reason list. There

is more space allocated in the edit return buffers than is necessary for the current edits in order to allow for future expansion of the number of edits.

In addition to the six individual dispositions, there is also an overall claim disposition, which summarizes the status of the claim.

Table 5 describes the "APC Return Buffer" that contains the APC for each line item along with the relevant information for computing OPPS payment. Two APC numbers are returned: HCPCS APC and payment APC.

Except for partial hospitalization and some inpatient-only procedure claims, the HCPCS APC and the payment APC are always the same. The APC return buffer contains the information that will be passed to the Pricer. The APC is only returned for HOPDs and the special conditions specified in Appendix F.

Partial hospitalizations are paid on a per diem basis. There is no HCPCS code that specifies a partial hospitalization related service. Partial hospitalizations are identified by means of condition codes; bill types and HCPCS codes specifying the individual services that constitute a partial hospitalization (See Appendix C). Thus, there are no input line items that directly correspond to the partial hospitalization service. In order to assign the partial hospitalization APC to one of the line items, the payment APC for one of the line items that represent one of the services that comprise partial hospitalization is assigned the partial hospitalization APC.

Reimbursement for a day of outpatient mental health services in a non-PH program is capped at the amount of the partial hospital per diem. On a non-PHP claim, the OCE totals the payments for all MH services with the same date of service; if the sum of the payments for the individual MH services exceeds the partial hospital per-diem, the OCE assigns a special "Daily Mental Health Service" payment APC to one of the line items that represent MH services. The packaging flag is turned on for all other MH services for that day (See appendix C). The payment rate for the Daily Mental Health Services APC is the same as that for the partial hospitalization APC.

For outpatients who undergo inpatient-only procedures on an emergency basis and who expire before they can be admitted to the hospital, a specified APC payment is made to the provider as reimbursement for all services on that day. The presence of modifier –CA on the inpatient-only procedure line assigns the specified payment APC and associated status and payment indicator to the line. The packaging flag is turned on for all other lines on that day. Payment is only allowed for one procedure with modifier -CA. If multiple inpatient-only procedures are submitted with the modifier –CA, the claim is returned to the provider. If modifier CA is submitted with an inpatient-only procedure for a patient who did not expire (patient status code is not 20), the claim is returned to the provider.

Inpatient-only procedures that are on the separate-procedure list (do not generate edit 18) are bypassed when performed incidental to a surgical procedure with Status Indicator T. The line(s) with the inpatient-separate procedure is rejected and the claim is processed according to usual OPPS rules.

When multiple occurrences of any APC that represents drug administration are assigned in a single day, modifier-59 is required on the code(s) in order to permit payment for additional units of that APC, up to a specified maximum; additional units above the maximum are packaged. If modifier –59 is not used, only one occurrence of any drug administration APC is allowed and any additional units are packaged (see Appendix I).

The use of a device, or multiple devices, is necessary to the performance of certain outpatient procedures. If any of these procedures is submitted without a code for the required device(s), the claim is returned to the provider. Discontinued procedures are not returned for a device code.

Observations may be paid separately if they meet specific criteria (See Appendix H).

Not all edits are performed for all sites of service. See "OPPS OCE Edits Applied by Bill Type" below for OPPS OCE edits that apply for each bill type.

OPPS PRICER computes the standard OPPS payment for a line item as the product of the payment amount corresponding 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 OPPS 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 is zero
- Payment method flag is zero

If payment adjustments are applicable to a line item (payment adjustment flag is not 0), then nonstandard calculations are necessary to compute payment for a line item (see Appendix E). The line item action flag is passed as input to the OPPS OCE as a means of allowing you to override a line item denial or rejection (used by you to override OPPS OCE and have OPPS PRICER compute payment ignoring the line item rejection or denial) or allowing you to indicate that the line item should be denied or rejected even if there are no OPPS OCE edits present. The action flag is also used for handling external line item adjustments. For some sites of service (e.g., HHAs) only some services are paid under OPPS. The line item action flag also impacts the computation of the discounting factor as described in Appendix D "Computation of Discounting Fraction". OPPS 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. The OPPS OCE overview below summarizes the process of filling in the APC return buffer.

If a claim spans more than 1 day, OPPS OCE 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 OPPS OCE deals with all multiple day claims issues by means of the return information. OPPS PRICER does not need to be aware of the issues associated with multiple day claims. It 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.

For the purpose of determining the version of the OPPS OCE to be applied, the from date on the header information is used.

Tables

Table 1: OPPS OCE Control Block

Pointer Name		UB-92 Form Locator	Number	Size (bytes)	Comment
Dxptr	ICD-9-CM diagnosis codes	76 (adx) 67-75 (pdx/sdx)	Up to 16	6	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First listed diagnosis is considered 'admit dx', second diagnosis is considered 'principal dx'
Ndxptr	Count of the number of diagnoses pointed to by *Dxptr*		1	4	Binary fullword count
Sgptr	Line item entries	44-46	Up to 450	Table 2	
Nsgptr	Count of the number of Line item entries pointed to by Sgptr		1	4	Binary fullword count
Flagptr	Line item action flag Flag set by FI and passed by OCE to Pricer		Up to 450	1	(See Table 7)
Ageptr	Numeric age in years		1	3	0-124
Sexptr	Numeric sex code	15	1	1	0, 1, 2 (unknown, male, female)
Dateptr	From and Through dates (yyyymmdd)	6	2	8	Used to determine multi-day claim
CCptr	Condition codes	24-30	Up to 7	2	Used to identify partial hospitalization and hospice claims
NCCptr	Count of the number of condition codes entered		1	4	Binary fullword count
Billptr	Type of bill	4	1	3	Used to identify CMHC and claims pending under OPPS. It is presumed that bill type has been edited for validity by the Standard System before the claim is sent to OCE
NPIProvptr	National provider identifier (NPI)	51	1	13	Pass on to Pricer
OSCARProvptr	OSCAR Medicare provider number	51	1	6	Pass on to Pricer
PstatPtr	Patient status	22	1	2	UB-92 values
OppsPtr	Opps/Non-OPPS flag		1	1	1=OPPS, 2=Non-OPPS (For future use)
OccPtr	Occurrence codes	36	Up to 10	2	For FI use
NOccptr	Count of number of occurrence codes		1	4	Binary fullword count
Dxeditptr	Diagnosis edit return buffer		Up to 16	Table 3	Count specified in Ndxptr
Proceditptr	Procedure edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Mdeditptr	Modifier edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Dteditptr	Date edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
Rceditptr	Revenue code edit return buffer		Up to 450	Table 3	Count specified in Nsgptr
APCptr	APC return buffer		Up to 450	Table 7	Count specified in Nsgptr
Claimptr	Claim return buffer		1	Table 5	
Wkptr	Work area pointer		1	512K	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by Wkptr		1	4	Binary fullword

For those using X12N 837 formats, the following is provided to assist in your implementation efforts:

The Medicare A 837 Health Care Claim version 4010 implementations 3A.01 and 1A.C1 (Appendix C of both documents have UB-92 mapping), along with the UB-92 version 6.0 are at www.hcfa.gov/medicare/edi/edi3.htm. These formats are effective through October 16, 2003. The X12N 837 version 4010 to UB-92 version 6.0 mapping is at http://cms.hhs.gov/providers/edi/hipaadoc.asp The HIPAA X12N 837 can be downloaded at www.wpc-edi.com.

Table 2: Edit Return Buffers

Name	Bytes	Number	Values	Description	Comments
Diagnosis edit return buffer	3	8	0,1-5	Three-digit code specifying the edits that applied to the diagnosis.	There is one 8x3 buffer for each of up to 16 diagnoses.
Procedure edit return buffer	3	30	0,6,8-9,11-21, 28,37-40, 42-45,47, 49-50,52-64, 66-69, 70-73	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	Three-digit code specifying the edits that applied to the modifier.	There is one 4x3 buffer for each of the five modifiers 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 line item dates.	There is one 4x3 buffer for each of up to 450 line items.
Revenue center edit return buffer	3	5	0, 41,48, 65	Three-digit code specifying the edits that applied to revenue centers.	There is one 5x3 buffer for each of up to 450 line items

Each of the return buffers is positionally representative of the source that it contains information for, in the order in which that source was passed to OPPS OCE. For example, the seventh diagnosis return buffer contains information about the seventh diagnosis; the fourth modifier edit buffer contains information about the modifiers in the fourth line item.

Table 3: Description of Edits/Claim Reasons

Edit	Description	Disposition
1	Invalid diagnosis code	RTP
2	Diagnosis and age conflict	RTP
3	Diagnosis and sex conflict	RTP
4[4]	Medicare secondary payor alert (**V1.0 and V1.1 only**)	Suspend
5[4]	E-diagnosis code can not be used as principal diagnosis	RTP
6	Invalid procedure code	RTP
7	Procedure and age conflict (**Not activated**)	RTP
8	Procedure and sex conflict	RTP
9	Non-covered for reasons other than statute	Line item denial
10	Service submitted for verification of denial (condition code 21)	Claim denial
11	Service submitted for FI review (condition code 20)	Suspend
12	Questionable covered service	Suspend
13	Separate payment for services is not provided by Medicare	Line Item Rejection
14	Code indicates a site of service not included in OPPS	Claim RTP
15	Service unit out of range for procedure [1]	RTP
16	Multiple bilateral procedures without modifier 50 (see Appendix A)	RTP
17	Inappropriate specification of bilateral procedure (see Appendix A)	RTP
18	Inpatient procedure [2]	Line item denial
19	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection
21	Medical visit on same day as a type “T” or “S” procedure without modifier 25 (see Appendix B)	Line item rejection
22	Invalid modifier	RTP
23	Invalid date	RTP
24	Date out of OCE range	Suspend
25	Invalid age	RTP
26	Invalid sex	RTP
27	Only incidental services reported [3]	Claim Denial
28	Code not recognized by Medicare; alternate code for same service may be available	Line item Rejection
	(see Appendix C for logic of edits 29-36, and 63-64)	
29	Partial hospitalization service for non-mental health diagnosis	RTP
30	Insufficient services on day of partial hospitalization	Suspend
31	Partial hospitalization on same day as ECT or type T procedure	Suspend
32	Partial hospitalization claim spans 3 or less days with insufficient services, or ECT or significant procedure on at least one of the days	Suspend
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	Suspend
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	Suspend
35	Only Mental Health education and training services provided	RTP

36	Extensive mental health services provided on day of ECT or type T procedure	Suspend

37	Terminated bilateral procedure or terminated procedure with units greater than one	RTP
38	Inconsistency between implanted device and implantation procedure	RTP
39	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present	Line item rejection
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection
41	Invalid revenue code	RTP
42	Multiple medical visits on same day with same revenue code without condition code G0 (see Appendix B)	RTP
43	Transfusion or blood product exchange without specification of blood product	RTP
44	Observation revenue code on line item with non-observation HCPCS code	RTP
45	Inpatient separate procedures not paid	Line item rejection
46	Partial hospitalization condition code 41 not approved for type of bill	RTP
47	Service is not separately payable	Line item rejection
48	Revenue center requires HCPCS	RTP
49	Service on same day as inpatient procedure	Line item denial
50	Non-covered based on statutory exclusion	Line item rejection
51	Multiple observations overlap in time (**Not activated**)	RTP
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions	RTP
53	Observation G codes only allowed with bill type 13x	Line item rejection
54	Multiple codes for the same service	RTP
55	Non-reportable for site of service	RTP
56	E/M-condition not met and line item date for obs code G0244 is not 12/31 or 1/1	RTP
57	E/M condition not met and line item date for obs code G0244 is 12/31 or 1/1	Suspend
58	G0263 only allowed with payable G0244	RTP
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis	RTP
60	Use of modifier CA with more than one procedure not allowed	RTP
61	Service can only be billed to the DMERC	RTP
62	Code not recognized by **OPPS**; alternate code for same service may be available	RTP
63	This OT code only billed on partial hospitalization claims (See appendix C)	RTP
64	AT service not payable outside the partial hospitalization program (See appendix C)	Line item rejection
65	Revenue code not recognized by Medicare	Line item rejection
66	Code requires manual pricing	Suspend
67	Service provided prior to FDA approval	Line item rejection
68	Service provided prior to date of National Coverage Determination (NCD) approval	Line item rejection
69	Service provided outside approval period	Line item rejection
70	CA modifier requires patient status code 20	RTP
71	Claim lacks required device code	RTP
72	Service not billable to the Fiscal Intermediary	RTP
73	Incorrect billing of blood and blood products	RTP

[1] **For Edit 15, units for all line items with same HCPCS on the same day are added together for the purposes of applying the edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line and the HCPCS is on a list of codes that are exempt, the unit edits are not applied.**

[2] **Edit 18 will cause all other line items on the same day to be line item denied with Edit 49 (see Table 5 "Line item denial or reject flag".) No other edits are performed on any lines with Edit 18 or 49.**

