CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10508	**Date: December 3, 2020**
	Change Request 11953

Transmittal 10417, dated October 30, 2020, is being rescinded and replaced by Transmittal 10508, dated, December 3, 2020, to split the effective and implementation dates between April 2021 and July 2021. All other information remains the same.

SUBJECT: Update to the Fiscal Intermediary Shared System (FISS) Integrated Outpatient Code Editor (IOCE) Claim and Return Buffer Interface Changes

I. SUMMARY OF CHANGES: Recently, the Centers for Medicare & Medicaid Services (CMS) implemented a new claim receipt date field in the IOCE Control Block Table and payment adjustment flag 2 from APC Return Buffer Table. The new claim receipt date field is populated to allow the IOCE to perform editing when editing required is based on the receipt date.

EFFECTIVE DATE: April 1, 2021 - Analysis, Design and Coding for screen changes, ECPS, and IDR; July 1, 2021 - Analysis, Design and Coding for IOCE, OPPS Pricer and OPPS Cloud Pricer. Testing and Implementation of all the CR components in July.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021 - Analysis, Design and Coding for screen changes, ECPS, and IDR; July 6, 2021 - Analysis, Design and Coding for IOCE, OPPS Pricer and OPPS Cloud Pricer. Testing and Implementation of all the CR components in July.

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
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Recently, the Centers for Medicare & Medicaid Services (CMS) implemented a new claim receipt date field in the IOCE Control Block Table and payment adjustment flag 2 from the Ambulatory Payment Classifications (APC) Return Buffer Table. The new claim receipt date field is populated to allow the IOCE to perform editing when editing required is based on the receipt date.

B. Policy: No new policy is being implemented.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11953.1	The Shared System Maintainer shall expand the IOCE interface to send a new "claim receipt date" field in the IOCE Control Block Table and receive a new "Payment Adjustment Flag 2" field when populated by the IOCE in the APC Return Buffer Table.					X				IOCE
11953.2	The Shared System Maintainer shall send the active claim receipt date from the claim record to the IOCE Control Block Table field "claim receipt date".					X				
11953.3	The Shared System Maintainer shall map the "Payment Adjustment Flag 2" field received from the IOCE APC Return Buffer Table to the claim record to display the Payment Adjustment Flag 2 field in a					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	claim screen (perhaps as IOCE Flag 10) and to also display it in a Direct Data Entry (DDE) claim screen.									
11953.3.1	The Shared System Maintainer shall pass the new field "Payment Adjustment Flag 2" on to the Integrated Data Repository (IDR) and Expert Claims Processing System (ECPS).					X				IDR
11953.3.2	The Shared System Maintainer shall create a display field for the Payment Adjustment Flag 2 in the IOCE bypass screen to be entered by the A/B Medicare Administrator Contractor (MAC) Part A, when necessary.	X				X				
11953.4	The Shared System Maintainer shall send the new "Payment Adjustment Flag 2" to the Outpatient Prospective Payment System (OPPS) Pricer. **Note:** The Payment Adjustment Flag 2 will be populated by the IOCE when a claim line requires multiple adjustments to be applied to the claim line. (i.e., a claim line that has **PAF=14** – PAMA Section 218 reduction on CT scan; also needs a **PAF=4** – Deductible not applicable (specific list of Healthcare Common Procedure Coding System (HCPCS) codes) or **PAF=9** – Deductible/co-insurance not applicable or **PAF=10** – Co-insurance not applicable).					X				OPPS Pricer
11953.5	The Shared System Maintainer shall take the "service units" from the IOCE found in the APC Return Buffer Table and apply them as the units to calculate reimbursement of the fee amounts on claim lines that have a Status Indicator of "A", "G", or "K", including when units are reduced to "0" by IOCE logic. These lines will also have a Payment Adjustment Flag of "25" applied by the IOCE.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov , Kajol Balani, kajol.balani@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 3

