CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1018	**Date: JULY 28, 2006**
	Change Request 5072

Subject: Uniform Billing (UB-04) Implementation

I. SUMMARY OF CHANGES: The CMS needs to be ready to receive the new UB-04 by March 1, 2007. Institutional providers can use the UB-04 beginning March 1, 2007, however, they will have a transitional period between March 1, 2007 and May 22, 2007 where they can use the UB-04 or the UB-92. Starting May 23, 2007 all institutional paper claims must use the UB-04. The UB-92 will no longer be accepted after this date. The UB-04 incorporates the National Provider Identifier (NPI), taxonomy, and additional codes (note the attached crosswalk file). Many UB-92 data locations have changed on the UB-04 although most of the data usage descriptions and allowable data values have not changed. Bill type processing will change. Note that this CR does not expand the claim record used for processing. Starting May 23, 2007, all UB-04s must include a valid NPI.

New / Revised Material
Effective Date: March 1, 2007
Implementation Date: March 1, 2007

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
R	25/TOC/Completing and Processing the CMS 1450 Data Set
R	25/50/Uniform Bill (UB) - Form CMS-1450 for Billing (UB-92)
R	25/60/General Instructions for Completion of Form CMS-1450 for Billing (UB-92)
R	25/70.1/Uniform Billing with form CMS-1450
R	25/70.2/Disposition of Copies of Completed Forms
R	25/75/General Instructions for Completion of Form CMS-1450 (UB-04)
R	25/75.1/Form Locators 1-15
R	25/75.2/Form Locators 16-30
R	25/75.3/Form Locators 31-41

R	25/75.4/Form Locator 42
R	25/75.5/Form Locators 43-81

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating Budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1018	Date: July 28, 2006	Change Request 5072

SUBJECT: Uniform Billing (UB-04) Implementation

I. GENERAL INFORMATION

A. Background: Following the close of a public comment period and careful review of comments received, the National Uniform Billing Committee (NUBC) approved the UB-04 as the replacement for the UB-92 at its February 2005 meeting. The CMS needs to be ready to receive the new UB-04 by March 1, 2007. Institutional providers can use the UB-04 beginning March 1, 2007; however, they will have a transitional period between March 1, 2007 and May 22, 2007 where they can use the UB-04 or the UB-92. This coincides with the NUBC's planned UB-04 implementation. Starting May 23, 2007 all institutional paper claims must be received on the UB-04. The UB-92 will no longer be accepted after this date. The UB-04 incorporates the National Provider Identifier (NPI), taxonomy, and additional codes.

Included in this change request are the UB-04 (front and back), the UB-92 to UB-04 crosswalk, and UB-04 mapping to the HIPAA institutional 837. To receive copies of the revised form with the specifications needed for testing purposes, contact TFP Data Systems at JRMagdaleno@tfpdata.com.

B. Policy: The Form UB-04 (CMS-1450) answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32. Just as CMS is applying the NPI requirement to both paper and electronic claims, we are also applying the same NPI editing requirements to NPIs submitted on either type of claim. **The internal claim record used for processing is not being expanded.**

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	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5072.1	Contractor and/or FISS shall modify front end systems (including on-line screens) to receive UB-04 data, except as limited by the following business requirements.	X	X			X				
5072.1.1	FISS shall modify on-line screens to permit only the 2nd through 4th positions of the bill type, treating the 2nd through 4th positions as the 1st through 3rd positions for processing (internal processing will not change), ignoring the leading zero (1st position) from the UB-04. For example Type of Bill 0111 shall be processed as Type of Bill 111.					X				
5072.1.1.1	After May 22, 2007, contractor shall not allow a UB-92 to be accepted as an adjustment claim.	X	X							
5072.1.2	For the UB-04 on-line screens, FISS shall retain the UB-92 limits as to permitting only up to the maximum number of the UB-04 codes (value codes, condition codes, occurrence codes occurrence span codes, etc) that may be reported for the UB-92 and not expand the size of these fields.					X				
5072.1.3	FISS shall modify edits to process the following UB-04 only value codes: 80 - Covered days (the number of days covered by the primary payer as qualified by the payer) 81 - Non-Covered Days (days of care not covered by the primary payer) 82 - Co-insurance Days (the inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness) 83 - Lifetime Reserve Days (under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5072.1.4	FISS shall include value code 80, 81, 82, or 83 data to on the internal claim file used to generate coordination of benefit claims.					X				
5072.2	FISS shall ignore data from hardcopy UB-04 Form Locators (FL) FL02 (Pay-to Information), FL3a (Medical/Health Record Number), FL08a (Patient Name-ID), FL25 (Condition Code), FL26 (Condition Code), FL27 (Condition Code), FL28 (Condition Code), FL29 (Accident State), FL66 (DX Version Qualifier), FL71 (PPS Code), FL72b (External Cause of Injury Code), and FL72c (External Cause of Injury Code) FL67I (Other Diagnosis), FL67J (Other Diagnosis), FL67K (Other Diagnosis), FL67L (Other Diagnosis), FL67M (Other Diagnosis), FL67N (Other Diagnosis), FL67O (Other Diagnosis), FL67P (Other Diagnosis), FL67Q (Other Diagnosis), FL79 (Other-ID), and FL81 (Code-code) except for code B3 (taxonomy).					X				
5072.2.1	FISS shall not expand on-line screens to support UB-04 FL02 (Pay-to Information), FL3a (Medical/Health Record Number), FL08a (Patient Name-ID), FL25 (Condition Code), FL26 (Condition Code), FL27 (Condition Code), FL28 (Condition Code), FL29 (Accident State), FL66 (DX Version Qualifier), FL71 (PPS Code), FL72b (External Cause of Injury Code), and FL72c (External Cause of Injury Code) FL67I (Other Diagnosis), FL67J (Other Diagnosis), FL67K (Other Diagnosis), FL67L (Other Diagnosis), FL67M (Other Diagnosis), FL67N (Other Diagnosis), FL67O (Other Diagnosis), FL67P (Other Diagnosis), FL67Q (Other Diagnosis), FL79 (Other-ID), and FL81 (Code-code) except for code B3 (taxonomy).					X				
5072.3	FISS shall use Uniform Bill Code "A" internally to represent the UB-04.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5072.3.1	Contractors that use Optical Character Recognition (OCR) equipment/software for institutional claims entry shall modify the equipment/software as needed for UB-04 entry.	X	X							
5072.3.2	Contractors that use OCR equipment/software shall modify the equipment/software to map only the 2nd through 4th positions of the bill type, treating the 2nd through 4th positions as the 1st through 3rd positions for processing (internal processing will not change), ignoring the leading zero (1st position) from the UB-04. For example Type of Bill 0111 shall be processed as Type of Bill 111.	X	X							
5072.4	Between March 1, 2007 and May 22, 2007, contactors shall accept either the UB-92 or the UB-04.	X	X							
5072.5	Contactors shall reject UB-92s received after May 22, 2007.	X	X							
5072.5.1	After May 22, 2007, contractors shall have the option to return a UB-92 to the submitter prior to data entry with a cover letter explaining why the UB-92 is being returned.	X	X							
5072.6	Contractors shall make all necessary changes to your internal business processes to receive, sort, process, and store the UB-04.	X	X							
5072.7	FISS shall make all the necessary shared system changes to accept only valid NPIs received on the UB-04 after May 22, 2007.					X				
5072.7.1	FISS shall make all the necessary shared system changes to accept valid NPIs received on the UB-04 between March 1, 2007 and May 22, 2007.					X				
5072.7.2	Prior to March 1, 2007, contractors shall have the option to return a UB-04 to the submitter with a cover letter explaining why the UB-04 is being returned.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5072.7.3	Contractor and/or FISS shall not implement additional NPI edits over and above those covered in Change Request 4023.	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	
5072.8	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							

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: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: March 1, 2007 for UB-92s and UB-04s accepted. **Implementation Date:** March 1, 2007 **Pre-Implementation Contact(s):** Matt Klischer (matthew.klischer@cms.hhs.gov) **Post-Implementation Contact(s):** Matt Klischer (matthew.klischer@cms.hhs.gov)	**Medicare contractors shall implement these instructions within their current FY 2007 operating budget.**