[3] **If Edit 27 is triggered, no other edits are performed on the claim.**

[4] **Not applicable for admitting diagnosis.**

[5] **Edits 67 & 68 are intended to line item reject any line that has a line item date of service that precedes the effective date of FDA approval (MMA 621 (a) (1) (15) OR the effective date of a National Coverage Determination (NCD) (MMA 731). If the service is provided prior to the effective date of FDA approval or prior to the effective date of a NCD, then the service is considered not covered by Medicare. Edits 67 & 68 were established to comply with MMA.**

Table 4: Claim Return Buffer

	Bytes	Number	Values	Description
Claim processed flag	1	1	0-3, 9	0 - Claim processed. 1 - Claim could not be processed (edits 23, 24, or 46[a]). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 9 - Fatal error; OCE can not run - the environment can not be set up as needed; exit immediately.
Num of line items	3	1	nnn	Input value from Nsgptr, or 450, whichever is less.
National provider identifier (NPI)	13	1	aaaaaaaaaaaaa	Transferred from input, for Pricer.
OSCAR Medicare provider number	6	1	aaaaaa	Transferred from input, for Pricer.
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 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 (edit 18 only).
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	1	1	0-1	0 - Claim not suspended. 1 - There are one or more edits present that cause the claim to be

disposition				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		Three-digit code specifying edits (See Table 6) that caused the claim to be rejected. There are currently no edits that cause a claim to be rejected.
Claim denial reasons	3	8	10, 27	Three-digit code specifying edits (see Table 6) that caused the claim to be denied. There are currently two active edits that cause a claim to be denied.
Claim returned to provider reasons	3	30	1-3, 5-6, 8, 14-17, 22-23, 25-26, 29, 35, 37-38, 41-44, 46, 48, 52, 54, 55,56, 58-63, 70-73	Three-digit code specifying edits (see Table 6) that caused the claim to be returned to provider. There are currently 38 active edits that cause a claim to be returned to provider.
Claim suspension reasons	3	16	4, 11, 12, 24, 30-34, 36, 57, 66	Three-digit code specifying the edits that caused the claim to be suspended (see Table 6). There are currently 12 active edits that cause a claim to be suspended.
Line item rejection reasons	3	12	13, 19, 20, 21, 28, 39, 40, 45, 47, 50, 53, 64, 65, 67-69	Three-digit code specifying the edits that caused the line item to be rejected (See Table 6). There are currently 16 active edits that cause a line item to be rejected.
Line item denied reasons	3	6	9, 18, 49	Three-digit code specifying the edits that caused the line item to be denied (see Table 6). There are currently 3 active edits that cause a line item denial.
APC return buffer flag	1	1	0-1	0 - No services paid under OPPS. APC return buffer filled in with default values (See Appx F). 1 - One or more services paid under OPPS. APC return buffer filled in.
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.

Table 5: APC Return Buffer

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 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	2	Alpha	A - Services not paid under OPPS B - Non-allowed item or service for OPPS

			C - Inpatient procedure E - Non-allowed item or service F - Corneal tissue acquisition and certain CRNA services G - Drug/Biological Pass-through H - Device pass-through J - New drug or new biological pass-through [1] K - Non pass-through drug / biological, radiopharmaceutical agent, certain brachytherapy sources L – Flu/PPV vaccines M – Service not billable to the FI N - Packaged incidental service P - Partial hospitalization service S - Significant procedure not subject to multiple procedure discounting T - Significant procedure subject to multiple procedure discounting V - Medical visit to clinic or emergency department W – Invalid HCPCS or Invalid revenue code with blank HCPCS X - Ancillary service Y – Non-implantable DME, Therapeutic Shoes Z – Valid revenue with blank HCPCS and no other SI assigned
Payment indicator	2	1- nn	1 - Paid standard hospital OPPS amount (status indicators K, S, T, V, X) 2 - Services not paid under OPPS (status indicator A) 3 - Not paid (M, W,Y, E), or not paid under OPPS (B, C, Z) 4 - Paid at reasonable cost (status indicator F, L) 5 – Additional payment for drug or biological (status indicator G) 6 – Additional payment for device (status indicator H) 7 – Additional payment for new drug or new biological (status indicator J) 8 - Paid partial hospitalization per diem (status indicator P) 9 - No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy), or G0177 (partial hospitalization program services))
Discounting formula number	1	1-8	See Appendix D for values
Line item denial or rejection flag	1	0-2	0 - Line item not denied or rejected 1 - Line item denied or rejected (edit return buffer for line item contains a 9, 13, 18, 19, 20, 21, 28, 39, 40, 45, 47 ,49, 50, 53, 64, 65, 67, 68, 69) 2- The line is not denied or rejected, but occurs on a day that has been denied or rejected (not used as of 4/1/02 - v3.0).
Packaging flag	1	0-4	0 - Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of partial hospital per diem or daily mental health service per diem 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01) 4 – Packaged as part of drug administration APC payment
Payment adjustment flag	2	0-6	0 - No payment adjustment 1 – Additional payment for drug or biological applies to APC (status indicator G) 2 – Additional payment for device applies to APC (status indicator H) 3 – Additional payment for new drug or new biological applies to APC (status indicator J) [1] 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

Payment Method Flag	1	0-4	0 - OPPS Pricer determines payment for service 1 - Based on OPPS coverage or billing rules, the service is not paid 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 FI; OCE not applied to line item
Service units	7	1-x	Transferred from input, for Pricer. For the line items assigned APCs 33 or 34, the service units are always assigned a value of one by the OCE even if the input service units were greater than one [Input service units also may be reduced for some Drug administration APCs, based on Appendix I]
Charge	10	nnnnnnnnnn	Transferred from input, for Pricer; COBOL pic 9(8)v99
Line item action flag	1	0-4	Transferred from input to Pricer, and can impact selection of discounting formula (AppxD). 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.

[1] Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)

Table 6: HCPCS Codes for Reporting Antigens, Hepatitis B Vaccines, Splints, and Casts

List of HCPCS codes in the following chart specify Hepatitis B vaccines, antigens, splints, and casts, which were paid under OPPS for hospitals. In addition and certain situations for HHAs and CORFs and to hospice patients for the treatment of a non-terminal illness.

Category	Code
Antigens	95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, 95180, 95199
Hepatitis B Vaccines	G0010, 90740, 90743, 90744, 90746, 90747
Splints	29105, 29125, 29126, 29130, 29131, 29505, 29515
Casts	29000, 29010, 29015, 29020, 29025, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29086, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29445, 29450, 29700, 29705, 29710, 29715, 29720, 29730, 29740, 29750, 29799

Changes in Payment of Influenza Virus and Pneumococcal Pneumonia Vaccine (PPV)

Effective for claims with dates of service on or after January 1, 2003, payment for influenza virus and PPV vaccines and their administration provided in a hospital outpatient department, home health agency (HHA), and comprehensive outpatient rehabilitation facility (CORF) will change. Payment will no longer be made based on the Outpatient Prospective Payment System (OPPS). Hospitals (bill type 13X), and HHAs (bill type 34X) will be paid based on reasonable cost for the vaccines and their administration. CORFs (bill type 75X) will be paid based on the lower of the charges or 95% of the average wholesale price (AWP) for the vaccine and on the Medicare Physician Fee Schedule for the administration.

A new Service Indicator (SI) of "L" (L = Paid reasonable cost or 95% of the AWP; not subject to deductible or coinsurance) has been assigned to influenza and PPV vaccines and their administration in the OPPS OCE. The applicable HCPCS codes are 90657,90658, 90659, 90732, G0008, and G0009.

The Shared System Maintainer (SSM) is required upon receipt of the SI "L" from the OPPS OCE to make the appropriate payment determination (reasonable cost or AWP) based on the type of bill submitted.

NOTE: Payment to all other providers for vaccines will remain the same. In addition, payment for Hepatitis B vaccine provided in any setting will also remain the same.

Correct Coding Initiative (CCI) Edits

The OPPS OCE will generate CCI edits. All CCI edits will be incorporated in the OPPS OCE with the exception of anesthesiology, E&M, mental health and certain drug administrative codes. In addition, CCI edits for computer-aided detection (CAD) devices were removed from the July 2003 version of the OPPS OCE. They will be re-incorporated in a subsequent release. Bypass modifiers and coding pairs in the OCE may differ from those in the NCCI because of differences between facility and professional services.

The CCI edits are applicable to claims submitted on behalf of the same beneficiary, provided by the same provider, and on the same date of service. The edits address two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. One such code combination consists of one code that represents a service 'with' something and the other is 'without' the something. The edit is set to pay the lesser-priced service.

Version 11.2 of CCI edits is included in the October OPPS OCE.

NOTE: The CCI edits in the OPPS OCE are always one quarter behind the Carrier CCI edits.

See Appendix F "OPPS OCE Edits Applied by Bill Type" for bill types that the OPPS OCE will subject to these and other OPPS OCE edits.

Units of Service Edit

The OPPS OCE edit 15 "Service Unit out of Range for Procedure" was revised for the April 2003 version of the OPPS OCE. As part of the recurring quarterly update of the OPPS OCE, CMS lifted the moratorium on application of the OPPS OCE Edit 15. Therefore, you were instructed to reactivate OPPS OCE Edit 15 for claims with dates of service on or after April 1, 2003. This unit

of service edit is not applied to all services at this time. Instead, there are limited edits applied to certain services beginning with the April 2003 release. However subsequent modifications to this edit will be made in upcoming OPPS OCE releases.

Appendix A
Bilateral Procedure Logic

There is a list of codes that are exclusively bilateral if a modifier of 50 is present*. The following edits apply to these bilateral procedures*.

Condition	Action	Edit
The same code which can be performed bilaterally occurs two or more times on the same date of service, all codes *without* a 50 modifier	Return claim to provider	16
The same code which can be performed bilaterally occurs two or more times (based on units and/or lines) on the same date of service, all or some codes *with* a 50 modifier	Return claim to provider	17

In addition, there is a list of codes that are considered inherently bilateral even if a modifier of 50 is not present. The following edits apply to these bilateral procedures.

Condition	Action	Edit
The same bilateral code occurs two or more times (based on units and/or lines) on the same date of service	Return claim to provider	17

Note: For ER and observation claims, all services on the claim are treated like any normal claim, including multiple day processing.

*Note: The “exclusively bilateral” list was eliminated, effective 10/1/05 (v6.3); edits 16 and 17 will not be triggered by the presence/absence of modifier 50 on certain bilateral codes for dates of service on or after 10/1/05.

Appendix B
Rules for Medical and Procedure Visits on the Same Day and for Multiple Medical Visits on Same Day

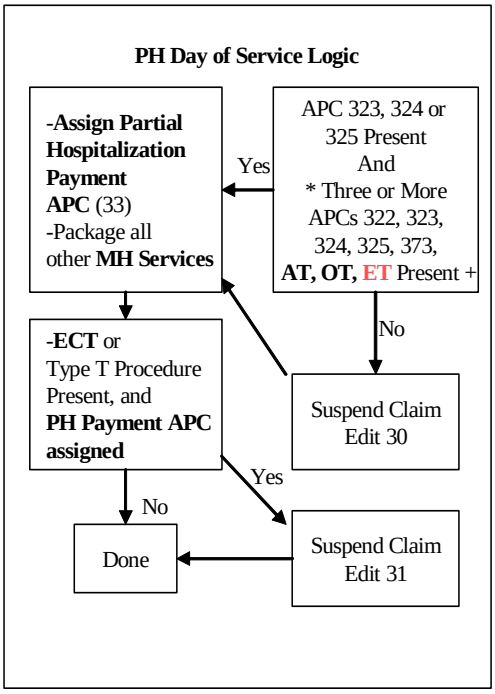
Under some circumstances, medical visits on the same date as a procedure will result in additional payments. A modifier of **25** with an Evaluation and Management (E&M) code, status indicator V, is used to report a medical visit that takes place on the same date that a procedure with status indicator S or T is performed, but that is significant and separately identifiable from the procedure. However, if any E&M code that occurs on a day with a type "T" or "S" procedure does not have a modifier of 25, then edit 21 will apply and there will be a line item rejection.