3.3.2 IOCE Control Block Table

Pointer Name	**Pointer Description**	**UB-04 Form Locator**	**Number**	**Size (bytes)**	**Comment**
Dxptr	ICD-10-CM diagnosis codes (ICD-9-CM diagnosis codes for historical claims with from dates prior to 10/1/2015)	70 a-c (Pt's rvdx) 67 (pdx) 67A-Q (sdx)	Up to 28	8 (7 for code, 1 for POA flag)	Diagnosis codes apply to whole claim and are not specific to a line item (left justified, blank filled). First three listed diagnoses are considered 'patient's reasons for visit dx', fourth diagnosis is considered 'principal dx'
Sgptr	Line item entries	42, 44-47	Up to 450	**73**	Table 3.3.1
Flagptr	Line item action flag Flag set by MAC and passed by OCE to Pricer	n/a	Up to 450	1	Used to bypass editing
Ageptr	Numeric age in years	n/a	1	3	0-124
Sexptr	Numeric sex code	11	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	18-28	Up to 30	2	Used to identify special circumstances impacting grouping results.
Billptr	Type of bill	4 (Pos 2-4)	1	3	Used to identify claims with bill types for special processing. It is presumed that bill type has been edited for validity by the Standard System before the claim is sent to IOCE.
NPIProvptr	National provider identifier (NPI)	56	1	13	Pass on to Pricer
OSCARProvptr	OSCAR Medicare provider number	57	1	6	Pass on to Pricer
PstatPtr	Patient status	17	1	2	UB-92 values
OppsPtr	Opps/Non-OPPS flag	n/a	1	1	1=OPPS, 2=Non-OPPS (A blank, zero or any other value is defaulted to 1)
OccPtr	Occurrence codes	31-34	Up to 30	2	For MAC use
VCAMTptr	Value codes and value code amounts	39-41	Up to 36	11	2-character Value Code followed by amount (nnnnnnnnn) zero-filled right justified **Note:** Value Code QA is provided on input and the value code amount provided should zero-fill the first 4 values, the next 5 values represent an IOCE calculated amount for total days and hours of PHP services. One byte for days and 4 bytes to record full and partial hours. For example, 2 days and 8 and ½ hours converts to the following value code amount 000020850. QA: Offset for combining partial PHP week on interim PHP claim
CPRDateptr	Claims Processing/Receipt Date (yyyymmdd)	n/a	1	8	Used to determine effective date for items that are effective based on claim receipt date.
Dxeditptr	Diagnosis edit return buffer	n/a	Up to 28	Table 6.1.2	Diagnosis edits returned
Proceditptr	Procedure edit return buffer	n/a	Up to 450	Table 6.1.2	Procedure edits returned
Mdeditptr	Modifier edit return buffer	n/a	Up to 450	Table 6.1.2	Modifier edits returned
Dteditptr	Date edit return buffer	n/a	Up to 450	Table 6.1.2	Date edits returned
Rceditptr	Revenue code edit return buffer	n/a	Up to 450	Table 6.1.2	Revenue code edits returned
APCptr	APC return buffer	n/a	Up to 450	Table 7.1.2	APC detail returned
Claimptr	Claim return buffer	n/a	1	Table 7.1.1	Claim detail returned
Wkptr	Work area pointer	n/a	1	1.25 MB	Working storage allocated in user interface
Wklenptr	Actual length of the work area pointed to by Wkptr	n/a	1	4	Binary full word