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

Attachments

** FL68,75,80 Size Updated 6/21/05*

*** FL07, 30 Size Updated 12/15/05*

UB-92					UB-04					Buffer
FL	**Description**	**Line**	**Type**	**Size**	**FL**	**Description**	**Line**	**Type**	**Size**	**Space Notes**
FL01	Provider Name	1	AN	25	FL01	Provider Name	1	AN	25	
FL01	Provider Street Address	2	AN	25	FL01	Provider Street Address	2	AN	25	
FL01	Provider City, State, Zip	3	AN	25	FL01	Provider City, State, Zip	3	AN	25	
FL01	Provider Telephone, Fax, Country Code	4	AN	25	FL01	Provider Telephone, Fax, Country Code	4	AN	25	
FL02	Unlabeled Fields	1	AN	20	FL02	Pay-to Name	1	AN	25	New
FL02	Unlabeled Fields	2	AN	30	FL02	Pay-to Address	2	AN	25	New
					FL02	Pay-to City, State	3	AN	25	New
					FL02	Not Used	4	AN	25	
FL03	Patient Control Number	1	AN	20	FL03a	Patient Control Number		AN	20	
					FL03b	Medical Record Number		AN	24	Moved/New
FL04	Type of Bill	1	AN	3	FL04	Type of Bill	1	AN	4	1 Expanded
FL05	Federal Tax Number	1	AN	4	FL05	Federal Tax Number	1	AN	4	
FL05	Federal Tax Number	2	AN	10	FL05	Federal Tax Number	2	AN	10	
FL06	Statement Covers Period - From/Through	1	N/N	6/6	FL06	Statement Covers Period - From/Through	1	N/N	6/6	1/1
					FL07	Unlabeled	1	AN	7**	
							2	AN	8**	
FL07	Covered Days	1	N	3		*Eliminated - Substitute new Value Code 80*				
FL08	Non-covered Days	1	N	4		*Eliminated - Substitute new Value Code 81*				
FL09	Coinsurance Days	1	N	3		*Eliminated - Substitute new Value Code 82*				
FL10	Lifetime Reserve Days	1	N	3		*Eliminated - Substitute new Value Code 83*				
FL11	Unlabeled	1		12		*Eliminated*				
FL11	Unlabeled	2		13		*Eliminated*				
FL12	Patient Name	1	AN	30	FL08	Patient Name - ID	1a	AN	19	New
					FL08	Patient Name	2b	AN	29	
FL13	Patient Address	1	AN	50	FL09	Patient Address - Street	1a	AN	40	1 Discrete
					FL09	Patient Address - City	2b	AN	30	2 Discrete
					FL09	Patient Address - State	2c	AN	2	1 Discrete
					FL09	Patient Address - ZIP	2d	AN	9	1 Discrete
					FL09	Patient Address - Country Code	2e	AN	3	Discrete
FL14	Patient Birthdate	1	N	8	FL10	Patient Birthdate	1	N	8	1
FL15	Patient Sex	1	AN	1	FL11	Patient Sex	1	AN	1	2
FL16	Patient Marital Status	1	AN	1		*Eliminated*				
FL17	Admission Date	1	N	6	FL12	Admission Date	1	N	6	
FL18	Admission Hour	1	AN	2	FL13	Admission Hour	1	AN	2	1
FL19	Type of Admission/Visit	1	AN	1	FL14	Type of Admission/Visit	1	AN	1	2
FL20	Source of Admission	1	AN	1	FL15	Source of Admission	1	AN	1	1
FL21	Discharge Hour	1	AN	2	FL16	Discharge Hour	1	AN	2	2

FL22	Patient Status/Discharge Code	1	AN	2	FL17	Patient Discharge Status	1	AN	2	2
FL23	Medical/Health Record Number		AN	17		*Moved to FL3b*				
FL24	Condition Codes		AN	2	FL18	Condition Codes		AN	2	1
FL25	Condition Codes		AN	2	FL19	Condition Codes		AN	2	1
					FL20	Condition Codes		AN	2	1

** FL68,75,80 Size Updated 6/21/05*

*** FL07, 30 Size Updated 12/15/05*

UB-92					UB-04					
FL	**Description**	**Line**	**Type**	**Size**	**FL**	**Description**	**Line**	**Type**	**Size**	**Buffer Space Notes**
FL26	Condition Codes		AN	2	FL21	Condition Codes		AN	2	1
					FL22	Condition Codes		AN	2	1
FL27	Condition Codes		AN	2	FL23	Condition Codes		AN	2	1
					FL24	Condition Codes		AN	2	1
FL28	Condition Codes		AN	2	FL25	Condition Codes		AN	2	1
					FL26	Condition Codes		AN	2	1 New
FL29	Condition Codes		AN	2	FL27	Condition Codes		AN	2	1 New
					FL28	Condition Codes		AN	2	1 New
FL30	Condition Codes		AN	2						
					FL29	Accident State	1	AN	2	1 New
					FL30	Unlabeled	1	AN	12	** No "Xs" on proof
					FL30	Unlabeled	2	AN	13	
FL31	Unlabeled	1		5						
FL31	Unlabeled	2		6						
FL32	Occurrence Code/Date	a	AN/N	2/6	FL31	Occurrence Code/Date	a	AN/N	2/6	1/1
FL32	Occurrence Code/Date	b	AN/N	2/6	FL31	Occurrence Code/Date	b	AN/N	2/6	1/1
FL33	Occurrence Code/Date	a	AN	2/6	FL32	Occurrence Code/Date	a	AN/N	2/6	1/1
FL33	Occurrence Code/Date	b	AN/N	2/6	FL32	Occurrence Code/Date	b	AN/N	2/6	1/1
FL34	Occurrence Code/Date	a	AN	2/6	FL33	Occurrence Code/Date	a	AN/N	2/6	1/1
FL34	Occurrence Code/Date	b	AN/N	2/6	FL33	Occurrence Code/Date	b	AN/N	2/6	1/1
FL35	Occurrence Code/Date	a	AN	2/6	FL34	Occurrence Code/Date	a	AN/N	2/6	1/1
FL35	Occurrence Code/Date	b	AN/N	2/6	FL34	Occurrence Code/Date	b	AN/N	2/6	1/1
FL36	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	FL35	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	1/1/1
FL36	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	FL35	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	1/1/1
					FL36	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	1/1/1 New
					FL36	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	1/1/1 New
					FL37	Unlabeled	a	AN	8	
					FL37	Unlabeled	b	AN	8	
FL37	ICN/DCN	A	AN	23		*Moved to FL64*				Relocated
FL37	ICN/DCN	B	AN	23		*Moved to FL64*				
FL37	ICN/DCN	C	AN	23		*Moved to FL64*				
FL38	Responsible Party Name/Address	1	AN	40	FL38	Responsible Party Name/Address	1	AN	40	2
FL38	Responsible Party Name/Address	2	AN	40	FL38	Responsible Party Name/Address	2	AN	40	2
FL38	Responsible Party Name/Address	3	AN	40	FL38	Responsible Party Name/Address	3	AN	40	2
FL38	Responsible Party Name/Address	4	AN	40	FL38	Responsible Party Name/Address	4	AN	40	2
FL38	Responsible Party Name/Address	5	AN	40	FL38	Responsible Party Name/Address	5	AN	40	2

FL39	Value Code - Code	a	AN	2	FL39	Value Code - Code	a	AN	2	1
FL39	Value Code - Amount	a	N	9	FL39	Value Code - Amount	a	N	9	1
FL39	Value Code - Code	b	AN	2	FL39	Value Code - Code	b	AN	2	1
FL39	Value Code - Amount	b	N	9	FL39	Value Code - Amount	b	N	9	1
FL39	Value Code - Code	c	AN	2	FL39	Value Code - Code	c	AN	2	1
FL39	Value Code - Amount	c	N	9	FL39	Value Code - Amount	c	N	9	1
FL39	Value Code - Code	d	AN	2	FL39	Value Code - Code	d	AN	2	1
FL39	Value Code - Amount	d	N	9	FL39	Value Code - Amount	d	N	9	1
FL40	Value Code - Code	a	AN	2	FL40	Value Code - Code	a	AN	2	1
FL40	Value Code - Amount	a	N	9	FL40	Value Code - Amount	a	N	9	1
FL40	Value Code - Code	b	AN	2	FL40	Value Code - Code	b	AN	2	1
FL40	Value Code - Amount	b	N	9	FL40	Value Code - Amount	b	N	9	1
FL40	Value Code - Code	c	AN	2	FL40	Value Code - Code	c	AN	2	1
FL40	Value Code - Amount	c	N	9	FL40	Value Code - Amount	c	N	9	1
FL40	Value Code - Code	d	AN	2	FL40	Value Code - Code	d	AN	2	1
FL40	Value Code - Amount	d	N	9	FL40	Value Code - Amount	d	N	9	1
FL41	Value Code - Code	a	AN	2	FL41	Value Code - Code	a	AN	2	1
FL41	Value Code - Amount	a	N	9	FL41	Value Code - Amount	a	N	9	1

** FL68,75,80 Size Updated 6/21/05*

*** FL07, 30 Size Updated 12/15/05*

UB-92

FL	Description	Line	Type	Size
FL41	Value Code - Code	b	AN	2
FL41	Value Code - Amount	b	N	9
FL41	Value Code - Code	c	AN	2
FL41	Value Code - Amount	c	N	9
FL41	Value Code - Code	d	AN	2
FL41	Value Code - Amount	d	N	9
FL42	Revenue Code	1-23	N	4
FL43	Revenue Code Description	1-23	AN	24
FL44	HCPCS/Rates/HIPPS Rate Codes	1-23	AN/N/AN	9
FL45	Service Date	1-23	N	6
FL46	Units of Service	1-23	N	7
FL47	Total Charges	1-23	N	10
FL48	Non-Covered Charges	1-23	N	10
FL49	Unlabeled	1-23	AN	4
FL50	Payer - Primary	A	AN	25
FL50	Payer - Secondary	B	AN	25
FL50	Payer - Tertiary	C	AN	25
FL51	Provider Number	A	AN	13
FL51	Provider Number	B	AN	13
FL51	Provider Number	C	AN	13
FL52	Release of Information - Primary	A	AN	1
FL52	Release of Information - Secondary	B	AN	1
Fl52	Release of Information - Tertiary	C	AN	1
FL53	Assignment of Benefits - Primary	A	AN	1
FL53	Assignment of Benefits - Secondary	B	AN	1