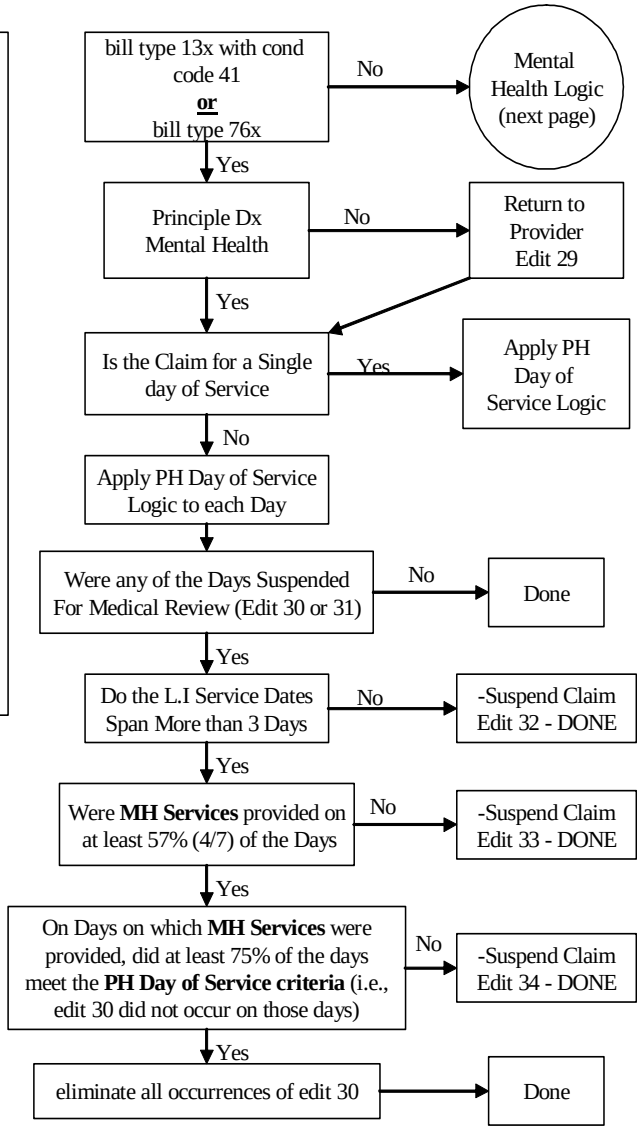
If there are multiple E&M codes on the same day, on the same claim the rules associated with multiple medical visits are shown in the following table.

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).

Appendix C
Partial Hospitalization Logic





PH = Partial Hospitalization (APC 33)
MH = Mental Health (APC 322-5, 373-4)
ECT = Electroconvulsive Therapy (APC 320)
AT = Activity Therapy (HCPCS G0176)
OT = PH Occupational Therapy (HCPCS G0129)
ET= Patient Education and Training Service (HCPCS G0177)

MH Service

322 Brief Individual Psychotherapy
323 Extended Individual Psychotherapy
324 Family Psychotherapy
325 Group Psychotherapy
373 Neuropsychological Testing
374 Monitoring Psychiatric Drugs
AT Activity Therapy
OT Occupational Therapy
ET Patient Education and Training Service

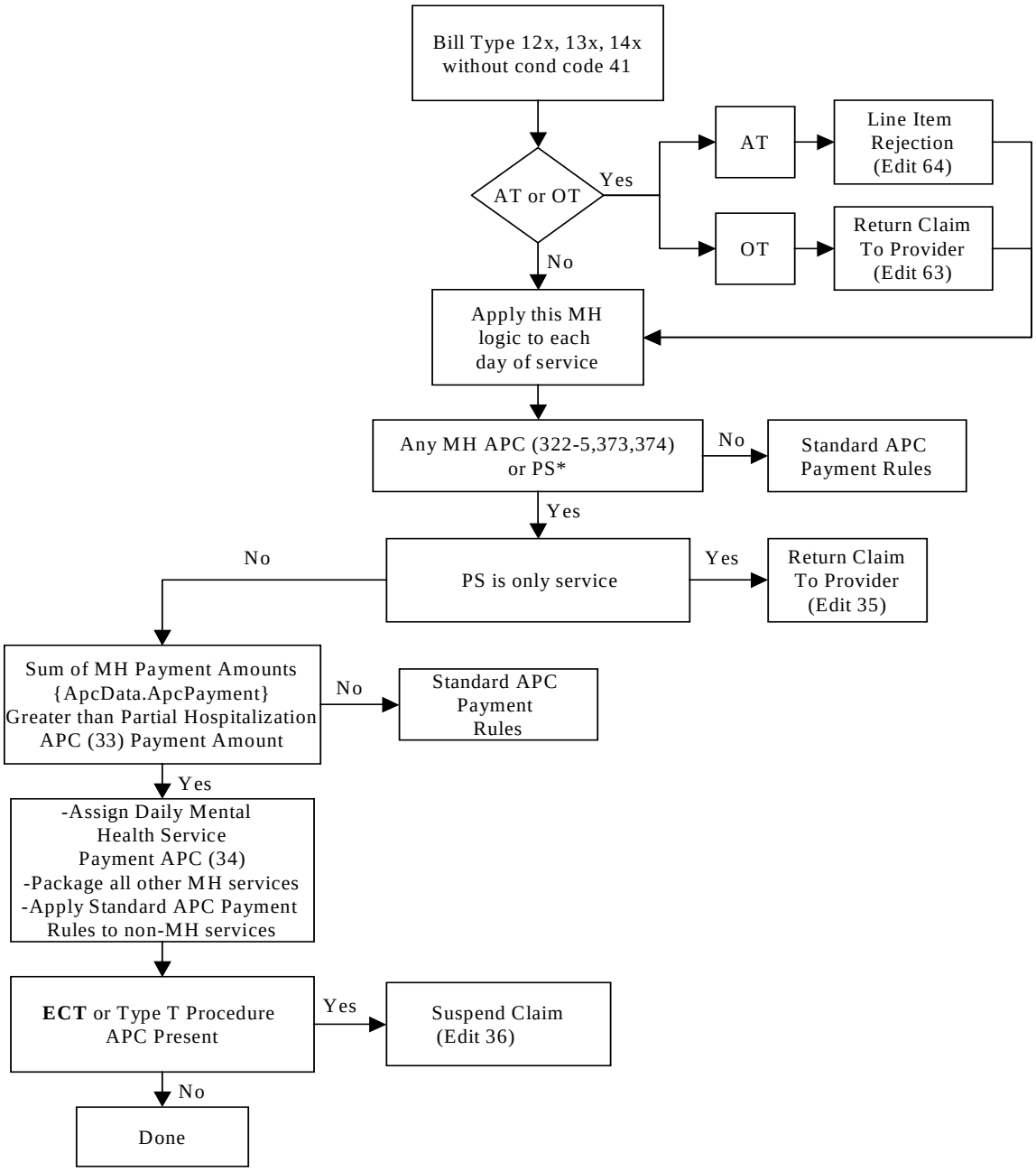
+ Multiple occurrences of APC 322, 323, 324, 325, and 373; AT and ET are treated as separate units in determining whether 3 or more MH services are present. However, multiple occurrences of OT are treated as a single service.

*To avoid confusion over this programming language, the OCE will continue to verify that the claim has, at a minimum, a total of 3 partial hospitalization HCPCS codes for each day of service, one of which must be a psychotherapy HCPCS that groups to APC 323, 324 or 325.

Assign Partial Hospitalization Payment APC
For any day that has an MH Service, the first listed line item with HCPCS APC from the hierarchical list of APCs (323, 324, 325, 322, 373, 374, AT, OT, ET) is assigned a payment APC of 33, 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, and a service unit of 1

For all other line items with a **mental health service** (APC 322, 323, 324, 325, 373, 374, AT, OT, ET)the packaging flag is set to 2.

Appendix C (cont'd)
Mental Health Logic



Assign Daily Mental Health Service Payment APC
The first listed line item with HCPCS APC from the list of MH APCs (322-5, 373, 374) is assigned a payment APC of 34, 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 and a service unit of 1.

For all other line items with a **mental health service** (APC 322-5, 373, 374, PS) the packaging flag is set to 2.

*NOTE: The use of code G0177 (PS) is allowed on MH claims that are not billed as Partial Hospitalization

Appendix D - Computation of Discounting Fraction

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 will *not* be multiple procedure discounted, and all other “T" line items will be multiple procedure discounted. All line items that do not have a status indicator of "T" will be ignored in determining the discount. A modifier of 73 indicates that a procedure was terminated prior to anesthesia. A terminated type “T” procedure will also be 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 for type "T" procedures should not occur, and have the discounting factor set so as to result in the equivalent of a single procedure. Bilateral procedures are identified from the “bilateral” field in the physician fee schedule. For non-type "T" procedures there is no terminated procedure or multiple bilateral discounting performed. 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 will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code. For bilateral procedures the type “T” procedure discounting rules will take precedence over the discounting specified in the physician fee schedule. All line items for which the line item denial or reject indicator is 1 and the line item action flag is zero, or the line item action flag is 2, 3 or 4, will be ignored in determining the discount; packaged line items, (the packaging flag is not zero or 3), will also be ignored in determining the discount. The discounting process will utilize an APC payment amount file. The discounting factor for bilateral procedures is the same as the discounting factor for multiple type “T” procedures.

There are eight different discount formulas that can be applied to a line item.

1. 1.0
2. (1.0 + D(U-1))/U
3. T/U
4. (1 + D)/U
5. D
6. TD/U
7. D(1 + D)/U
8. 2.0

Where

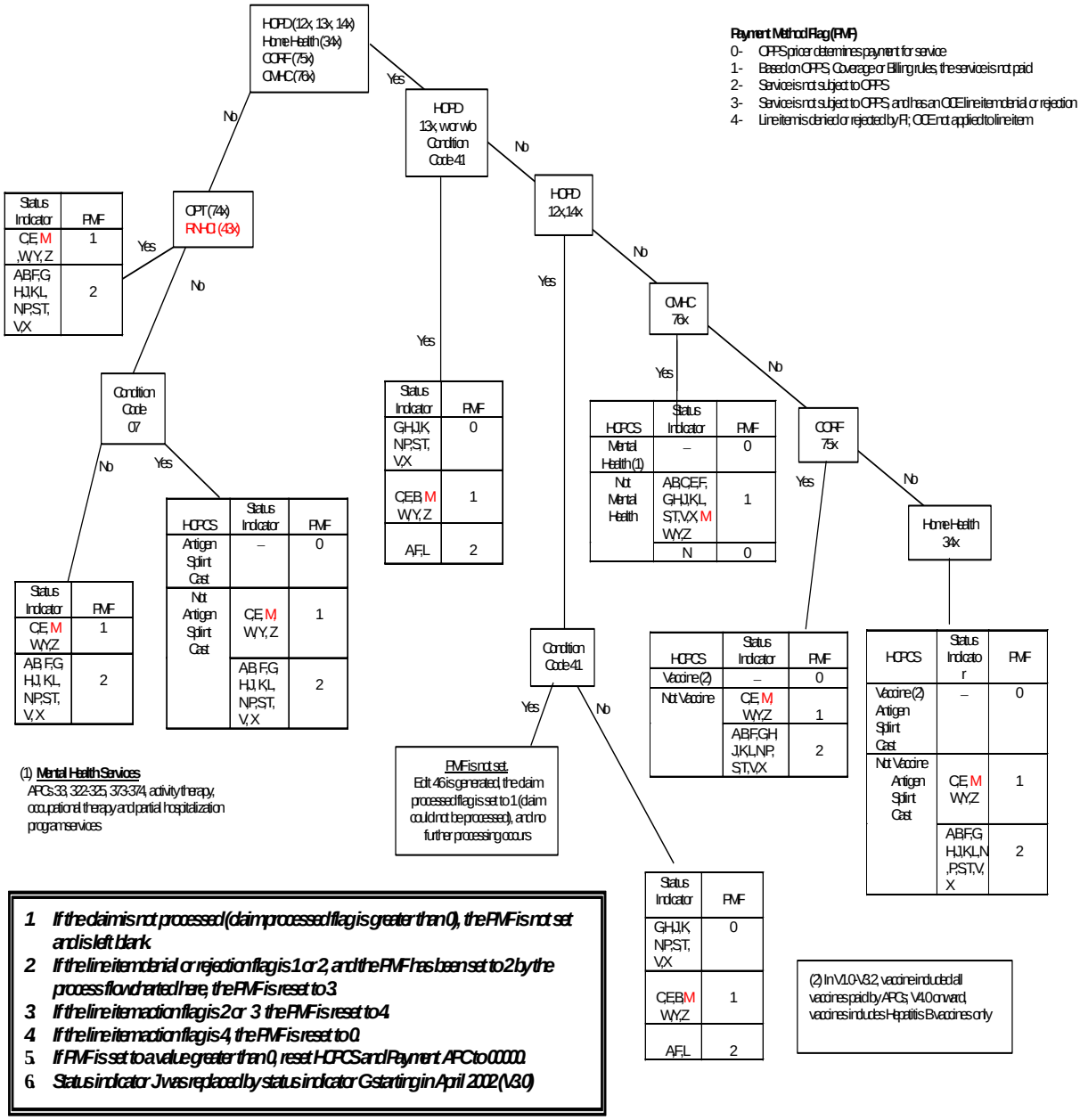
D = discounting fraction (currently 0.5)
U = number of units
T = terminated procedure discount (currently 0.5)

The discount formula that applies is summarized in the following table.