7.1.2 APC Return Buffer Table

Name	Size (bytes)	Values	Description
HCPCS procedure code	5	Alpha	For potential future use by Pricer; transfer from input.
Payment APC	5	00001-nnnnn	APC used to determine payment. If no APC assigned to line item, the value 00000 is assigned. For partial hospitalization and some inpatient-only, and other procedure claims, the payment APC may be different than the APC assigned to the HCPCS code.
HCPCS APC	5	00001-nnnnn	APC assigned to HCPCS code
Status Indicator (SI) *No Longer Applicable	2	Alpha	A – Services not paid under OPPS; paid under fee schedule or other payment system B – Non-allowed item or service for OPPS C – Inpatient procedure E – Non-allowed item or service* (Replaced by SI = E1 & E2 eff. V18.0) E1 – Non-allowed item or service E2 - Items and services for which pricing information and claims data are not available F – Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines G – Drug/Biological Pass-through H – Pass-through device categories J – New drug or new biological pass-through * (Replaced by SI G eff. V3.0) J1 – Hospital Part B services paid through a comprehensive APC J2 – Hospital Part B services that may be paid through a comprehensive APC K – Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals L – Flu/PPV vaccines M – Service not billable to the MAC N – Items and Services packaged into APC rates P – Partial hospitalization service Q – Packaged services subject to separate payment based on payment criteria* (Replaced by SI Q# v10.0) Q1 – STV-Packaged codes Q2 – T-Packaged codes Q3 – Codes that may be paid through a composite APC Q4 – Conditionally packaged laboratory services R – Blood and blood products S – Procedure or service, not discounted when multiple T – Procedure or service, multiple reduction applies U – Brachytherapy sources V – Clinic or emergency department visit W – Invalid HCPCS or Invalid revenue code with blank HCPCS X – Ancillary service* (Deactivated as of v16.0) Y – Non-implantable DME Z – Valid revenue code with blank HCPCS and no other SI assigned
Payment Indicator	2	Numeric (1-nn)	1 – Paid standard hospital OPPS amount (status indicators J1, J2, R, S, T, U, V, X) 2 – Services not paid by OPPS Pricer; paid under fee schedule or other payment system (SI of A, G, K) 3 – Not paid (Q, Q1, Q2, Q3, Q4, M, W, Y, E, E1), or not paid under OPPS (B, C, Z) 4 – Paid at reasonable cost (status indicator F, L) 5 – Paid standard amount for pass-through drug or biological (status indicator G) * 6 – Payment based on charge adjusted to cost (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, G0177 or G0129) 10 – Paid FQHC encounter payment 11 – Not paid or not included under FQHC encounter payment 12 – No additional payment, included in payment for FQHC encounter 13 – Paid FQHC encounter payment for New patient or IPPE/AWV 14 – Grandfathered tribal FQHC encounter payment
Discounting Formula Number	1	1-9	See Discounting formula for discounting fraction values 1-9
Line Item Denial or Rejection Flag	1	0-3	0 - Line item not denied or rejected 1 - Line item denied or rejected 2 – The line is not denied or rejected but occurs on a day that has been denied or rejected (not used as of 4/1/2002 - v3.0) 3 - Line item not denied or rejected; identified for informational alert only
Packaging Flag	1	0-6	0 – Not packaged 1 – Packaged service (status indicator N, or no HCPCS code and certain revenue codes) 2 – Packaged as part of PH per diem or daily mental health service per diem (v1.0-v9.3 only) 3 – Artificial charges for surgical procedure (submitted charges for surgical HCPCS < $1.01) 4 – Packaged as part of drug administration APC payment (v6.0 – v7.3 only) 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment not subject to coinsurance payment