UB-04

FL	Description	Line	Type	Size	Buffer Space	Notes
FL41	Value Code - Code	b	AN	2	1	
FL41	Value Code - Amount	b	N	9	1	
FL41	Value Code - Code	c	AN	2	1	
FL41	Value Code - Amount	c	N	9	1	
FL41	Value Code - Code	d	AN	2	1	
FL41	Value Code - Amount	d	N	9	1	
FL42	Revenue Code	1-23	N	4	0.5	
FL43	Revenue Code Description	1-22	AN	24	0.5	
FL43 44	***PAGE ___ OF ___ CREATION DATE***	23	N/N	3/3	0.5	New
FL44	HCPCS/Rates/HIPPS Rate Codes	1-22	AN/N/AN	14	0.5	Expanded size
FL45	Service Date	1-22	N	6	0.5	
FL45	Creation Date	23	N	6	0.5	New
FL46	Units of Service	1-22	N	7	0.5	
FL47	Total Charges	1-23	N	9	0.5	Removed sign field
FL48	Non-Covered Charges	1-23	N	9	0.5	Removed sign field
FL49	Unlabeled	1-23	AN	2	0.5	
FL50	Payer Name - Primary	A	AN	23		
FL50	Payer Name - Secondary	B	AN	23		
FL50	Payer Name - Tertiary	C	AN	23		
FL51	Health Plan ID	A	AN	15		
FL51	Health Plan ID	B	AN	15		
FL51	Health Plan ID	C	AN	15		
FL52	Release of Information - Primary	A	AN	1	1	
FL52	Release of Information - Secondary	B	AN	1	1	
FL52	Release of Information - Tertiary	C	AN	1	1	
FL53	Assignment of Benefits - Primary	A	AN	1	1	
FL53	Assignment of Benefits - Secondary	B	AN	1	1	

FL53	Assignment of Benefits - Tertiary	C	AN	1	FL53	Assignment of Benefits - Tertiary	C	AN	1	1
FL54	Prior Payments - Primary	A	N	10	FL54	Prior Payments - Primary	A	N	10	1
FL54	Prior Payments - Secondary	B	N	10	FL54	Prior Payments - Secondary	B	N	10	1
FL54	Prior Payments - Tertiary	C	N	10	FL54	Prior Payments - Tertiary	C	N	10	1
FL54	Prior Payments - Patient	4	N	10		*Eliminated Patient Prior Payments*				
FL55	Estimated Amount Due - Primary	A	N	10	FL55	Estimated Amount Due - Primary	A	N	10	1
FL55	Estimated Amount Due - Secondary	B	N	10	FL55	Estimated Amount Due - Secondary	B	N	10	1
FL55	Estimated Amount Due - Tertiary	C	N	10	FL55	Estimated Amount Due - Tertiary	C	N	10	1
FL55	Estimated Amount Due - Patient	4	N	10		*Eliminated Due from Patient*				
FL56	Unlabeled	1		13	FL56	NPI	1	AN	15	
FL56	Unlabeled	2		14	FL57	Other Provider ID - Primary	A	AN	15	
					FL57	Other Provider ID - Secondary	B	AN	15	
					FL57	Other Provider ID - Tertiary	C	AN	15	
FL57	Unlabeled	1		27		*Deleted from UB-04*				
FL58	Insured’s Name - Primary	A	AN	25	FL58	Insured’s Name - Primary	A	AN	25	1
FL58	Insured's Name - Secondary	B	AN	25	FL58	Insured's Name - Secondary	B	AN	25	1
FL58	Insured's Name - Tertiary	C	AN	25	FL58	Insured's Name - Tertiary	C	AN	25	1
FL59	Patient’s Relationship - Primary	A	AN	2	FL59	Patient’s Relationship - Primary	A	AN	2	1
FL59	Patient's Relationship - Secondary	B	AN	2	FL59	Patient's Relationship - Secondary	B	AN	2	1

FL	Description	Line	Type	Size	Buffer Space	Notes
FL59	Patient's Relationship - Tertiary	C	AN	2	1	
FL60	Insured's Unique ID - Primary	A	AN	20		
FL60	Insured's Unique ID - Secondary	B	AN	20		
FL60	Insured's Unique ID - Tertiary	C	AN	20		
FL61	Insurance Group Name - Primary	A	AN	14	1	
FL61	Insurance Group Name -Secondary	B	AN	14	1	
FL61	Insurance Group Name - Tertiary	C	AN	14	1	
FL62	Insurance Group Number - Primary	A	AN	17	1	
FL62	Insurance Group Number - Secondary	B	AN	17	1	
FL62	Insurance Group Number - Tertiary	C	AN	17	1	
FL63	Treatment Authorization Code - Primary	A	AN	30	1	
FL63	Treatment Authorization Code - Secondary	B	AN	30	1	
FL63	Treatment Authorization Code - Tertiary	C	AN	30	1	
FL64	Document Control Number	A	AN	26		
FL64	Document Control Number	B	AN	26		
FL64	Document Control Number	C	AN	26		
Deleted from UB-04						
Deleted from UB-04						
Deleted from UB-04						
FL65	Employer Name - Primary	A	AN	25		
FL65	Employer Name - Secondary	B	AN	25		
FL65	Employer Name - Tertiary	C	AN	25		
Deleted from UB-04						
Deleted from UB-04						
Deleted from UB-04						

FL66	DX Version Qualifier		AN	1	New Denotes ICD v.
FL67	Principal Diagnosis Code		AN	8	Expanded field
FL67A	Other Diagnosis		AN	8	Expanded field
FL67B	Other Diagnosis		AN	8	Expanded field
FL67C	Other Diagnosis		AN	8	Expanded field
FL67D	Other Diagnosis		AN	8	Expanded field
FL67E	Other Diagnosis		AN	8	Expanded field
FL67F	Other Diagnosis		AN	8	Expanded field
FL67G	Other Diagnosis		AN	8	Expanded field
FL67H	Other Diagnosis		AN	8	Expanded field
FL67I	Other Diagnosis		AN	8	New
FL67J	Other Diagnosis		AN	8	New
FL67K	Other Diagnosis		AN	8	New
FL67L	Other Diagnosis		AN	8	New
FL67M	Other Diagnosis		AN	8	New
FL67N	Other Diagnosis		AN	8	New
FL67O	Other Diagnosis		AN	8	New
FL67P	Other Diagnosis		AN	8	New
FL67Q	Other Diagnosis		AN	8	New
FL68	Unlabeled	1a	AN	8*	
FL68	Unlabeled	1b	AN	9*	
FL69	Admitting Diagnosis Code	1	AN	7	Expanded by 1
FL70	Patient's Reason for Visit Code	A	AN	7	Distinct FL
FL70	Patient's Reason for Visit Code	B	AN	7	Distinct FL
FL70	Patient's Reason for Visit Code	C	AN	7	Distinct FL

** FL68,75,80 Size Updated 6/21/05*

*** FL07, 30 Size Updated 12/15/05*

UB-92					UB-04			
FL	**Description**	**Line**	**Type**	**Size**	**FL Description**	**Line**	**Type Size**	**Buffer Space Notes**
					FL71 PPS Code	1	AN 3	2 New
FL77	External Cause of Injury Code	1	AN	6	FL72 External Cause of Injury Code	1a	AN 8	
					FL72 External Cause of Injury Code	1b	AN 8	New
					FL72 External Cause of Injury Code	1c	AN 8	New
FL78	Unlabeled				FL73 Unlabeled	1	AN 9	
FL79	Procedure Coding Method Used	1	N	1	*Deleted from UB-04*			Deleted
FL80	Principal Procedure Code/Date	1	N/N	6/6	FL74 Principal Procedure Code/Date		N/N 7/6	1/1 Expanded by 1
FL81	Other Procedure Code/Date	A	N/N	6/6	FL74a Other Procedure Code/Date		N/N 7/6	1/1 Expanded by 1
FL81	Other Procedure Code/Date	B	N/N	6/6	FL74b Other Procedure Code/Date		N/N 7/6	1/1 Expanded by 1
FL81	Other Procedure Code/Date	C	N/N	6/6	FL74c Other Procedure Code/Date		N/N 7/6	1/1 Expanded by 1
FL81	Other Procedure Code/Date	D	N/N	6/6	FL74d Other Procedure Code/Date		N/N 7/6	1/1 Expanded by 1

FL81	Other Procedure Code/Date	E	N/N	6/6	FL74e Other Procedure Code/Date		N/N 7/6	1/1 Expanded by 1	
					FL75 Unlabeled	1	AN 4*	0*	
					FL75 Unlabeled	2	AN 4	1	
					FL75 Unlabeled	3	AN 4	1	
					FL75 Unlabeled	4	AN 4	1	
FL82	Attending Physician ID	a	AN	23	FL76 Attending - NPI/QUAL/ID	1	AN/AN/AN 11/2/9		New Layout
FL82	Attending Physician ID	b	AN	32	FL76 Attending - Last/First	2	AN/AN 16/12		New Layout
FL83A	Other Physician ID	a	AN	25	FL77 Operating - NPI/QUAL/ID	1	AN/AN/AN 11/2/9		New Layout
FL83A	Other Physician ID	b	AN	32	FL77 Operating - Last/First	2	AN/AN 16/12		New Layout
FL83B	Other Physician ID	a	AN	25	FL78 Other ID - QUAL/NPI/QUAL/ID	1	AN/AN/ AN/AN 2/11/2/9		New Layout
FL83B	Other Physician ID	b	AN	32	FL78 Other ID - Last/First	2	AN/AN 16/12		New Layout
					FL79 Other ID - QUAL/NPI/QUAL/ID	1	AN/AN/ AN/AN 2/11/2/9		New
					FL79 Other ID - Last/First	2	AN/AN 16/12		New
FL84	Remarks	1	AN	43	FL80 Remarks	1	AN 19*		Reduced Field Size
FL84	Remarks	2	AN	48	FL80 Remarks	2	AN 24*		Reduced Field Size
FL84	Remarks	3	AN	48	FL80 Remarks	3	AN 24*		Reduced Field Size
FL84	Remarks	4	AN	48	FL80 Remarks	4	AN 24*		Reduced Field Size
					FL81 Code-Code - QUAL/CODE/VALUE	a	AN/AN/AN 2/10/12		New
					FL81 Code-Code - QUAL/CODE/VALUE	b	AN/AN/AN 2/10/12		New
					FL81 Code-Code - QUAL/CODE/VALUE	c	AN/AN/AN 2/10/12		New
					FL81 Code-Code - QUAL/CODE/VALUE	d	AN/AN/AN 2/10/12		New
FL85	Provider Rep. Signature	1	AN	22	*Deleted from UB-04*				
FL86	Date Bill Submitted	1	Date	6	*Deleted from UB-04; See FL45, line 23*				

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. **If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.**
2. **If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.**
3. **Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.**
4. **For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.**
5. **Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.**
6. **The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.**
7. **For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.**
8. **For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.**
9. **For TRICARE Purposes:**

   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically and appropriate for the health of the patient;

   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

UB-04 Printing Standards

The UB-04 is designed to accommodate 10-pitch Pica type, 6 lines per inch. Once adjusted to the left and right, alignment points in the first print line and characters appear within form lines as shown in the print file matrix in Exhibit __.