			Discounting Formula Number			
			Type "T" Procedure		**Non Type “T” Procedure**	
Payment Amount	**Modifier 73**	**Modifier 50**	**Conditional or Independent Bilateral**	**Inherent or Non Bilateral**	**Conditional or Independent Bilateral**	**Inherent or Non Bilateral**
Highest	No	No	2	2	1	1
Highest	Yes	No	3	3	1	1
Highest	No	Yes	4	2	8	1
Highest	Yes	Yes	3	3	8	1
Not Highest	No	No	5	5	1	1
Not Highest	Yes	No	6	6	1	1
Not Highest	No	Yes	7	5	8	1
Not Highest	Yes	Yes	6	6	8	1

For the purpose of determining which APC has the highest payment amount, the terminated procedure discount (**T**) will be applied prior to selecting the type T procedure with the highest payment amount.

Appendix E
Logic for Assigning Payment Method Flag Values



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 has been set to 2 by the process flowcharted here, 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 HCPCS and Payment APC to 00000.*
6. *Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)*

a/apc/pmf

Appendix F - OCE Edits Applied by Bill Type

FLOW CHART CELL (*)	Provider/Bill Types	Dx & Proc [1-12,50,53[c],54,59, 69]	HCPC [6,13]	OPPS site of svc [14]	Non Meare [28] Non OPPS [62]	Proc & Modifier [18,38,43,45,47,49,71,73]	HCPC Req'd [48[d]]	Modifier [16,17,[b],22,37]	CCI [19,20,39,40]	[a] Line Item Date [23]	Units [15]	Rev Code [41,44, 65]	Age, Sex [25,26]	Partial Hosp [29,34]	APC [21,27,42]	MH [35,36, 63, 64]	Bill Type [46]	APC buffer completed	Obs Logic [52,56,57], DirAdm [58], Spec Inpt [60], Manual Price [66, 70], FDA/NCD [67, 68]	Opps Proc (55)	DME (61); Not F1 (72)
1	12X or 14X w condition code 41	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No
2	12X or 14X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	No	Yes
3	13X w condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
4	13X w.o condition code 41	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes
5	76X (CMHC)	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	Yes
6	34X (HHA) w Vaccine[e], Antigen, Splint or Cast	Yes	Yes	No	Yes	Yes	No	No	No	Yes	No	Yes	Yes	No	No	No	No	Yes	No	Yes	No
7	34X (HHA) w.o Vaccine[e], Antigen, Splint or Cast	Yes	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No
8	75X (CORF) w Vaccine[e] (PPS)	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes
9	43X (RNHCI)	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	No	No	Yes	No
10	Any bill type except 12x, 13x, 14x, 76x, 34x, or [75x with Vaccine[e]], w condition code 07, w Antigen, Splint or Cast	Yes[f]	Yes	No	Yes	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	No
11	75X (CORFs) w.o Vaccine[e]	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
12	22X[j], 23X[j] (SNF), 24X[g]	Yes	Yes	No	Yes	No	No	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes
13	32X, 33X (HHA)	Yes[f]	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No
14	71X (RHC), 73X (FQHC)	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
15	72X (ESRD)	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
16	74X (OPTs)	Yes	Yes	No	No	No	Yes	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
17	81x (Hospice), 82x	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes

(*) FLOW CHART CELLS ARE IN HIERARCHICAL ORDER

Yes = edits apply, No = edits do not apply

Edit 10, and Edits 23 and 24 for From/Through dates, are not dependent on AppxF

[a] if edit 23 is not applied, the lowest service (or From) date is substituted for invalid dates, and processing continues.

[b] Bypass edit 22 if Revenue code is 540 [c] Edits 53 not relevant for bill type 13x

[d] Bypass edit 48 if Revenue code is 100x, 210x or 310x 0905 0906 0907

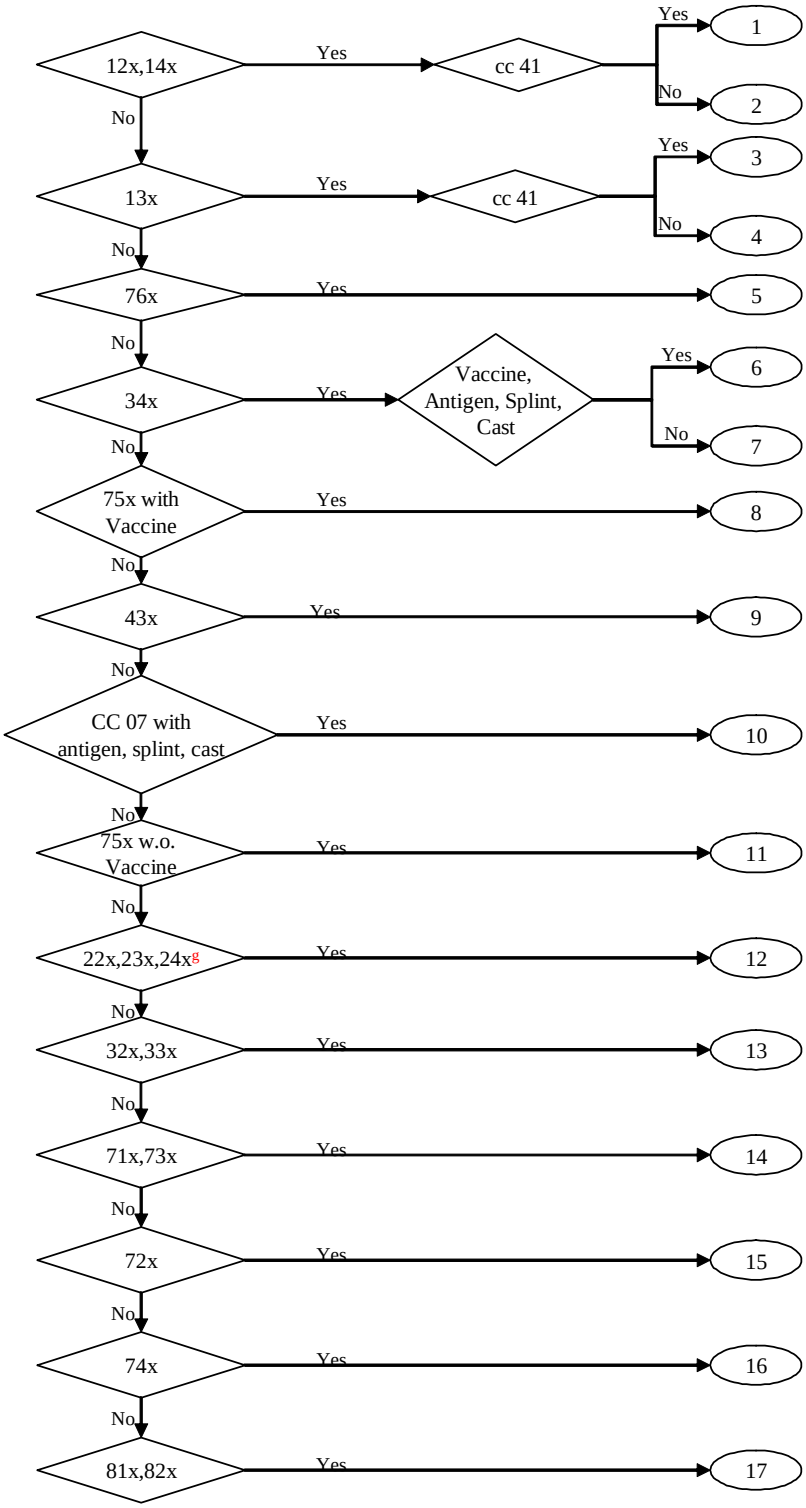
[e] In V1.0 to V3.2,"vaccines" included all vaccines paid by APCs; from V4.0 onward, "vaccines" includes Hepatitis B vaccines only

[f] Bypass diagnosis edits (1-5) for bill types 32X and 33X (HHA) if from date is <10/1/xx and Through date is >= 10/1/xx

[g] Delete TOB 24X effective 10/1/05

[j] Apply edits 28,62 effective 10/1/05

Appendix F Flow Chart



Appendix G

The payment adjustment flag for a line item is set based on the criteria in the following chart:

Criteria	**Payment Adjustment Flag Value**
Status indicator G	1
Status indicator H	2
Status indicator J [1]	3
Code is flagged as 'deductible not applicable'	4
Blood product with modifier BL on RC 38X line[2]	5
Blood product with modifier BL on RC 39X line[2]	6
All others	0

[1] Status indicator J was replaced by status indicator G starting in April 2002 (V3.0)
[2] See Appendix J for assignment logic (v6.2)

Appendix H
OCE Observation Criteria

Assumptions

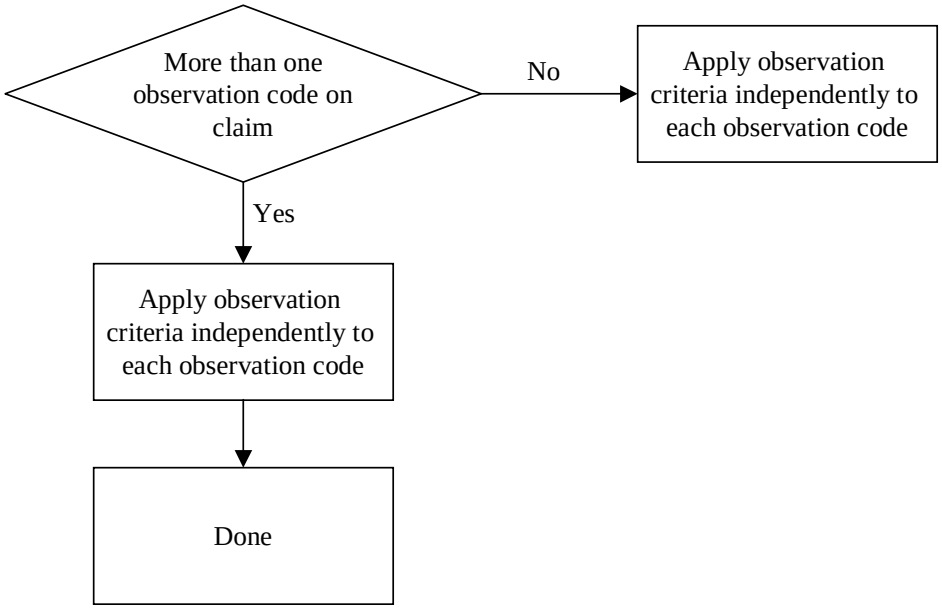
1. Separately payable observation is identified by code G0244.
2. Code G0244 has default Status indicator 'S', and default APC 339.
3. Observation logic is performed only for claims with bill type 13x, with or without condition code 41. Lines with G0244, G0263 and G0264 are rejected if the bill type is not 13x.
4. If any of the observation criteria is not met, the claim is Returned to Provider or suspended, according to the disposition of the observation edits.
5. Each observation must be paired with a unique E/M or critical care (C/C) visit, or with code G0263 (Direct admission from physician's office).
   E/M or C/C visit is required the day before or day of observation; Direct admission is required on the day of observation..
   If E/M is coded the same day as an S or T procedure (Observation G0244 has SI = S), it must have modifier 25 coded also. Otherwise, Edit 21 is generated for the E/M visit and it is ignored.
   If an observation cannot be paired with an E/M or C/C visit or Direct admission, the claim is Returned to Provider.
6. E/M or C/C visit or Direct admission on the same day as observation takes precedence over E/M or C/C visit on the day before observation.
7. E/M, C/C visit or Direct admission that have been denied or rejected, either externally or by OCE edits, are ignored.
8. Both the associated E/M and or the C/C visit (APCs 600-602, 610-612, 620) and observation are paid separately if the observation criteria are met.
9. Multiple observations on a claim are paid separately if the required criteria are met for each one.
10. If there are multiple observations within the same time period and only one meets the criteria for APC payment, the observation with the most hours is considered to have met the criteria, and the other observations will cause the claim to be Returned to Provider.
11. Observation date is assumed to be the date admitted for observation.
12. The diagnoses (admitting or principal) required for the observation criteria are:

Chest Pain	Asthma	CHF
4110, 1, 81, 89	49301, 02, 11, 12, 21, 22, 91, 92	3918
4130, 1, 9		39891
78605, 50, 51, 52, 59		40201, 11, 91
		40401, 03, 11, 13, 91, 93
		4280, 1, 9, 20-23, 30-33, 40-43