Name	Size (bytes)	Values	Description
Payment Adjustment Flag 1	2	0-nn [Right justified, blank filled]	0 – No payment adjustment 1 – Paid standard amount for pass-through drug or biological 2 – Payment based on charge adjusted to cost 3 – Additional payment for new drug or new biological applies to APC 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 7 – Item provided without cost to provider 8 – Item provided with partial credit to provider 9 – Deductible/co-insurance not applicable 10 – Co-insurance not applicable 11 – Multiple service units reduced to one by OCE processing; payment based on single payment rate 12 – Offset for first device pass-through 13 – Offset for second device pass-through 14 – PAMA Section 218 reduction on CT scan 15 – Reserved for future use 16 – Terminated procedure with pass-through device 17 – Condition for device credit present 18 – Offset for first pass-through drug or biological 19 – Offset for second pass-through drug or biological 20 – Offset for third pass-through drug or biological 21 – CAA Section 502(b) reduction on film X-ray 22 – CAA Section 502(b) reduction on computed radiography technology 23 – Co-insurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b) 24 – Co-insurance deductible n/a, as well as subject to a reduction due to computed radiography technology (CAA Section 502b) 91 – 99 Each composite APC present, same value for prime and non-prime codes (v 9.0 – v9.3 only)
Payment Method Flag	1	0-x	0 - OPPS Pricer determines payment for service 1 - Service not paid based on coverage or billing rules 2 - Service is not subject to OPPS 3 - Service is not subject to OPPS, and has an OCE line item denial or rejection 4 - Line item is denied or rejected by MAC; OCE not applied to line item 5 - Payment for service determined under FQHC PPS 6 - CMHC outlier limitation reached 7 - Section 603 service with no reduction in OPPS Pricer 8 - Section 603 service with PFS reduction applied in OPPS Pricer 9 - CMHC outlier limitation bypassed A - Payment reduction for off-campus clinic visit B - Payer only testing C - Payment made by FQHC PPS and coinsurance is n/a (COVID-19) V - Contractor bypass applied to FQHC PPS service and coinsurance is n/a (COVID-19) W - Contractor bypass applied to off-campus clinic visit for payment reduction X - Contractor bypass applied to Section 603 service with no reduction applied in OPPS Pricer Y - Contractor bypass applied to Section 603 service with reduction applied in OPPS Pricer Z - Contractor bypass determines payment for services
Service Units	9	1-x	Transferred from input, for Pricer. For line items assigned to APCs for daily mental health, PHP, composite APC or comprehensive APC, the service units are assigned a value of one by the IOCE even if the input service units were greater than one, and payment adjustment flag 11 is provided (v16.1). Service units are also assigned to one for payable conditionally packaged lines (SI = Q1, Q2) and FQHC payment codes; payment adjustment flag 11 is provided (v16.2). Input service units also may be reduced for some Drug administration APCs (v6.0 – v7.3 only).
Charge	10	nnnnnnnnnn	Transferred from input for Pricer; COBOL pic 9(8)v99
Line Item Action Flag	1	0-5	Transferred from input to Pricer and can impact selection of discounting formula. 0 – OCE line item denial or rejection is not ignored 1 – OCE line item denial or rejection is ignored 2 – External line item denial. Line item is denied even if no OCE edits 3 – External line item rejection. Line item is rejected even if no OCE edits 4 – External line item adjustment. Technical charge rules apply 5 – Non-covered service excluded from payment under FQHC PPS
Composite Adjustment Flag	2	Alphanumeric	00 – Not a composite 01 – ZZ: First thru the nth composite APC present; same composite flag identifies the prime and non-prime codes in each composite APC group. For FQHC PPS claims (bill type 77x) only, the following values are defined for composite adjustment flag: 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit

			03 – Subsequent FQHC medical clinic visit (modifier 59 reported)
HCPCS Modifier	4	Alphanumeric	Assigned by IOCE for final payment determination (Note: Up to 2 occurrences of 2 characters each may be returned, currently only one 2-character modifier is returned) Reserved for future use
Payment Adjustment Flag 2	2	0-nn [Right justified, blank filled]	0 – No payment adjustment 1 – Paid standard amount for pass-through drug or biological 2 – Payment based on charge adjusted to cost 3 – Additional payment for new drug or new biological applies to APC 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 7 – Item provided without cost to provider 8 – Item provided with partial credit to provider 9 – Deductible/co-insurance not applicable 10 – Co-insurance not applicable 11 – Multiple service units reduced to one by OCE processing; payment based on single payment rate 12 – Offset for first device pass-through 13 – Offset for second device pass-through 14 – PAMA Section 218 reduction on CT scan 15 – Reserved for future use 16 – Terminated procedure with pass-through device 17 – Condition for device credit present 18 – Offset for first pass-through drug or biological 19 – Offset for second pass-through drug or biological 20 – Offset for third pass-through drug or biological 21 – CAA Section 502(b) reduction on film X-ray 22 – CAA Section 502(b) reduction on computed radiography technology 23 – Co-insurance deductible n/a, as well as subject to a reduction due to film x-ray (CAA Section 502b) 24 – Co-insurance deductible n/a, as well as subject to a reduction due to computed radiography technology (CAA Section 502b) 91 – 99 Each composite APC present, same value for prime and non-prime codes (v 9.0 – v9.3 only)

Line Item Input Information Table

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