The Printing Standards are used in conjunction with the negative layout that was approved by the National Uniform Billing Committee (NUBC) and distributed by TFP Data Systems. Compliance with these standards is required to facilitate the use of image processing technology such as Optical Character Recognition, facsimile transmissions, and image storage.

Contact Information for purchase of License agreement and negatives should be made with TFP Data Systems Compliance Department: 800-482-9367 ext. 1770.

The National Uniform Billing Committee has responsibility for the printing specifications for Form CMS-1450 (paper UB-04). These specifications are as follows:

Cut Sheet:

Size - 8 ½ inches (plus or minus 0.1 inch) by 11 inches (plus or minus 1/6 inch).
217mm by 281mm plus or minus 2mm.

Print - Face and back, head to head.

Margins:

Face-The top margin from the top edge of the form to the first print position is 1/6 inches or .4 mm. The left margin is 0.15 inches to the left end of the first print position.

Back - x.xx inch head and foot, x.xx inch left and right. (TBD)

Offset -The X and Y offset for margins must not vary by more than +/-0.1 inch from sheet to sheet.

The X offset refers to the horizontal distance from the left edge of the paper to the beginning of the printing. The Y offset refers to the vertical distance between the top of the paper and the beginning of the printing.

Askewity - The askewity of the printed image must be no greater than 0.15mm in 100mm.

Paper Stock - White, OCR Bond, 20 lbs., equal to JCP-O-25. Cut square with each corner 90 degrees, plus or minus 0.025 degrees.

Ink color:

Front - Ink is to be PMS no. 192 (OCR-Red) (For Example, Flint J6983, formerly known as Sinclair Valentine). There is to be no contamination with “Black” ink or pigment. Printed product must meet specifications established as ANSI Standard X-3.86. Printer must maintain proper ink reflectance limits of the OCR reader specified by the purchaser.

Back - Ink is to be PMS no. 421 (Grey)

Titles - Placement will be indicated on negative;

One Part Marginally Punched Continuous Form:

Size - Same dimensions as for Cut Sheet, plus 0.5” left and right, (overall: 9.5” by 11”; detached: 8.5” by 11”).

Print - Face and back, head to head.

Margins - On detached sheet, same as for Cut Sheet.

Askewity - On detached sheet, same as for Cut Sheet.

Paper Stock - Same as for Cut Sheet

Ink Color - Same as for Cut Sheet.

Perforations- Marginally ½” left and right, tear line horizontally every 11”

Titles - Placement will be indicated on negative.
Two Part Marginally Punched Continuous Forms:
Size - Same dimensions as for Cut Sheet, plus ½” left and right, (overall: 9.5” x 11”; detached: 8.5” x 11”).
Print:
Part 1 - Face and back, head to head.
Part 2 - Face and back, head to head.
Margins - On detached sheet, same as for Cut Sheet.
Askewity - On detached sheet, same as for Cut Sheet.
Paper Stock:
Part 1 - Same as for Cut Sheet.
Part 2 - Any color or weight that does not interfere with scanning of part 1 sheet. Suggest the following sequence:
1st part is 20 CB - OCR
• 2nd part is 14 CFB (if not last part)
• Last part is 15 CF
CB = Coated Back (Carbonless black print)
CFB = Coated Front and Back (Carbonless black print)
CF = Coated Front (Carbonless black print)
Ink Color:
Part 1 - Same as for cut sheet.
Part 2 - Any color that will not interfere with scanning of the part 1 sheet.
Perforations - Marginally ½” left and right, tear line horizontally every 11”.
Titles - Placement will be indicated on negative.
The top copy is to be labeled “OCR/Original”.
The remaining copies are to be labeled copy 1, copy 2, copy 3, etc.
Color of the above titles is to be in the same ink as the form (see above).
Note: Users may determine the number of parts that are applicable to their needs. Up to four total parts are feasible on some printers; some other printers may limit the readability of multiple plies.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC® National Uniform Billing Committee

LIC9213257

Medicare Claims Processing Manual
Chapter 25 - Completing and Processing *the CMS 1450* Data Set

Table of Contents
(Rev.1018, 07-28-06)

Crosswalk to Old Manuals

50 - Uniform Bill *(UB)* - Form CMS-1450 *(UB-92)*

60 - General Instructions for Completion of Form CMS-1450 for Billing *(UB-92)*

50 - Uniform Bill *(UB)* - Form CMS-1450 *(UB-92)*

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

60 - General Instructions for Completion of Form CMS-1450 for Billing *(UB-92)*

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

This section contains Medicare requirements for use of codes maintained by the National Uniform Billing Committee that are needed in completion of the Form CMS-1450 and compliant X12N 837 version 4010A1 institutional claims.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. If required data is omitted, the FI obtains it from the provider or other sources and maintains it on its history record. The FI need not search paper files to annotate missing data unless it does not have an electronic history record. It need not obtain data that is not needed to process the claim.

Data elements in the CMS uniform electronic billing specifications are consistent with the Form CMS-1450 data set to the extent that one processing system can handle both. Definitions are identical. In some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Also, for a few data elements not used by Medicare, conversion may be needed from an alpha code to a numeric, but these do not affect Medicare processing. The revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the Form CMS-1450, this simply means that the FI accepts claims of up to 9 pages. Effective October 16, 2003, all state fields are discontinued and reclassified as reserved for national assignment.

70 - Uniform Bill - Form CMS-1450 (UB-04)

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

70.1 - Uniform Billing with Form CMS-1450

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

This form, also known as the UB-04, is a uniform institutional provider bill suitable for use in billing multiple third party payers. Because it serves many payers, a particular payer may not need some data elements. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form. All items on Form CMS-1450 are described. The FI must be able to capture all NUBC-approved input data described in section 75 for audit trail purposes and be able to pass all data to other payers with whom it has a coordination of benefits agreement.

70.2 - Disposition of Copies of Completed Forms

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

The provider retains the copy designated "Institution Copy" and submits the remaining copies of the completed Form CMS-1450 to its FI, managed care plan, or other insurer. Where it knows that a managed care plan will pay the bill, it sends the bill and any necessary supporting documentation directly to the managed care plan for coverage determination, payment, and/or denial action. It sends to the FI bills that it knows will be paid and processed by the FI.

75 - General Instructions for Completion of Form CMS-1450 for Billing (UB-04)

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

This section contains Medicare requirements for use of codes maintained by the National Uniform Billing Committee that are needed in completion of the Form CMS-1450 and compliant X12N 837 version 4010A1 institutional claims. ***Note that the internal claim record used for processing is not being expanded.*** *Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. The FI need not search paper files to annotate missing data unless it does not have an electronic history record. It need not obtain data that is not needed to process the claim.*

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the Form CMS-1450, this simply means that the FI accepts claims of up to 9 pages. Effective October 16, 2003, all state fields are discontinued and reclassified as reserved for national assignment. The following layout describes the data specifications for the UB-04.

UB-04 LAYOUT SUMMARY

FL	*Description*	*Line*	*Type*	*Size*	*Buffer Space*
FL01	*[Provider Name]*	*1*	*AN*	*25*	
FL01	*[Provider Street Address]*	*2*	*AN*	*25*	
FL01	*[Provider City, State, Zip]*	*3*	*AN*	*25*	
FL01	*[Provider Telephone, Fax, Country Code]*	*4*	*AN*	*25*	
FL02	*[Pay-to Name]*	*1*	*AN*	*25*	
FL02	*[Pay-to Address]*	*2*	*AN*	*25*	
FL02	*[Pay-to City, State]*	*3*	*AN*	*25*	
FL02	*[Pay-to ID]*	*4*	*AN*	*25*	
FL03a	*Patient Control Number*		*AN*	*24*	

FL03b	*Medical Record Number*		*AN*	*24*	
FL04	*Type of Bill*	*1*	*AN*	*4*	*1*
FL05	*Federal Tax Number*	*1*	*AN*	*4*	
FL05	*Federal Tax Number*	*2*	*AN*	*10*	
FL06	*Statement Covers Period - From/Through*	*1*	*N/N*	*6/6*	*1/1*
FL07	*Unlabeled*	*1*	*AN*	*7*	
FL07	*Unlabeled*	*2*	*AN*	*8*	
FL08	*Patient Name - ID*	*1a*	*AN*	*19*	
FL08	*Patient Name*	*2b*	*AN*	*29*	
FL09	*Patient Address - Street*	*1a*	*AN*	*40*	*1*
FL09	*Patient Address - City*	*2b*	*AN*	*30*	*2*
FL09	*Patient Address - State*	*2c*	*AN*	*2*	*1*
FL09	*Patient Address - ZIP*	*2d*	*AN*	*9*	*1*
FL09	*Patient Address - Country Code*	*2e*	*AN*	*3*	
FL10	*Patient Birthdate*	*1*	*N*	*8*	*1*
FL11	*Patient Sex*	*1*	*AN*	*1*	*2*
FL12	*Admission Date*	*1*	*N*	*6*	