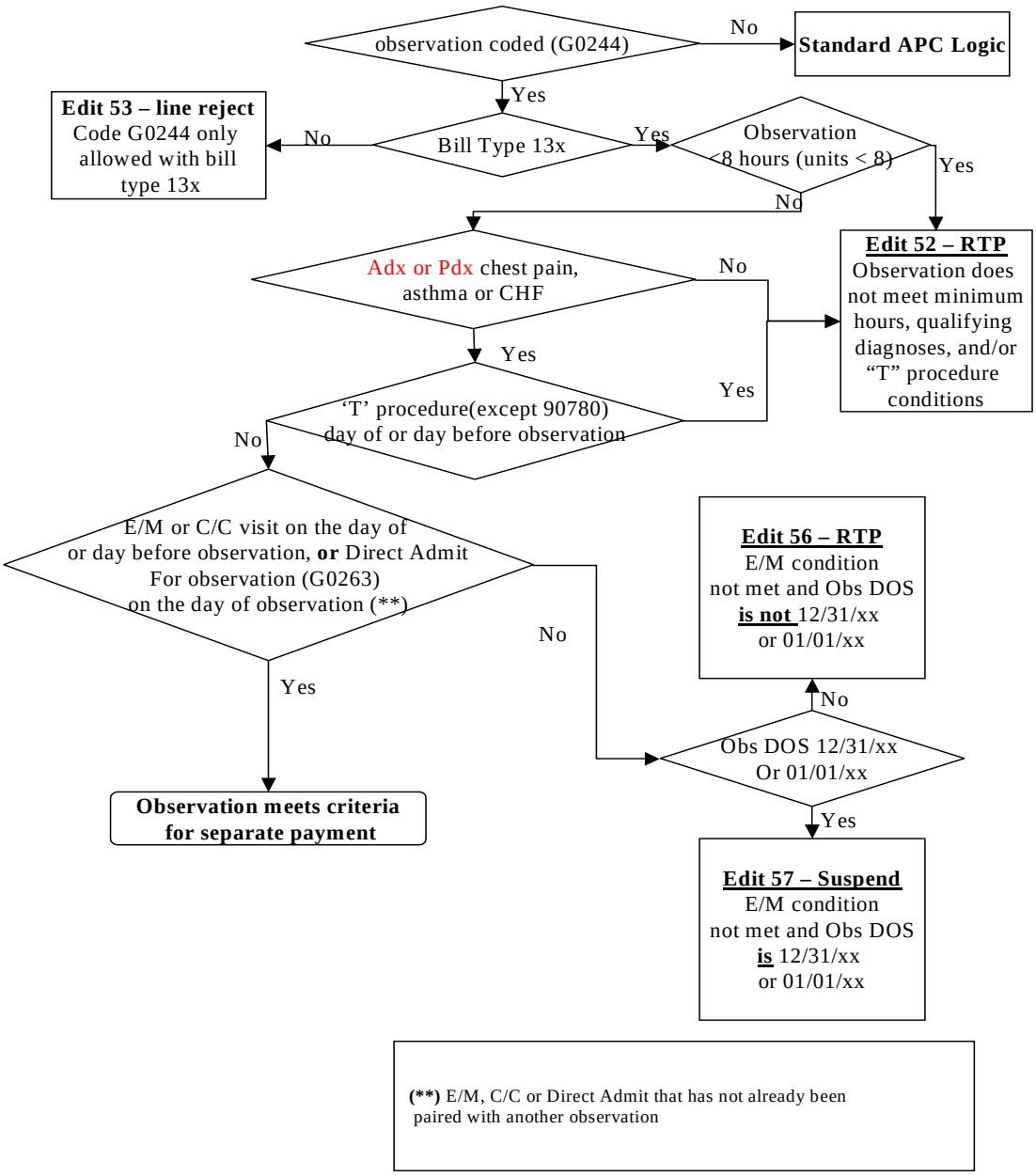
13. The APCs required for the observation criteria to identify E/M or C/C visits are 600*-602, 610-612, 620**.**

*Except when APC 600 is assigned based on code G0264.

Appendix H - OCE Observation



Appendix H
OCE Observation Criteria (cont'd)

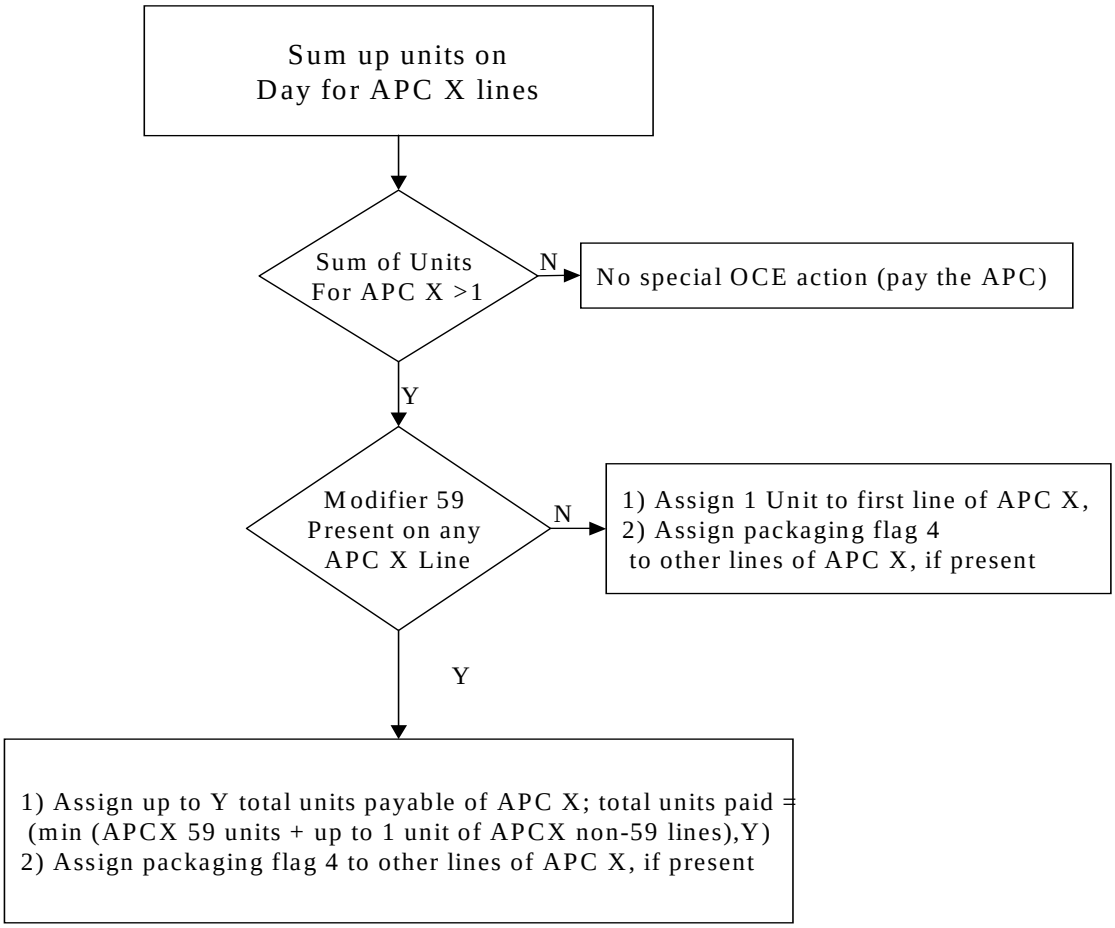


(**) E/M, C/C or Direct Admit that has not already been paired with another observation

Appendix I

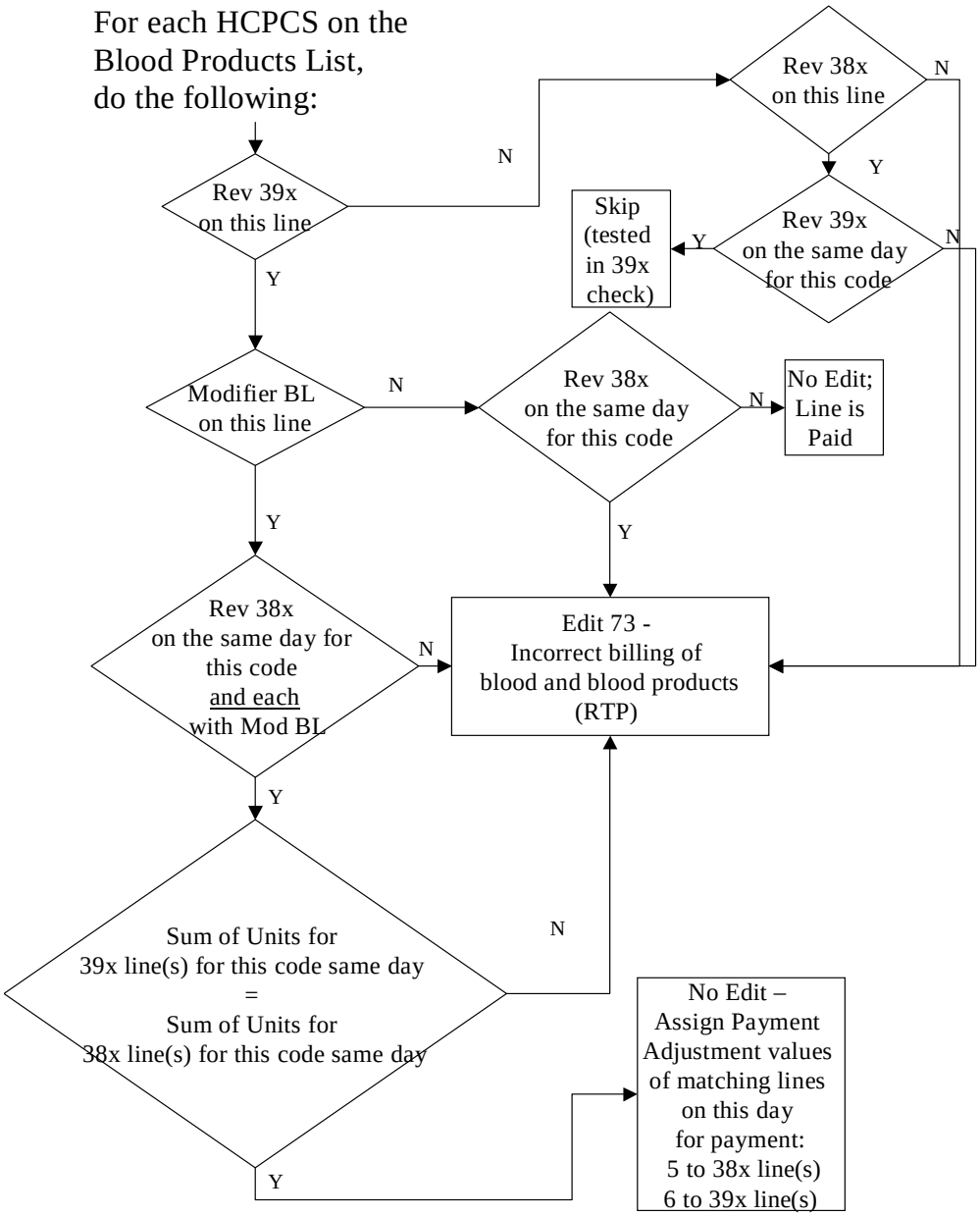
Drug Administration

For each APC X subjected to Y maximum allowed units do the following (each day);



Appendix J

Billing for Blood/ Blood Products



Appendix K
OCE overview

1. If 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.

2. 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 are as follows:

Payment APC	00000
HCPCS APC	00000
Status indicator	A
Payment indicator	2
Discounting formula number	1
Line item denial or rejection flag	0
Packaging flag	0
Payment adjustment flag	0
Payment method flag	Assigned in steps 8, 17 and 18

3. If no HCPCS code is on a line item 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.

	N-list	E-list	B-list	F-list
HCPCS APC	00000	00000	00000	00000
Payment APC:	00000	00000	00000	00000
Status Indicator:	N	E	B	F
Payment Indicator	9	3	3	4
Packaging flag:	1	0	0	0

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:

HCPCS APC	00000
Payment APC:	00000
Status Indicator:	**Z**
Payment Indicator	3
Packaging flag:	0

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

HCPCS APC	00000
Payment APC:	00000
Status Indicator:	**W**
Payment Indicator	3
Packaging flag:	0

4. If applicable based on Appendix F, assign HCPCS APC in the APC return buffer for each line item that contains an applicable HCPCS code.

5. If procedure with status indicator “C” and modifier CA is present on a claim and patient status = 20, assign payment APC 375 to “C” procedure line and set the discounting factor to 1. Change SI to “N” and set the packaging flag to 1 for all other line items occurring on the same day as the line item with status indicator “C” and modifier CA. 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.

Appendix K
OCE Overview (cont'd)

6. If edit 18 is present on a claim, generate edit 49 for all other line items occurring on the same day as the line item with edit 18, and set the line item denial or rejection flag to 1 for each of them. Go to step 13.
7. If all of the lines on the claim are incidental, and all of the line item action flags are zero, generate edit 27. Go to step 13.
8. If the line item action flag for a line item has a value of 2 or 3 then reset the values of the Payment APC and HCPCS APC to 00000, and set the payment method flag to 4. If the line item action flag for a line item has a value of 4, set the payment method flag to 0. Ignore line items with a line item action flag of 2, 3 or 4 in all subsequent steps.
9. If bill type is 13x and condition code = 41, or type of bill = 76x, apply partial hospitalization logic from Appendix C. Go to step 11.
10. If bill type is 12x, 13x or 14x without condition code 41 apply mental health logic from Appendix C.
11. If bill type is 13x apply observation logic from Appendix H.