FL13	*Admission Hour*	*1*	*AN*	*2*	*1*
FL14	*Type of Admission/Visit*	*1*	*AN*	*1*	*2*
FL15	*Source of Admission*	*1*	*AN*	*1*	*2*
FL16	*Discharge Hour*	*1*	*AN*	*2*	*1*
FL17	*Patient Status Code*	*1*	*AN*	*2*	*1*
FL18	*Condition Codes*		*AN*	*2*	*1*
FL19	*Condition Codes*		*AN*	*2*	*1*
FL20	*Condition Codes*		*AN*	*2*	*1*
FL21	*Condition Codes*		*AN*	*2*	*1*

FL22	*Condition Codes*		*AN*	*2*	*1*
FL23	*Condition Codes*		*AN*	*2*	*1*
FL24	*Condition Codes*		*AN*	*2*	*1*
FL25	*Condition Codes*		*AN*	*2*	*1*
FL26	*Condition Codes*		*AN*	*2*	*1*
FL27	*Condition Codes*		*AN*	*2*	*1*
FL28	*Condition Codes*		*AN*	*2*	*1*
FL29	*Accident State*		*AN*	*2*	*1*
FL30	*Unlabeled*	*1*	*AN*	*12*	
FL30	*Unlabeled*	*2*	*AN*	*13*	
FL31	*Occurrence Code/Date*	*a*	*AN/N*	*2/6*	*1/1*
FL31	*Occurrence Code/Date*	*b*	*AN/N*	*2/6*	*1/1*
FL32	*Occurrence Code/Date*	*a*	*AN/N*	*2/6*	*1/1*
FL32	*Occurrence Code/Date*	*b*	*AN/N*	*2/6*	*1/1*
FL33	*Occurrence Code/Date*	*a*	*AN/N*	*2/6*	*1/1*
FL33	*Occurrence Code/Date*	*b*	*AN/N*	*2/6*	*1/1*

FL34	*Occurrence Code/Date*	*a*	*AN/N*	*2/6*	*1/1*
FL34	*Occurrence Code/Date*	*b*	*AN/N*	*2/6*	*1/1*
FL35	*Occurrence Span Code/From/Through*	*a*	*AN/N/N*	*2/6/6*	*1/1/1*
FL35	*Occurrence Span Code/From/Through*	*b*	*AN/N/N*	*2/6/6*	*1/1/1*
FL36	*Occurrence Span Code/From/Through*	*a*	*AN/N/N*	*2/6/6*	*1/1/1*
FL36	*Occurrence Span Code/From/Through*	*b*	*AN/N/N*	*2/6/6*	*1/1/1*
FL37	*Unlabeled*	*a*	*AN*	*8*	
FL37	*Unlabeled*	*b*	*AN*	*8*	
FL38	*Responsible Party Name/Address*	*1*	*AN*	*40*	*2*
FL38	*Responsible Party Name/Address*	*2*	*AN*	*40*	*2*
FL38	*Responsible Party Name/Address*	*3*	*AN*	*40*	*2*
FL38	*Responsible Party Name/Address*	*4*	*AN*	*40*	*2*
FL38	*Responsible Party Name/Address*	*5*	*AN*	*40*	*2*

FL39	*Value Codes*	*a*	*AN*	*2*	*1*
FL39	*Value Codes*	*a*	*N*	*9*	*1*
FL39	*Value Codes*	*b*	*AN*	*2*	*1*
FL39	*Value Codes*	*b*	*N*	*9*	*1*
FL39	*Value Codes*	*c*	*AN*	*2*	*1*
FL39	*Value Codes*	*c*	*N*	*9*	*1*
FL39	*Value Codes*	*d*	*AN*	*2*	*1*
FL39	*Value Codes*	*d*	*N*	*9*	*1*
FL40	*Value Codes*	*a*	*AN*	*2*	*1*
FL40	*Value Codes*	*a*	*N*	*9*	*1*
FL40	*Value Codes*	*b*	*AN*	*2*	*1*
FL40	*Value Codes*	*b*	*N*	*9*	*1*
FL40	*Value Codes*	*c*	*AN*	*2*	*1*
FL40	*Value Codes*	*c*	*N*	*9*	*1*
FL40	*Value Codes*	*d*	*AN*	*2*	*1*
FL40	*Value Codes*	*d*	*N*	*9*	*1*

FL41	*Value Codes*	*a*	*AN*	*2*	*1*
FL41	*Value Codes*	*a*	*N*	*9*	*1*
FL41	*Value Codes*	*b*	*AN*	*2*	*1*
FL41	*Value Codes*	*b*	*N*	*9*	*1*
FL41	*Value Codes*	*c*	*AN*	*2*	*1*
FL41	*Value Codes*	*c*	*N*	*9*	*1*
FL41	*Value Codes*	*d*	*AN*	*2*	*1*
FL41	*Value Codes*	*d*	*N*	*9*	*1*
FL42	*Revenue Code*	*1-23*	*N*	*4*	
FL43	*Revenue Code Description*	*1-23*	*AN*	*24*	
FL44	*HCPCS/Rates/HIPPS Rate Codes*	*1-23*	*N*	*14*	
FL45	*Service Date*	*1-23*	*N*	*6*	
FL46	*Units of Service*	*1-23*	*N*	*7*	
FL47	*Total Charges*	*1-23*	*N*	*9*	
FL48	*Non-Covered Charges*	*1-23*	*N*	*9*	

FL49	*Unlabeled*	*1-23*	*AN*	*2*	
FL50	*Payer Identification - Primary*	*A*	*AN*	*23*	
FL50	*Payer Identification - Secondary*	*B*	*AN*	*23*	
FL50	*Payer Identification - Tertiary*	*C*	*AN*	*23*	
FL51	*Health Plan ID*	*A*	*AN*	*15*	
FL51	*Health Plan ID*	*B*	*AN*	*15*	
FL51	*Health Plan ID*	*C*	*AN*	*15*	
FL52	*Release of Information - Primary*	*A*	*AN*	*1*	*1*
FL52	*Release of Information - Secondary*	*B*	*AN*	*1*	*1*
FL52	*Release of Information - Tertiary*	*C*	*AN*	*1*	*1*

FL53	*Assignment of Benefits - Primary*	*A*	*AN*	*1*	*1*
FL53	*Assignment of Benefits - Secondary*	*B*	*AN*	*1*	*1*
FL53	*Assignment of Benefits - Tertiary*	*C*	*AN*	*1*	*1*
FL54	*Prior Payments - Primary*	*A*	*N*	*10*	*1*
FL54	*Prior Payments - Secondary*	*B*	*N*	*10*	*1*
FL54	*Prior Payments - Tertiary*	*C*	*N*	*10*	*1*
FL55	*Estimated Amount Due - Primary*	*A*	*N*	*10*	*1*
FL55	*Estimated Amount Due - Secondary*	*B*	*N*	*10*	*1*
FL55	*Estimated Amount Due - Tertiary*	*C*	*N*	*10*	*1*
FL56	*NPI*	*1*	*AN*	*15*	
FL57	*Other Provider ID*	*A*	*AN*	*15*	
FL57	*Other Provider ID*	*B*	*AN*	*15*	
FL57	*Other Provider ID*	*C*	*AN*	*15*	
FL58	*Insured's Name - Primary*	*A*	*AN*	*25*	*1*
FL58	*Insured's Name - Secondary*	*B*	*AN*	*25*	*1*
FL58	*Insured's Name -Tertiary*	*C*	*AN*	*25*	*1*
FL59	*Patient's Relationship - Primary*	*A*	*AN*	*2*	*1*
FL59	*Patient's Relationship - Secondary*	*B*	*AN*	*2*	*1*
FL59	*Patient's Relationship - Tertiary*	*C*	*AN*	*2*	*1*
FL60	*Insured's Unique ID - Primary*	*A*	*AN*	*20*	

FL60	*Insured's Unique ID - Secondary*	*B*	*AN*	*20*	
FL60	*Insured's Unique ID - Tertiary*	*C*	*AN*	*20*	
FL61	*Insurance Group Name - Primary*	*A*	*AN*	*14*	*1*
FL61	*Insurance Group Name - Secondary*	*B*	*AN*	*14*	*1*
FL61	*Insurance Group Name -Tertiary*	*C*	*AN*	*14*	*1*
FL62	*Insurance Group No. - Primary*	*A*	*AN*	*17*	*1*
FL62	*Insurance Group No. - Secondary*	*B*	*AN*	*17*	*1*
FL62	*Insurance Group No. - Tertiary*	*C*	*AN*	*17*	*1*

FL63	*Treatment Authorization Codes - Primary*	*A*	*AN*	*30*	*1*
FL63	*Treatment Authorization Code - Secondary*	*B*	*AN*	*30*	*1*
FL63	*Treatment Authorization Code - Tertiary*	*C*	*AN*	*30*	*1*
FL64	*Document Control Number*	*A*	*AN*	*26*	
FL64	*Document Control Number*	*B*	*AN*	*26*	
FL64	*Document Control Number*	*C*	*AN*	*26*	
FL65	*Employer Name - Primary*	*A*	*AN*	*25*	
FL65	*Employer Name - Secondary*	*B*	*AN*	*25*	
FL65	*Employer Name - Tertiary*	*C*	*AN*	*25*	
FL66	*DX Version Qualifier*		*AN*	*1*	
FL67	*Principal Diagnosis Code*		*AN*	*8*	
FL67A	*Other Diagnosis*		*AN*	*8*	
FL67B	*Other Diagnosis*		*AN*	*8*	
FL67C	*Other Diagnosis*		*AN*	*8*	
FL67D	*Other Diagnosis*		*AN*	*8*	
FL67E	*Other Diagnosis*		*AN*	*8*	
FL67F	*Other Diagnosis*		*AN*	*8*	
FL67G	*Other Diagnosis*		*AN*	*8*	
FL67H	*Other Diagnosis*		*AN*	*8*	
FL67I	*Other Diagnosis*		*AN*	*8*	
FL67J	*Other Diagnosis*		*AN*	*8*	
FL67K	*Other Diagnosis*		*AN*	*8*	
FL67L	*Other Diagnosis*		*AN*	*8*	
FL67M	*Other Diagnosis*		*AN*	*8*	
FL67N	*Other Diagnosis*		*AN*	*8*	

FL67O	*Other Diagnosis*		*AN*	*8*	
FL67P	*Other Diagnosis*		*AN*	*8*	
FL67Q	*Other Diagnosis*		*AN*	*8*	
FL68	*Unlabeled*	*1*	*AN*	*8*	
FL68	*Unlabeled*	*2*	*AN*	*9*	

FL69	*Admitting Diagnosis Code*		*AN*	*7*	
FL70a	*Patient Reason for Visit Code*		*AN*	*7*	
FL70b	*Patient Reason for Visit Code*		*AN*	*7*	
FL70c	*Patient Reason for Visit Code*		*AN*	*7*	
FL71	*PPS Code*		*AN*	*3*	*2*
FL72a	*External Cause of Injury Code*		*AN*	*8*	
FL72b	*External Cause of Injury Code*		*AN*	*8*	
FL72c	*External Cause of Injury Code*		*AN*	*8*	
FL73	*Unlabeled*		*AN*	*9*	
FL74	*Principal Procedure Code/Date*		*N/N*	*7/6*	*1/1*
FL74a	*Other Procedure Code/Date*		*N/N*	*7/6*	*1/1*
FL74b	*Other Procedure Code/Date*		*N/N*	*7/6*	*1/1*
FL74c	*Other Procedure Code/Date*		*N/N*	*7/6*	*1/1*
FL74d	*Other Procedure Code/Date*		*N/N*	*7/6*	*1/1*
FL74e	*Other Procedure Code/Date*		*N/N*	*7/6*	*1/1*
FL75	*Unlabeled*	*1*	*AN*	*3*	*1*
FL75	*Unlabeled*	*2*	*AN*	*4*	*1*
FL75	*Unlabeled*	*3*	*AN*	*4*	*1*
FL75	*Unlabeled*	*4*	*AN*	*4*	*1*
FL76	*Attending - NPI/QUAL/ID*	*1*	*AN*	*11/2/9*	
FL76	*Attending – Last/First*	*2*	*AN*	*16/12*	
FL77	*Operating - NPI/QUAL/ID*	*1*	*AN*	*11/2/9*	
FL77	*Operating - Last/First*	*2*	*AN*	*16/12*	
FL78	*Other - QUAL/NPI/QUAL/ID*	*1*	*AN*	*2/11/2/9*	

FL78	*Other - Last/First*	*2*	*AN*	*16/12*	

FL79	*Other - QUAL/NPI/QUAL/ID*	*1*	*AN*	*2/11/2/9*	
FL79	*Other - Last/First*	*2*	*AN*	*16/12*	
FL80	*Remarks*	*1*	*AN*	*21*	
FL80	*Remarks*	*2*	*AN*	*26*	
FL80	*Remarks*	*3*	*AN*	*26*	
FL80	*Remarks*	*4*	*AN*	*26*	
FL81	*Code-Code - QUAL/CODE/VALUE*	*a*	*AN/AN/AN*	*2/10/12*	
FL81	*Code-Code - QUAL/CODE/VALUE*	*b*	*AN/AN/AN*	*2/10/12*	
FL81	*Code-Code - QUAL/CODE/VALUE*	*c*	*AN/AN/AN*	*2/10/12*	
FL81	*Code-Code - QUAL/CODE/VALUE*	*d*	*AN/AN/AN*	*2/10/12*	

75.1 - Form Locators 1-15

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

Form Locator (FL) 1 - (Untitled) Provider Name, Address, and Telephone Number
Required*. The minimum entry is the provider name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.*

FL 2 – Pay-to Name, address, and Secondary Identification Fields
Situational. *Required when the pay-to name and address information is different than the Billing Provider information in FL1. If used, the minimum entry is the provider name, address, city, State, and ZIP code.*

FL 3a - Patient Control Number
Required*. The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.*

FL 3b – Medical/Health Record Number
Situational*. The number assigned to the patient's medical/health record by the provider (not FL3a).*

FL 4 - Type of Bill
Required*. This four-digit alphanumeric code gives three specific pieces of information after a leading zero.* ***CMS will ignore the leading zero. CMS will continue to process three specific pieces of information.*** *The second digit identifies the type of facility. The*

third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure

2nd Digit-Type of Facility (CMS will process this as the 1st digit)

1. *Hospital*
2. *Skilled Nursing*
3. *Home Health (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)*
4. *Religious Nonmedical (Hospital)*
5. *Reserved for national assignment (discontinued effective 10/1/05).*
6. *Intermediate Care*
7. *Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).*
8. *Special facility or hospital ASC surgery (requires special information in second digit below).*
9. *Reserved for National Assignment*

3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)

1. *Inpatient (Part A)*
2. *Inpatient (Part B) - (For HHA non PPS claims, Includes HHA visits under a Part B plan of treatment, for HHA PPS claims, indicates a Request for Anticipated Payment - RAP.) Note: For HHA PPS claims, CMS determines from which Trust Fund payment is made. Therefore, there is no need to indicate Part A or Part B on the bill.*
3. *Outpatient (For non-PPS HHAs, includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment). For home health agencies paid under PPS, CMS determines from which Trust Fund, Part A or Part B. Therefore, there is no need to indicate Part A or Part B on the bill.*
4. *Other (Part B) - Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim.* ***NOTE: 24X is discontinued effective 10/1/05.***
5. *Intermediate Care - Level I*
6. *Intermediate Care - Level II*
7. *Reserved for national assignment (discontinued effective 10/1/05).*
8. *Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).*
9. *Reserved for National Assignment*

3rd Digit-Classification (Clinics Only) (CMS will process this as the 2nd digit)

1. *Rural Health Clinic (RHC)*
2. *Hospital Based or Independent Renal Dialysis Facility*
3. *Free Standing Provider-Based Federally Qualified Health Center (FQHC)*
4. *Other Rehabilitation Facility (ORF)*
5. *Comprehensive Outpatient Rehabilitation Facility (CORF)*
6. *Community Mental Health Center (CMHC)*

7-8. Reserved for National Assignment
9. OTHER

3rd Digit-Classification (Special Facilities Only) (CMS will process this as the 2nd digit)

1. Hospice (Nonhospital Based)
2. Hospice (Hospital Based)
3. Ambulatory Surgical Center Services to Hospital Outpatients
4. Free Standing Birthing Center
5. Critical Access Hospital
6-8. Reserved for National Assignment
9. OTHER

4th Digit-Frequency – Definition (CMS will process this as the 3rd digit)

A	*Admission/Election Notice*	*Used when the hospice or Religious Non-medical Health Care Institution is submitting Form CMS-1450 as an Admission Notice.*
B	*Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation Notice*	*Used when the Form CMS-1450 is used as a notice of termination/revocation for a previously posted Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.*
C	*Hospice Change of Provider Notice*	*Used when Form CMS-1450 is used as a Notice of Change to the hospice provider.*
D	*Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel*	*Used when Form CMS-1450 is used as a Notice of a Void/Cancel of Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.*
E	*Hospice Change of Ownership*	*Used when Form CMS-1450 is used as a Notice of Change in Ownership for the hospice.*
F	*Beneficiary Initiated Adjustment Claim*	*Used to identify adjustments initiated by the beneficiary. For FI use only.*
G	*CWF Initiated Adjustment Claim*	*Used to identify adjustments initiated by CWF. For FI use only.*
H	*CMS Initiated Adjustment Claim*	*Used to identify adjustments initiated by CMS. For FI use only.*
I	*FI Adjustment Claim (Other than QIO or Provider*	*Used to identify adjustments initiated by the FI. For FI use only*
J	*Initiated Adjustment Claim-Other*	*Used to identify adjustments initiated by other entities. For FI use only.*
K	*OIG Initiated Adjustment Claim*	*Used to identify adjustments initiated by OIG. For FI use only.*
M	*MSP Initiated Adjustment Claim*	*Used to identify adjustments initiated by MSP. For FI use only. Note: MSP takes precedence over other adjustment sources.*

P	*QIO Adjustment Claim*	*Used to identify an adjustment initiated as a result of a QIO review. For FI use only.*
0	*Nonpayment/Zero Claims*	*Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care.*
1	*Admit Through Discharge Claim*	*The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.*
2	*Interim-First Claim*	*Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. For HHAs, used for the submission of original or replacement RAPs.*
3	*Interim-Continuing Claims (Not valid for PPS Bills)*	*Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.*
4	*Interim-Last Claim (Not valid for PPS Bills)*	*This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL 6) is the discharge for this treatment.*
5	*Late Charge Only*	*Used for outpatient claims only. Late charges are not accepted for Medicare inpatient, home health, or Ambulatory Surgical Center (ASC) claims.*
7	*Replacement of Prior Claim*	*This is used to correct a previously submitted bill. The provider applies this code to the corrected or "new" bill.*
8	*Void/Cancel of a Prior Claim*	*The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.*
9	*Final Claim for a Home Health PPS Episode*	*This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.*

Bill Type Codes

The following table lists "Type of Bill," FL4, codes by Provider Number Range(s). For a definition of each facility type, see the Medicare State Operations Manual.