    If bill type is not 13x, and observation G codes (G0244, G0263, G0264) present, generate edit 53.
12. If the payment APC for a line item has not been assigned a value in step 9 or 10, set payment APC in the APC return buffer for the line item equal to the HCPCS APC for the line item.
13. If edits 9, 13, 19, 20, 21, 28 39, 40, 45, 47, 49, 50, 53, 64, 65, 67, 68, 69 are present in the edit return buffer for a line item, the line item denial or rejection flag for the line item is set to 1.
14. Compute the discounting formula number based on Appendix D for each line item that has a status indicator of “T”, a modifier of 73 or 50, or is a non type “T” bilateral procedure. Note: If the SI or APC of a code is changed during claims processing, the newly assigned SI or APC is used in computing the discount formula. Line items that meet any of the following conditions are not included in the discounting logic.

    Line item action flag is 2, 3, or 4
    Line item rejection disposition or line item denial disposition in the APC return buffer is 1 and the line item action flag is not 1
    Packaging flag is not 0 or 3
15. If the packaging flag has not been assigned a value of 1 or 2 in previous steps and the status indicator is “N”, then set the packaging flag for the line item to 1.
16. If the submitted charges for HCPCS surgical procedures (SI = T, or SI = S in code range 10000-69999) is less than $1.01 for any line with a packaging flag of 0, then reset the packaging flag for that line to 3 when there are other surgical procedures on the claim with charges greater than $1.00.
17. For all bill types were APCs are assigned, apply drug administration APC consolidation logic from appendix I
18. Set the payment adjustment flag for a line item based on the criteria in Appendix G and Appendix J.
19. Set the payment method flag for a line item based on the criteria in Appendix E. If any payment method flag is set to a value that is greater than zero, reset the HCPCS and Payment APC values for that line to '00000'.
20. If the line item denial or rejection flag is 1 or 2 and the payment method flag has been set to 2 in the previous step, reset the payment method flag to 3.

Appendix L

Summary of Modifications

The modifications of the OCE/APC for the October 2005 release (V6.3) are summarized in the attached table. *Readers should also read through the specifications and note the highlighted sections, which also indicate change from the prior release of the software.*

Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

	Mod. Type	**Effective Date**	**Edit**	
1.	Logic	10/1/05	N/A	Modify tables 2, 4 and 5 to expand four fields in the OCE interface: **Field Name** — **Field Size** — **Attributes** Status Indicator — 2 bytes — Right justify, blank fill (alpha) Edit numbers — 3 bytes — Right justify, zero fill (numeric) Payment Indicator — 2 bytes — Right justify, blank fill (numeric) Payment Adjust flag — 2 bytes — Right justify, blank fill (numeric)
2.	Logic	10/1/05	71	Implement Phase 2 of the procedure/device edit; add second device, where specified, to the requirement for edit 71.
3.	Logic	10/1/05	28, 62	Modify appendix F to apply edits 28 and 62 to bill types 22x and 23x
4.	Logic	10/1/05		Modify appendix F to delete bill type 24x
5.	Logic	**7/1/05**		Modify table 1 to increase the working storage requirement from 256K to 512K **(Note:** Applies to MF application only**)**
6.	Logic	N/A	N/A	Verify that all pass-through fields are enabled to accept data and pass it to the return buffers and output reports whether or not the data is used by the OCE/APC program.

7	Content			Make HCPCS/APC/SI and modifier changes, as specified by CMS.
8	Content		19,20, 39,40	Implement version **11.2** of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), MH (90804-90911) or Drug Admin (96400-96450; 96542-96549; 90780,90781)
9.	Content	**1/1/05**		Make bilateral procedure indicators in the OCE consistent with the MPFS
10	Content	**1/1/04**	17	Make bilateral procedure indicator in the OCE for code 73720 consistent with the MPFS
11	Content	**1/1/05**	22	Delete modifier GX from the list of valid modifiers
12	Content	**4/1/03, 8/1/00**	41	Delete revenue codes 3100 (4/1/03) and 0091 (8/1/00) from the list of valid revenue codes, retroactive to the dates when they were added.
13	Content	10/1/05	1	Update valid diagnosis list with ICD-9-CM changes
14	Content	10/1/05	29	Add new ICD-9-CM codes 29182 and 29285 to the list of mental health diagnoses
15	Content	10/1/05	14	Update diagnosis/age and diagnosis/sex conflict edits with MCE changes
16	Content	10/1/05	16, 17	Eliminate the Exclusive Bilateral list used for edits 16 and 17
17	Doc			Update table 7 to change the Payment Indicator field value from ‘alphanumeric’ to ‘numeric’
18	Doc			Change reference description for code G0177 to ‘Patient education and training service (ET)’ in the Partial Hospitalization and the Mental Health flowcharts in appendix C

Attachment B

Final

Summary of Data Changes

OCE/APC v6.3

Effective October 1, 2005

Table of Contents

CPT codes, descriptions, and material only are Copyright 2004 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

DEFINITIONS 3
DIAGNOSIS CODE CHANGES 4
Added Diagnosis Codes 4
Deleted Diagnosis Codes 7
Diagnosis Edit Changes 8
APC CHANGES 9
Added APCs 9
APC Status Indicator Changes 10
HCPCS/CPT PROCEDURE CODE CHANGES 10
Added HCPCS/CPT Procedure Codes 10
Deleted HCPCS/CPT Procedure Codes 11
HCPCS Description Changes 11
HCPCS Changes- APC, Status Indicator and/or Edit Assignments 11
HCPCS Approval and/or Termination Date Changes 14
Edit Assignments 15
Procedure/ Device Pair Changes 21
MODIFIERS 28
Deleted Modifiers 28
REVENUE CODES 28
Deleted Revenue Codes 28

DEFINITIONS

- A blank in a field indicates ‘no change’

- The “old” column describes the attribute prior to the change being made in the current update, which is indicated in the “new” column. If the effective date of the change is the same as the effective date of the new update, ‘old’ describes the attribute up to the last day of the previous quarter. If the effective date is retroactive, then ‘old’ describes the attribute for the same date in the previous release of the software.

- “Unassigned”, “Pre-defined” or “Placeholder” in APC or HCPCS descriptions indicates that the APC or HCPCS code is inactive. When the APC or HCPCS code is activated, it becomes valid for use in the OCE, and a new description appears in the “new description” column, with the appropriate effective date.

- Activation Date (ActivDate) indicates the mid-quarter date of FDA approval for a drug, or the mid-quarter date of a new or changed code resulting from a National Coverage Determination (NCD). The Activation Date is the date the code becomes valid for use in the OCE. If the Activation Date is blank, then the effective date takes precedence.

- Termination Date (TermDate) indicates the mid-quarter date when a code or change becomes inactive. A code is not valid for use in the OCE after its termination date.

DIAGNOSIS CODE CHANGES

Added Diagnosis Codes

The following new diagnosis codes were added to the OCE/APC, **effective 10-01-05**

Diagnosis	CodeDesc
2595	Androgen insensitvty syn
27650	Volume depletion NOS
27651	Dehydration
27652	Hypovolemia
27802	Overweight
28730	Prim thrombocytopen NOS
28731	Immune thrombocyt purpra
28732	Evans' syndrome
28733	Cong/herid thromb purpra
28739	Prim thrombocytopen NEC
29182	Alcoh induce sleep disor
29285	Drug induced sleep disor
32700	Organic insomnia NOS
32701	Insomnia in other dis
32702	Insomnia dt mental disor
32709	Organic insomnia NEC
32710	Organic hypersomnia NOS
32711	Idio hypersom-long sleep
32712	Idio hypersom-no lng slp
32713	Recurrent hypersomnia
32714	Hypersomnia in other dis
32715	Hypersom dt mental disor
32719	Organic hypersomnia NEC
32720	Organic sleep apnea NOS
32721	Prim central sleep apnea
32722	High altitude breathing
32723	Obstructive sleep apnea
32724	Idiopath sleep hypovent
32725	Cong cntrl hypovent synd
32726	Sleep hypovent oth dis
32727	Cntrl sleep apnea ot dis
32729	Organic sleep apnea NEC
32730	Circadian rhym sleep NOS
32731	Circadian rhy-delay slp
32732	Circadian rhy-advc sleep
32733	Circadian rhym-irreg slp
32734	Circadian rhym-free run
32735	Circadian rhythm-jetlag
32736	Circadian rhy-shift work
32737	Circadian rhym oth dis
32739	Circadian rhym sleep NEC
32740	Organic parasomnia NOS

Diagnosis	CodeDesc
32741	Confusional arousals
32742	REM sleep behavior dis
32743	Recurrnt sleep paralysis
32744	Parasomnia oth diseases
32749	Organic parasomnia NEC
32751	Periodic limb movement
32752	Sleep related leg cramps
32753	Sleep related bruxism
32759	Organic sleep movemt NEC
3278	Sleep organic disord NEC
36203	Nonprolf db retnoph NOS
36204	Mild nonprolf db retnoph
36205	Mod nonprolf db retinoph
36206	Sev nonprolf db retinoph
36207	Diabetic macular edema
42682	Long QT syndrome
44382	Erythromelalgia
52540	Complete edentulism NOS
52541	Comp edentulism,class I
52542	Comp edentulism,class II
52543	Comp edentulsm,class III
52544	Comp edentulism,class IV
52550	Partial edentulism NOS
52551	Part edentulism,class I
52552	Part edentulism,class II
52553	Part edentulsm,class III
52554	Part edentulism,class IV
56721	Peritonitis (acute) gen
56722	Peritoneal abscess
56723	Spontan bact peritonitis
56729	Suppurat peritonitis NEC
56731	Psoas muscle abscess
56738	Retroperiton abscess NEC
56739	Retroperiton infect NEC
56781	Choleperitonitis
56782	Sclerosing mesenteritis
56789	Peritonitis NEC
5851	Chro kidney dis stage I
5852	Chro kidney dis stage II
5853	Chr kidney dis stage III
5854	Chr kidney dis stage IV
5855	Chron kidney dis stage V
5856	End stage renal disease
5859	Chronic kidney dis NOS
59960	Urinary obstruction NOS
59969	Urinary obstruction NEC
65170	Mul gest-fet reduct unsp
65171	Mult gest-fet reduct del
65173	Mul gest-fet reduct ante
76077	Mat anticonv aff NB/fet
76078	Mat antimetabol aff NB

Diagnosis	CodeDesc
76384	Meconium dur del aff NB
77010	Meconium asp NOS
77011	Meconium asp wo resp sym
77012	Meconium asp w resp symp
77013	Amniotc asp w/o resp sym
77014	Amniotic asp w resp sym
77015	Blood asp w/o resp sympt
77016	Blood asp w resp sympt
77017	NB asp w/o resp symp NEC
77018	NB asp w resp symp NEC
77085	Stomch cont asp w/o resp
77086	Stomach cont asp w resp
77984	Meconium staining
78095	Excessive crying NEC
79901	Asphyxia
79902	Hypoxemia
99640	Cmp int orth dev/gft NOS
99641	Mech loosening pros jt
99642	Dislocate prosthetic jt
99643	Prosthtc jt implant fail
99644	Periprosthetc fx-pros jt
99645	Periprosthetc osteolysis
99646	Articular wear prosth jt
99647	Mech com pros jt implant
99649	Mech com orth dev NEC
V1242	Personl hx infection CNS
V1260	Hx resp system dis NOS
V1261	Prsnl hx recur pneumonia
V1269	Hx resp system dis NEC
V1302	Personal history UTI
V1303	Personl hx nephrotic syn
V1588	Personal history of fall
V1781	Family hx osteoporosis
V1789	Fam hx musculosk dis NEC
V189	Fam hx genet dis carrier
V2631	Test genetic dis carrier
V2632	Genetic testing NEC
V2633	Genetic counseling
V4613	Weaning from respirator
V4614	Mech comp respirator
V4984	Bed confinement status
V5811	Antineoplastic chemo enc
V5812	Immunotherapy encounter
V5970	Egg donor NEC
V5971	Egg donor age <35 anon
V5972	Egg donor age <35 desig
V5973	Egg donor age 35+ anon
V5974	Egg donor age 35+ desig
V6284	Suicidal ideation
V6400	No vaccination NOS
V6401	No vaccin-acute illness

Diagnosis	CodeDesc
V6402	No vaccin-chronc illness
V6403	No vaccin-immune comp
V6404	No vaccin-allergy to vac
V6405	No vaccin-caregiv refuse
V6406	No vaccination-pt refuse
V6407	No vaccination-religion
V6408	No vaccin-prev disease
V6409	No vaccination NEC
V695	Behav insomnia-childhood
V7242	Pregnancy test-positive
V7286	Blood typing encounter
V850	BMI less than 19,adult
V851	BMI between 19-24,adult
V8521	BMI 25.0-25.9,adult
V8522	BMI 26.0-26.9,adult
V8523	BMI 27.0-27.9,adult
V8524	BMI 28.0-28.9,adult
V8525	BMI 29.0-29.9,adult
V8530	BMI 30.0-30.9,adult
V8531	BMI 31.0-31.9,adult
V8532	BMI 32.0-32.9,adult
V8533	BMI 33.0-33.9,adult
V8534	BMI 34.0-34.9,adult
V8535	BMI 35.0-35.9,adult
V8536	BMI 36.0-36.9,adult
V8537	BMI 37.0-37.9,adult
V8538	BMI 38.0-38.9,adult
V8539	BMI 39.0-39.9,adult
V854	BMI 40 and over,adult