Bill Type Code

011X	*Hospital Inpatient (Part A)*
012X	*Hospital Inpatient Part B*
013X	*Hospital Outpatient*
014X	*Hospital Other Part B*
018X	*Hospital Swing Bed*
021X	*SNF Inpatient*
022X	*SNF Inpatient Part B*
023X	*SNF Outpatient*
028X	*SNF Swing Bed*
032X	*Home Health*
033X	*Home Health*
034X	*Home Health (Part B Only)*
041X	*Religious Nonmedical Health Care Institutions*
071X	*Clinical Rural Health*
072X	*Clinic ESRD*
073X	*Federally Qualified Health Centers*
074X	*Clinic OPT*
075X	*Clinic CORF*
076X	*Community Mental Health Centers*
081X	*Nonhospital based hospice*
082X	*Hospital based hospice*
083X	*Hospital Outpatient (ASC)*
085X	*Critical Access Hospital*

FL 5 - Federal Tax Number
Required. *The format is NN-NNNNNNN.*

FL 6 - Statement Covers Period (From-Through)
Required*. The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY). Days before the patient's entitlement are not shown. With the exception of home health PPS claims, the period may not span two accounting years. The FI uses the "From" date to determine timely filing.*

FL 7
Not Used.

FL 8 - Patient's Name
Required*. The provider enters the patient's last name, first name, and, if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).*

FL 9 - Patient's Address
Required. *The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.*

FL 10 - Patient's Birth Date
Required. *The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.*

FL 11 - Patient's Sex
Required. *The provider enters an "M" (male) or an "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.*

FL 12 - Admission Date
Required For Inpatient and Home Health. *The hospital enters the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.*

FL 13 - Admission Hour
Not Required. *If submitted, the data will be ignored.*

FL 14 - Type of Admission/Visit
Required on inpatient bills only. *This is the code indicating priority of this admission.*
Code Structure:

- *1 Emergency - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.*
- *2 Urgent- The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.*
- *3 Elective - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.*
- *4 Newborn - Use of this code necessitates the use of a Special Source of Admission codes.*
- *5 Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.*
- *6-8 Reserved for National Assignment*
- *9 Information Not Available – Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.*

FL 15 – Source of Admission
Required. *The provider enters the code indicating the source of the referral for this admission or visit.*
Code Structure:
1 Physician Referral ***Inpatient****: The patient was admitted to this facility upon*

		the recommendation of their personal physician. ***Outpatient****: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral).*
2	*Clinic Referral*	***Inpatient****: The patient was admitted to this facility upon the recommendation of this facility's clinic physician.* ***Outpatient****: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.*
3	*Managed Care Plan Referral*	***Inpatient****: The patient was admitted to this facility upon the recommendation of a Managed Care Plan physician.* ***Outpatient****: The patient was referred to this facility for outpatient or referenced diagnostic services by a Managed Care Plan physician.*
4	*Transfer from a Hospital (different facility *)*	***Inpatient****: The patient was admitted to this facility as a transfer from a different acute care facility where they were an inpatient* ***Outpatient****: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility.* ** For transfers from hospital inpatient in the same facility, see code D.*
5	*Transfer from a SNF*	***Inpatient****: The patient was admitted to this facility as a transfer from a SNF where he or she was an inpatient.* ***Outpatient****: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she was an inpatient.*
6	*Transfer from Another Health Care Facility*	***Inpatient****: The patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a non-skilled level of care.* ***Outpatient****: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where they are an inpatient.*
7	*Emergency Room*	***Inpatient****: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.* ***Outpatient****: The patient received services in this facility's emergency department.*
8	*Court/Law Enforcement*	***Inpatient****: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.*

		***Outpatient**: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.*
9	*Information Not Available*	***Inpatient**: The means by which the patient was admitted to this facility is not known.* ***Outpatient**: For Medicare outpatient bills, this is not a valid code.*
A	*Transfer from a Critical Access Hospital (CAH)*	***Inpatient**: The patient was admitted to this facility as a transfer from a CAH where he or she was an inpatient.* ***Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient was an inpatient.*
B	*Transfer From Another Home Health Agency*	*The patient was admitted to this home health agency as a transfer from another home health agency*
C	*Readmission to Same Home Health Agency*	*The patient was readmitted to this home health agency within the same home health episode period.*
D	*Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer*	*The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.*
E-Z		*Reserved for national assignment.*

75.2 - Form Locators 16-30

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

FL 16 – Discharge Hour
***Not Required**.*

FL 17 – Patient Status
***Required**. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's status as of the "Through" date of the billing period (FL 6).*

Code	***Structure***
01	*Discharged to home or self care (routine discharge)*
02	*Discharged/transferred to a short-term general hospital for inpatient care.*
03	*Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.*
04	*Discharged/transferred to an Intermediate Care Facility (ICF)*
05	*Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05).*

Code	***Structure***
	Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions.
06	*Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).*
07	*Left against medical advice or discontinued care*
08	*Reserved for National Assignment*
**09*	*Admitted as an inpatient to this hospital*
10-19	*Reserved for National Assignment*
20	*Expired (or did not recover - Religious Non Medical Health Care Patient)*
21-29	*Reserved for National Assignment*
30	*Still patient or expected to return for outpatient services*
31-39	*Reserved for National Assignment*
40	*Expired at home (Hospice claims only)*
41	*Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)*
42	*Expired - place unknown (Hospice claims only)*
43	*Discharged/transferred to a federal health care facility. (effective 10/1/03)*
	<u>Usage note:</u> Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration (VA) hospital or VA hospital or a VA nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
44-49	*Reserved for national assignment*
50	*Discharged/transferred to Hospice - home*
51	*Discharged/transferred to Hospice - medical facility*
52-60	*Reserved for national assignment*
61	*Discharged/transferred within this institution to a hospital based Medicare approved swing bed.*
62	*Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital*
63	*Discharged/transferred to long term care hospitals*
64	*Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare*
65	*Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.*
66	*Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)*
67-99	*Reserved for national assignment*

**In situations where a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.*

FLs 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28 - Condition Codes

Situational. *The provider enters the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period.*

Code	***Title***	***Definition***
02	*Condition is Employment Related*	*Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment.*
03	*Patient Covered by Insurance Not Reflected Here*	*Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.*
04	*Information Only Bill*	*Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan and the hospital expects to receive payment from the plan.*
05	*Lien Has Been Filed*	*The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.*
06	*ESRD Patient in the First 18 Months of Entitlement Covered By Employer Group Health Insurance*	*Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 18 months of end stage renal disease entitlement.*
07	*Treatment of Non-terminal Condition for Hospice Patient*	*The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.*
08	*Beneficiary Would Not Provide Information Concerning Other Insurance Coverage*	*The beneficiary would not provide information concerning other insurance coverage. The FI develops to determine proper payment.*
09	*Neither Patient Nor Spouse is Employed*	*In response to development questions, the patient and spouse have denied employment.*
10	*Patient and/or Spouse is Employed but no EGHP Coverage Exists*	*In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient.*
11	*Disabled Beneficiary But no Large Group Health Plan (LGHP)*	*In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but*

Code	*Title*	*Definition*
		have no group coverage from an LGHP.
12-14	*Payer Codes*	*Codes reserved for internal use only by third party payers. The CMS will assign as needed for FI use. Providers will not report.*
15	*Clean Claim Delayed in CMS's Processing System (Medicare Payer Only Code)*	*The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to CPE/CPT standards.*
16	*SNF Transition Exemption (Medicare Payer Only Code)*	*An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.*
17	*Patient is Homeless*	*The patient is homeless.*
18	*Maiden Name Retained*	*A dependent spouse entitled to benefits who does not use her husband's last name.*
19	*Child Retains Mother's Name*	*A patient who is a dependent child entitled to benefits that does not have his/her father's last name.*
20	*Beneficiary Requested Billing*	*Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)*
21	*Billing for Denial Notice*	*The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.*
26	*VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility*	*Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.*
27	*Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test*	*(Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.*
28	*Patient and/or Spouse's EGHP is Secondary to Medicare*	*In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is*

Code	*Title*	*Definition*
		a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	*Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare*	*In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part time employees; or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.*
30	*Qualifying Clinical Trials*	*Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.*
31	*Patient is a Student (Full-Time - Day)*	*Patient declares that they are enrolled as a full-time day student.*
32	*Patient is a Student (Cooperative/Work Study Program)*	*Patient declares that they are enrolled in a cooperative/work study program.*
33	*Patient is a Student (Full-Time - Night)*	*Patient declares that they are enrolled as a full-time night student.*
34	*Patient is a Student (Part-Time)*	*Patient declares that they are enrolled as a part-time student.*
Accommodations		
35	*Reserved for National Assignment*	*Reserved for National Assignment.*
36	*General Care Patient in a Special Unit*	*(Not used by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available.* *Accommodation charges for this period are at the prevalent semi-private rate.*
37	*Ward Accommodation at Patient's Request*	*(Not used by hospitals under PPS.) The patient was assigned to ward accommodations at their own request.*
38	*Semi-private Room Not Available*	*(Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private*

Code	*Title*	*Definition*
		accommodations were not available.
NOTE: *If revenue charge codes indicate a ward accommodation was assigned and neither code 37 nor code 38 applies, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, Medicare pays semi-private costs.*		
39	*Private Room Medically Necessary*	*(Not used by hospitals under PPS.) The patient needed a private room for medical reasons.*
40	*Same Day Transfer*	*The patient was transferred to another participating Medicare provider before midnight on the day of admission.*
41	*Partial Hospitalization*	*The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).*
42	*Continuing Care Not Related to Inpatient Admission*	*Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.*
43	*Continuing Care Not Provided Within Prescribed Post Discharge Window*	*Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.*
44	*Inpatient Admission Changed to Outpatient*	*For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. (Note: For Medicare, the change in patient status from inpatient to outpatient is made prior to discharge or release while the patient is still a patient of the hospital).*
45		*Reserved for national assignment*
46	*Non-Availability Statement on File*	*A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.*
47		*Reserved for TRICARE*
48	*Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)*	*Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.*
49	*Product replacement within*	*Replacement of a product earlier than the*