Deleted Diagnosis Codes

The following deleted diagnosis codes were deleted from the OCE/APC, **effective 10-01-05**

Diagnosis	CodeDesc
2765	Hypovolemia
2873	Primary thrombocytopenia
5672	Suppurat peritonitis NEC
5678	Peritonitis NEC
585	Chronic renal failure
5996	Urinary obstruction NOS
7701	Meconium aspiratn syndrm
7990	Asphyxia
9964	Malf int orthped dev/grf
V126	Hx-respiratory sys dis
V178	Fam hx-muscloskl dis NEC
V263	Genetic counsel & test
V581	Chemotherapy encounter
V640	No vaccin/contraindicat

Diagnosis Edit Changes

The following code(s) were added to the list of newborn only diagnoses, age 0 years old, **effective 10-01-05**

Diagnosis
76077
76078
76384
77010
77011
77012
77013
77014
77015
77016
77017
77018
77085
77086
77984
7966

The following code(s) were added to the list of pediatric diagnoses, age 0-17 years old, **effective 10-01-05**

Diagnosis
V695

The following code(s) were added to the list of maternity diagnoses, age 12-55 years old, **effective 10-01-05**

Diagnosis
65170
65171
65173
V7242

The following code(s) were added to the list of adult only diagnoses, age 15-124 years old, **effective 10-01-05**

Diagnosis
V850
V851
V8521
V8522
V8523
V8524
V8525
V8530
V8531
V8532
V8533
V8534
V8535

Diagnosis
V8536
V8537
V8538
V8539
V854

The following code(s) were added to the list of mental health diagnoses, **effective 10-01-05**

Diagnosis
29182
29285

The following code(s) were removed from the list of male diagnoses, **effective 10-01-05**

Diagnosis
2572
2578

The following code(s) were added to the list of female diagnoses, **effective 10-01-05**

Diagnosis
65170
65171
65173
V5970
V5971
V5972
V5973
V5974
V7242

APC CHANGES

Added APCs

The following Apc(s) were added to the OCE/APC, **effective 04-01-05**

APC	APCDesc	StatusIndicator
09224	Injection, galsulfase	K

The following Apc(s) were added to the OCE/APC, **effective 10-01-05**

APC	APCDesc	StatusIndicator
02637	Brachytx, Ytterbium-169	H
09225	Fluocinolone acetonide	G
09226	Ziconotide intrathecal inf	G

APC Status Indicator Changes

The following Apc(s) had Status Indicator changes, **effective 07-01-05**

APC	Old SI	New SI
09126	K	G
09129	K	G

HCPCS/CPT PROCEDURE CODE CHANGES

Added HCPCS/CPT Procedure Codes

The following new HCPCS/CPT code(s) were added to the OCE/APC, **effective 04-01-05**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
C9224	Injection, galsulfase	K	09224	55	20050531	

The following new HCPCS/CPT code(s) were added to the OCE/APC, **effective 07-01-05**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
Q4080	Iloprost inhalation solution	B	00000	62		

The following new HCPCS/CPT code(s) were added to the OCE/APC, **effective 10-01-05**

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
C2637	Brachytx, Ytterbium-169	H	02637	55		
C9225	Fluocinolone acetonide	G	09225	55		
C9226	Ziconotide intrathecal inf	G	09226	55		
C9725	Place endorectal app	S	01507	55		
Q0480	driver pneumatic vad, rep	A	00000			
Q0481	microprcsr cu elec vad, rep	A	00000			
Q0482	microprcsr cu combo vad, rep	A	00000			
Q0483	monitor elec vad, rep	A	00000			
Q0484	monitor elec or comb vad rep	A	00000			
Q0485	monitor cable elec vad, rep	A	00000			
Q0486	mon cable elec/pneum vad rep	A	00000			
Q0487	leads any type vad, rep only	A	00000			
Q0488	pwr pack base elec vad, rep	A	00000			
Q0489	pwr pck base combo vad, rep	A	00000			
Q0490	emr pwr source elec vad, rep	A	00000			
Q0491	emr pwr source combo vad rep	A	00000			
Q0492	emr pwr cbl elec vad, rep	A	00000			
Q0493	emr pwr cbl combo vad, rep	A	00000			
Q0494	emr hd pmp elec/combo, rep	A	00000			
Q0495	charger elec/combo vad, rep	A	00000			
Q0496	battery elec/combo vad, rep	A	00000			
Q0497	bat clps elec/comb vad, rep	A	00000			
Q0498	holster elec/combo vad, rep	A	00000			
Q0499	belt/vest elec/combo vad rep	A	00000			
Q0500	filters elec/combo vad, rep	A	00000			

HCPCS	CodeDesc	SI	APC	Edit	ActivDate	TermDate
Q0501	shwr cov elec/combo vad, rep	A	00000			
Q0502	mobility cart pneum vad, rep	A	00000			
Q0503	battery pneum vad replacemnt	A	00000			
Q0504	pwr adpt pneum vad, rep veh	A	00000			
Q0505	miscl supply/accessory vad	A	00000			

Deleted HCPCS/CPT Procedure Codes

The following HCPCS/CPT code(s) were deleted from the OCE/APC, **effective 04-01-05 and re-added effective 10-1-05**

HCPCS	CodeDesc
G9041	Low vision serv occupational
G9042	Low vision orient/mobility
G9043	Low vision rehab therapist
G9044	Low vision rehab teacher

HCPCS Description Changes

The following code descriptions were changed, **effective 10-01-05**

HCPCS	Old Description	New Description
C9128	Inj pegaptamib sodium	Inj pegaptanib sodium

HCPCS Changes- APC, Status Indicator and/or Edit Assignments

The following code(s) had an APC and/or SI and/or edit change, **effective 01-01-05** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
J2545	Pentamidine isethionte/300mg			Y	B	61	62
J7608	Acetylcysteine inh sol u d			Y	B	61	62
J7611	Albuterol concentrated form			Y	B	61	62
J7612	Levalbuterol concentrated			Y	B	61	62
J7613	Albuterol unit dose			Y	B	61	62
J7614	Levalbuterol unit dose			Y	B	61	62
J7616	Albuterol compound solution			Y	B	61	62
J7622	Beclomethasone inhalatn sol			A	B	N/A	62
J7624	Betamethasone inhalation sol			A	B	N/A	62
J7626	Budesonide inhalation sol			A	B	N/A	62
J7628	Bitolterol mes inhal sol con			Y	B	61	62
J7629	Bitolterol mes inh sol u d			Y	B	61	62
J7631	Cromolyn sodium inh sol u d			Y	B	61	62
J7633	Budesonide concentrated sol			N	B	N/A	62
J7635	Atropine inhal sol con			Y	B	61	62
J7636	Atropine inhal sol unit dose			Y	B	61	62

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
J7637	Dexamethasone inhal sol con			Y	B	61	62
J7638	Dexamethasone inhal sol u d			Y	B	61	62
J7639	Dornase alpha inhal sol u d			Y	B	61	62
J7641	Flunisolide, inhalation sol			A	B	N/A	62
J7642	Glycopyrrolate inhal sol con			Y	B	61	62
J7643	Glycopyrrolate inhal sol u d			Y	B	61	62
J7644	Ipratropium brom inh sol u d			Y	B	61	62
J7648	Isoetharine hcl inh sol con			Y	B	61	62
J7649	Isoetharine hcl inh sol u d			Y	B	61	62
J7658	Isoproterenolhcl inh sol con			Y	B	61	62
J7659	Isoproterenol hcl inh sol ud			Y	B	61	62
J7668	Metaproterenol inh sol con			Y	B	61	62
J7669	Metaproterenol inh sol u d			Y	B	61	62
J7680	Terbutaline so4 inh sol con			Y	B	61	62
J7681	Terbutaline so4 inh sol u d			Y	B	61	62
J7682	Tobramycin inhalation sol			Y	B	61	62
J7683	Triamcinolone inh sol con			Y	B	61	62
J7684	Triamcinolone inh sol u d			Y	B	61	62

The following code(s) had an APC and/or SI and/or edit change, **effective 07-01-05** **A blank in the field indicates no change.

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
C9129	Inj clofarabine			K	G		
L3000	Ft insert ucb berkeley shell			B	A	14	N/A
L3001	Foot insert remov molded spe			B	A	14	N/A
L3002	Foot insert plastazote or eq			B	A	14	N/A
L3003	Foot insert silicone gel eac			B	A	14	N/A
L3010	Foot longitudinal arch suppo			B	A	14	N/A
L3020	Foot longitud/metatarsal sup			B	A	14	N/A
L3030	Foot arch support remov prem			B	A	14	N/A
L3031	Foot lamin/prepreg composite			E	A	28	N/A
L3040	Ft arch suprt premold longit			B	A	14	N/A
L3050	Foot arch supp premold metat			B	A	14	N/A
L3060	Foot arch supp longitud/meta			B	A	14	N/A
L3070	Arch suprt att to sho longit			B	A	14	N/A
L3080	Arch supp att to shoe metata			B	A	14	N/A
L3090	Arch supp att to shoe long/m			B	A	14	N/A
L3100	Hallus-valgus nght dynamic s			B	A	14	N/A
L3140	Abduction rotation bar shoe			B	A	14	N/A
L3150	Abduct rotation bar w/o shoe			B	A	14	N/A
L3160	Shoe styled positioning dev			B	A	14	N/A
L3170	Foot plastic heel stabilizer			B	A	14	N/A
L3201	Oxford w supinat/pronat inf			B	A	14	N/A
L3202	Oxford w/ supinat/pronator c			B	A	14	N/A
L3203	Oxford w/ supinator/pronator			B	A	14	N/A
L3204	Hightop w/ supp/pronator inf			B	A	14	N/A
L3206	Hightop w/ supp/pronator chi			B	A	14	N/A
L3207	Hightop w/ supp/pronator jun			B	A	14	N/A
L3208	Surgical boot each infant			B	A	14	N/A
L3209	Surgical boot each child			B	A	14	N/A

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
L3211	Surgical boot each junior			B	A	14	N/A
L3212	Benesch boot pair infant			B	A	14	N/A
L3213	Benesch boot pair child			B	A	14	N/A
L3214	Benesch boot pair junior			B	A	14	N/A
L3215	Orthopedic ftwear ladies oxf			B	A	14	N/A
L3216	Orthoped ladies shoes dpth i			B	A	14	N/A
L3217	Ladies shoes hightop depth i			B	A	14	N/A
L3219	Orthopedic mens shoes oxford			B	A	14	N/A
L3221	Orthopedic mens shoes dpth i			B	A	14	N/A
L3222	Mens shoes hightop depth inl			B	A	14	N/A
L3230	Custom shoes depth inlay			B	A	14	N/A
L3250	Custom mold shoe remov prost			B	A	14	N/A
L3251	Shoe molded to pt silicone s			B	A	14	N/A
L3252	Shoe molded plastazote cust			B	A	14	N/A
L3253	Shoe molded plastazote cust			B	A	14	N/A
L3254	Orth foot non-stndard size/w			B	A	14	N/A
L3255	Orth foot non-standard size/			B	A	14	N/A
L3257	Orth foot add charge split s			B	A	14	N/A
L3260	Ambulatory surgical boot eac			B	A	14	N/A
L3265	Plastazote sandal each			B	A	14	N/A
L3300	Sho lift taper to metatarsal			B	A	14	N/A
L3310	Shoe lift elev heel/sole neo			B	A	14	N/A
L3320	Shoe lift elev heel/sole cor			B	A	14	N/A
L3330	Lifts elevation metal extens			B	A	14	N/A
L3332	Shoe lifts tapered to one-ha			B	A	14	N/A
L3334	Shoe lifts elevation heel /i			B	A	14	N/A
L3340	Shoe wedge sach			B	A	14	N/A
L3350	Shoe heel wedge			B	A	62	N/A
L3360	Shoe sole wedge outside sole			B	A	14	N/A
L3370	Shoe sole wedge between sole			B	A	14	N/A
L3380	Shoe clubfoot wedge			B	A	14	N/A
L3390	Shoe outflare wedge			B	A	14	N/A
L3400	Shoe metatarsal bar wedge ro			B	A	14	N/A
L3410	Shoe metatarsal bar between			B	A	14	N/A
L3420	Full sole/heel wedge btween			B	A	14	N/A
L3430	Sho heel count plast reinfor			B	A	14	N/A
L3440	Heel leather reinforced			B	A	14	N/A
L3450	Shoe heel sach cushion type			B	A	14	N/A
L3455	Shoe heel new leather standa			B	A	14	N/A
L3460	Shoe heel new rubber standar			B	A	14	N/A
L3465	Shoe heel thomas with wedge			B	A	14	N/A
L3470	Shoe heel thomas extend to b			B	A	14	N/A
L3480	Shoe heel pad & depress for			B	A	14	N/A
L3485	Shoe heel pad removable for			B	A	14	N/A
L3500	Ortho shoe add leather insol			B	A	14	N/A
L3510	Orthopedic shoe add rub insl			B	A	14	N/A
L3520	O shoe add felt w leath insl			B	A	14	N/A
L3530	Ortho shoe add half sole			B	A	14	N/A
L3540	Ortho shoe add full sole			B	A	14	N/A
L3550	O shoe add standard toe tap			B	A	14	N/A

HCPCS	CodeDesc	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
L3560	O shoe add horseshoe toe tap			B	A	14	N/A
L3570	O shoe add instep extension			B	A	14	N/A
L3580	O shoe add instep velcro clo			B	A	14	N/A
L3590	O shoe convert to sof counte			B	A	14	N/A
L3595	Ortho shoe add march bar			B	A	14	N/A
L3600	Trans shoe calip plate exist			B	A	14	N/A
L3610	Trans shoe caliper plate new			B	A	14	N/A
L3620	Trans shoe solid stirrup exi			B	A	14	N/A
L3630	Trans shoe solid stirrup new			B	A	14	N/A
L3640	Shoe dennis browne splint bo			B	A	14	N/A
L3649	Orthopedic shoe modifica NOS			B	A	14	N/A
Q4079	Injection, Natalizumab, 1 MG			K	G		

HCPCS Approval and/or Termination Date Changes

The following code(s) had approval and /or termination date changes

HCPCS	Old ApprovalDt	New ApprovalDt	Old TerminationDt	New TerminationDt
78459	20050129	20050128		
78491	20050129	20050128		
78492	20050129	20050128		
78608	20050129	20050128		
78609	20050129	20050128		
78811	20050129	20050128		
78812	20050129	20050128		
78813	20050129	20050128		
78814	20050129	20050128		
78815	20050129	20050128		
78816	20050129	20050128		
G0030			20050128	20050127
G0031			20050128	20050127
G0032			20050128	20050127
G0033			20050128	20050127
G0034			20050128	20050127
G0035			20050128	20050127
G0036			20050128	20050127
G0037			20050128	20050127
G0038			20050128	20050127
G0039			20050128	20050127
G0040			20050128	20050127
G0041			20050128	20050127
G0042			20050128	20050127
G0043			20050128	20050127
G0044			20050128	20050127
G0045			20050128	20050127
G0046			20050128	20050127

G0047			20050128	20050127
G0210			20050128	20050127
G0211			20050128	20050127
G0212			20050128	20050127
G0213			20050128	20050127
G0214			20050128	20050127
G0215			20050128	20050127
G0216			20050128	20050127
G0217			20050128	20050127
G0218			20050128	20050127
G0220			20050128	20050127
G0221			20050128	20050127
G0222			20050128	20050127
G0223			20050128	20050127
G0224			20050128	20050127
G0225			20050128	20050127
G0226			20050128	20050127
G0227			20050128	20050127
G0228			20050128	20050127
G0229			20050128	20050127
G0230			20050128	20050127
G0231			20050128	20050127
G0232			20050128	20050127
G0233			20050128	20050127
G0234			20050128	20050127
G0253			20050128	20050127
G0254			20050128	20050127
G0296			20050128	20050127
G0297	20031001	0	20050128	0
G0336			0	20050127
G0336			20050128	20050127
G0337	20050101	0	20050128	0
J8501	20050406	20050404		
Q1001	0	20050401	0	20050519
Q1002	0	20050401	0	20050519

Edit Assignments

The following code(s) were added to edit 67, 68, or 69 **effective 07-01-04**

HCPCS	Edit#	ActivDate	TermDate
G0336	69		20050127

The following code(s) were added to edit 67, 68, or 69 **effective 04-01-05**

HCPCS	Edit#	ActivDate	TermDate
C9224	67	20050531	0
Q1001	69	20050401	20050519
Q1002	69	20050401	20050519

The following code(s) were removed from edit 67, 68, or 69 **effective 10-01-03**

HCPCS	Edit#	ActivDate	TermDate
G0297	69	20031001	20050128

The following code(s) were removed from edit 67, 68, or 69 **effective 07-01-04**

HCPCS	Edit#	ActivDate	TermDate
G0336	68		0

The following code(s) were removed from edit 67, 68, or 69 **effective 01-01-05**

HCPCS	Edit#	ActivDate	TermDate
G0337	69	20050101	20050128

The following code(s) were added to edit 55 "Non Reportable for Site of Service", **effective 04-01-05**

HCPCS	Edit#
C9224	55

The following code(s) were added to edit 55 "Non Reportable for Site of Service", **effective 10-01-05**

HCPCS	Edit#
C2637	55
C9225	55
C9226	55
C9725	55

The following code(s) were added to the conditional bilateral list, **effective 01-01-05**

HCPCS
0037T
20690
23410
28008
28304
28305
28306
28307
28308
28309
29868
32020
34812
34820
34900
35522
36005
36470
36471
37208
37609
47525
50080

HCPCS
50081
50120
50125
50130
50135
50200
50205
50220
50225
50230
52327
52352
52355
55530
55535
55540
60260
61880
61885
61888
63043
63044
64640
67810
67820
67825
67830
67835
67840
67850
67875
67880
67882
67900
67930
67935
67938
67950
67961
67966
67971
67973
67974
67975
67999
68020
68040
68100
68110
68115
68130

HCPCS
68135
68320
68325
68326
68328
68330
68335
68340
68360
68362
68371
68399
68400
68420
68440
68500
68505
68510
68520
68525
68530
68540
68550
68700
68705
68720
68745
68750
68770
68840
68850
68899
69300
69440
69450
69501
69502
69505
69511
69530
69535
69540
69550
69552
69554
69601
69602
69603
69604
69605
69610

HCPCS
69620
69631
69632
69633
69635
69636
69637
69641
69642
69643
69644
69645
69646
69650
69660
69661
69662
69666
69667
69670
69700
69711
69714
69715
69717
69718
69720
69725
69740
69745
69799
69801
69802
69805
69806
69820
69840
69905
69910
69915
69930
69949
69950
69955
69960
69970
69979

The following code(s) were removed from the conditional bilateral list, **effective 01-01-05**

HCPCS

HCPCS
0020T
19000
19001
20551
20552
20553
35646
35654
G0253
G0254

The following code(s) were added to the independent bilateral list, **effective 01-01-04**

HCPCS
73720

The following code(s) were added to the independent bilateral list, **effective 01-01-05**

HCPCS
73218
73219
73222
73223
73700
73701
73702
73718
73719
73722
73723
73725
75685
76519
92136

The following code(s) were added to the inherently bilateral list, **effective 01-01-05**

HCPCS
63045
63046
63047
76092
76514
G0202

The following code(s) were removed from the inherently bilateral list, **effective 01-01-04**

HCPCS
73720

The following code(s) were removed from the inherently bilateral list, **effective 01-01-05**

HCPCS

HCPCS
33979
33980
60260
73700
73701
73702
73725
76519
92136

The following code(s) were removed from the exclusively bilateral list, **effective 10-01-05**

HCPCS
15820
15821
15822
19140
19160
19162
19180
19182
19200
19220
19240
19290
19316
19318
19324
19325
19328
19330
19340
19342
19350
19357
19361
19364
19366
19367
19368
19369
19380
20802
20805
20808
20824
20827
20838
21480
21485
24343
24344

HCPCS
24345
24346
24900
24920
24925
24930
24931
25001
25024
25025
25394
25431
25900
25905
25907
25909
27090
27091
27125
27134
27137
27138
28800
28805
29086
29805
29806
29807
29900
29901
29902
29999
32491
49491
49492
50320
50340
50365
54680
63020
63040
63042
65101
65103
65105
65110
65112
65114
65125
65130
65135

HCPCS
65140
65150
65155
65175
65710
65730
65750
65755
66825
66830
66840
66850
66852
66920
66930
66940
67036
67038
67039
67040
67101
67105
67107
67108
67110
67112
67120
67121
67311
67312
67314
67316
67318
67901
67902
67903
67904
67906
67908

Procedure/ Device Pair Changes

The following procedure/device code pair requirements were added, **effective 10-01-05**

Proc	Device 1
19325	C1789
19325	L8600
19342	C1789
19342	L8600

Proc	Device 1
27446	C1776
33213	C1785
33213	C2619
33213	C2621
33282	C1764
35261	C1768
35261	L8670
35266	C1768
35266	L8670
35286	C1768
35286	L8670
36560	C1751
36560	C1788
36561	C1751
36561	C1788
36565	C1750
36565	C1751
36565	C1752
36582	C1751
36582	C1788
36582	C1881
36800	C1750
36800	C1752
36810	C1750
36810	C1752
36815	C1750
36815	C1752
36835	C1750
36835	C1752
36861	C1757
36870	C1757
37204	C1887
37205	C1874
37205	C1875
37205	C1876
37205	C1877
37205	C2617
37205	C2625
37206	C1874
37206	C1875
37206	C1876
37206	C1877
37206	C2617
37206	C2625
37207	C1874
37207	C1875
37207	C1876
37207	C1877
37207	C2617
37207	C2625
37208	C1874

Proc	Device 1
37208	C1875
37208	C1876
37208	C1877
37208	C2625
47525	C1729
49419	C1788
50398	C1729
50688	C1729
50688	C1758
51710	C2627
51715	L8603
51715	L8606
53440	C1762
53440	C1763
53440	C1771
53440	C1781
53440	C2631
53444	C1815
53445	C1815
53447	C1815
54400	C2622
54401	C1813
54405	C1813
54410	C1813
54416	C1813
54416	C2622
57288	C1762
57288	C1763
57288	C1771
57288	C1781
57288	C2631
58356	C2618
62361	C1891
62361	C2626
62362	C1772
63650	C1778
63655	C1778
64553	C1778
64555	C1778
64560	C1778
64561	C1778
64565	C1778
64573	C1778
64575	C1778
64577	C1778
64580	C1778
64581	C1778
69930	L8614
92978	C1753
92980	C1874
92980	C1875

Proc	Device 1
92980	C1876
92980	C1877
92981	C1874
92981	C1875
92981	C1876
92981	C1877
93501	C1769
93501	C1887
93508	C1769
93508	C1887
93510	C1769
93510	C1887
93511	C1769
93511	C1887
93514	C1769
93514	C1887
93524	C1769
93524	C1887
93526	C1769
93526	C1887
93527	C1769
93527	C1887
93528	C1769
93528	C1887
93529	C1769
93529	C1887
93530	C1769
93530	C1887
93531	C1769
93531	C1887
93532	C1769
93532	C1887
93533	C1769
93533	C1887
93619	C1730
93619	C1731
93619	C1732
93619	C1733
93619	C1766
93619	C1892
93619	C1893
93619	C1894
93619	C2629
93619	C2630
93620	C1730
93620	C1731
93620	C1732
93620	C1733
93620	C1766
93620	C1892
93620	C1893

Proc	Device 1
93620	C1894
93620	C2629
93620	C2630
93621	C1730
93621	C1731
93621	C1732
93621	C1733
93621	C1766
93621	C1892
93621	C1893
93621	C1894
93621	C2629
93621	C2630
93622	C1730
93622	C1731
93622	C1732
93622	C1733
93622	C1766
93622	C1892
93622	C1893
93622	C1894
93622	C2629
93622	C2630
93650	C1732
93650	C1733
93650	C1766
93650	C1892
93650	C1893
93650	C1894
93650	C2629
93650	C2630
93651	C1732
93651	C1733
93651	C1766
93651	C1892
93651	C1893
93651	C1894
93651	C2629
93652	C1732
93652	C1733
93652	C1766
93652	C1892
93652	C1893
93652	C1894
93652	C2629
93652	C2630
93662	C1759
G0290	C1874
G0290	C1875
G0291	C1874
G0291	C1875

The following procedure/device code requirements were added, **effective 10-01-05**

Proc	Device 1	Device 2
33206	C1786	C1779
33206	C2620	C1898
33207	C1786	C1779
33207	C2620	C1898
33207	C2621	
33208	C1785	C1779
33208	C2619	C1898
33208	C2621	
33214	C1785	C1779
33214	C2619	C1898
33214	C2621	

MODIFIERS

Deleted Modifiers

The following modifier(s) were deleted from the list of valid modifiers, **effective 01-01-05**

modif
GX

REVENUE CODES

Deleted Revenue Codes

The following revenue code(s) were deleted from the list of valid revenue codes, **effective 08-01-00**

RevenueCode	SI
0091	B

The following revenue code(s) were deleted from the list of valid revenue codes, **effective 04-01-03**

RevenueCode	SI
3100	E