Code	Title	Definition
	product lifecycle	anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product replacement for known recall of a product	Manufacturer or FDA has identified the product for recall and therefore replacement.
51-54		Reserved for national assignment
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	The patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Managed Care Organization Enrollee	Code indicates that patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
59	Non-primary ESRD Facility	Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. Effective 10/01/04
60	Operating Cost Day Outlier	Day Outlier obsolete after FY 1997. (Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. The FI indicates the cost outlier portion paid value code 17.
61	Operating Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI indicates the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Bill was paid under PIP. The FI records this from its system.
63	Payer Only Code	Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment
64	Other Than Clean Claim	(Not reported by providers.) The claim is

Code	Title	Definition
		not "clean." The FI records this from its system.
65	Non-PPS Bill	(Not reported by providers.) Bill is not a PPS bill. The FI records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Cost Outlier Payment	The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	The beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	The beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/DGME/N&A Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health.
70	Self-Administered Anemia Management Drug	Code indicates the billing is for a home dialysis patient who self administers an anemia management drug such as erythropoetin alpha (EPO) or darbepoetin alpha.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis services at home.
75	Home 100-percent	Not used for Medicare.
76	Back-up In-Facility Dialysis	The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by Managed	The bill is for a newly covered service under Medicare for which a managed care plan

Code	*Title*	*Definition*
	Care Plan	*does not pay. (For outpatient bills, condition code 04 should be omitted.)*
79	*CORF Services Provided Off-Site*	*Physical therapy, occupational therapy, or speech pathology services were provided off-site.*
80	*Home Dialysis-Nursing Facility*	*Home dialysis furnished in a SNF or Nursing Facility.*
81-99		*Reserved for National assignment.*

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

A0	*TRICARE External Partnership Program*	*Not used for Medicare.*
A3	*Special Federal Funding*	*This code is for uniform use by State uniform billing committees.*
A5	*Disability*	*This code is for uniform use by State uniform billing committees.*
A6	*PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment*	*Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services.*
A7-A8		*Reserved for national assignment*
A9	*Second Opinion Surgery*	*Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.*
AA	*Abortion Performed due to Rape*	*Self-explanatory – Effective 10/1/02*
AB	*Abortion Performed due to Incest*	*Self-explanatory – Effective 10/1/02*
AC	*Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality*	*Self-explanatory – Effective 10/1/02*
AD	*Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself*	*Self-explanatory – Effective 10/1/02*
AE	*Abortion Performed due to Physical Health of Mother that is not Life Endangering*	*Self-explanatory – Effective 10/1/02*
AF	*Abortion Performed due to Emotional/psychological Health of the Mother*	*Self-explanatory – Effective 10/1/02*
AG	*Abortion Performed due to Social Economic Reasons*	*Self-explanatory – Effective 10/1/02*

Code	Title	Definition
AH	Elective Abortion	Self-explanatory – Effective 10/1/02
AI	Sterilization	Self-explanatory – Effective 10/1/02
AJ	Payer Responsible for Copayment	Self-explanatory – Effective 4/1/03
AK	Air Ambulance Required	For ambulance claims. Air ambulance required – time needed to transport poses a threat – Effective 10/16/03
AL	Specialized Treatment/bed Unavailable	For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate facility. – Effective 10/16/03
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective 10/16/03
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening. Effective 1/1/04
AO-AZ		Reserved for national assignment
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.
B1	Beneficiary is Ineligible for Demonstration Program	Full definition pending
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the Ambulance Fee Schedule
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable Law. – Effective 10/16/03
B4	Admission Unrelated to Discharge	Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004. Effective January 1, 2005
B5-BZ		Reserved for national assignment
QIO Approval Indicator Codes		
C1	Approved as Billed	Claim has been reviewed by the QIO and has been fully approved including any outlier.
C3	Partial Approval	The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	The patient's need for inpatient services was

Code	Title	Definition
		reviewed and the QIO found that none of the stay was medically necessary.
C5	Post-payment Review Applicable	Any medical review will be completed after the claim is paid.
C6	Preadmission/Pre-procedure	The QIO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
C8-CZ		Reserved for national assignment
Claim Change Reasons		
D0	Changes to Service Dates	Self-explanatory
D1	Changes to Charges	Self-explanatory
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Changes In ICD-9-CM Diagnosis and/or Procedure Code	Use for inpatient acute care hospital, long-term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF).
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory
DA – DQ		Reserved for national assignment
DR	Disaster related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
DS – DZ		Reserved for national assignment
E0	Change in Patient Status	Self-explanatory
E1 –		Reserved for national assignment

Code	***Title***	***Definition***
FZ		
G0	*Distinct Medical Visit*	*Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.*
G1 – GZ		*Reserved for national assignment*
H0	*Delayed Filing, Statement Of Intent Submitted*	*Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.*
H1-LZ		*Reserved for national assignment*
M0	*All Inclusive Rate for Outpatient Services (Payer Only Code)*	*Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient.*
M1-MZ		*Reserved for national assignment*
N0-OZ		*Reserved for national assignment*
P0-PZ		*Reserved for national assignment. FOR PUBLIC HEALTH DATA REPORTING ONLY*
Q0-VZ		*Reserved for national assignment.*
W0	*United Mine Workers of America (UMWA) Demonstration Indicator*	*United Mine Workers of America (UMWA) Demonstration Indicator ONLY*
W1-ZZ		*Reserved for national assignment.*

FL 29 – Accident State
Not used. *Data entered will be ignored.*

FL 30 - (Untitled)
Not used. *Data entered will be ignored.*

75.3 - Form Locators 31-41

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

FLs 31, 32, 33, and 34 - Occurrence Codes and Dates

Situational. *Required when there is a condition code that applies to this claim.*

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

Due to the varied nature of Occurrence and Occurrence Span Codes, provisions have been made to allow the use of both type codes within each. The Occurrence Span Code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as 10 Occurrence Codes to be utilized. With respect to Occurrence Codes, complete field 31a - 34a (line level) before the "b" fields. Occurrence and Occurrence Span codes are mutually exclusive. An example of Occurrence Code use: A Medicare beneficiary was confined in hospital from January 1, 2005 to January 10, 2005, however, his Medicare Part A benefits were exhausted as of January 8, 2005, and he was not entitled to Part B benefits. Therefore, Form Locator 31 should contain code A3 and the date 010805.

The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved. Occurrence and occurrence span codes are mutually exclusive. When FLs 36 A and B are fully used with occurrence span codes, FLs 34a and 34b and 35a and 35b may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field. Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

Code Structure (Only codes affecting Medicare payment/processing are shown.)

Code	***Title***	***Definition***
01	*Accident/Medical Coverage*	*Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury*
02	*No-Fault Insurance Involved - Including Auto Accident/Other*	*Date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).*
03	*Accident/Tort Liability*	*Date of an accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.*
04	*Accident/Employment Related*	*Date of an accident that relates to the patient's employment.*

Code	*Title*	*Definition*
05	*Accident/No Medical or Liability Coverage*	*Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.*
06	*Crime Victim*	*Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.*
07-08		*Reserved for national assignment.*
09	*Start of Infertility Treatment Cycle*	*Code indicating the date of start of infertility treatment cycle.*
10	*Last Menstrual Period*	*Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.*
11	*Onset of Symptoms/Illness*	*(Outpatient claims only.) Date that the patient first became aware of symptoms/illness.*
12	*Date of Onset for a Chronically Dependent Individual (CDI)*	*(HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.*
13-15		*Reserved for national assignment*
16	*Date of Last Therapy*	*Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).*
17	*Date Outpatient Occupational Therapy Plan Established or Reviewed*	*The date the occupational therapy plan was established or last reviewed.*
18	*Date of Retirement Patient/Beneficiary*	*Date of retirement for the patient/beneficiary.*
19	*Date of Retirement Spouse*	*Date of retirement for the patient's spouse.*
20	*Guarantee of Payment Began*	*(Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision.*
21	*UR Notice Received*	*(Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary.*
22	*Date Active Care Ended*	*Date on which a covered level of care ended in a SNF or general hospital, or date on*

Code	*Title*	*Definition*
		which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	*Date of Cancellation of Hospice Election Period. For FI Use Only. Providers Do Not Report.*	*Code is not required if code "21" is used.*
24	*Date Insurance Denied*	*Date of receipt of a denial of coverage by a higher priority payer.*
25	*Date Benefits Terminated by Primary Payer*	*The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.*
26	*Date SNF Bed Available*	*The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.*
27	*Date of Hospice Certification or Re-Certification*	*The date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.*
28	*Date CORF Plan Established or Last Reviewed*	*The date a plan of treatment was established or last reviewed for CORF care.*
29	*Date OPT Plan Established or Last Reviewed*	*The date a plan was established or last reviewed for OPT.*
30	*Date Outpatient Speech Pathology Plan Established or Last Reviewed*	*The date a plan was established or last reviewed for outpatient speech pathology.*
31	*Date Beneficiary Notified of Intent to Bill (Accommodations)*	*The date the hospital notified the beneficiary that the beneficiary does not (or no longer) requires inpatient care and that coverage has ended.*
32	*Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)*	*The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be reasonable or necessary under Medicare.*
33	*First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP*	*The first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.*
34	*Date of Election of Extended Care Services*	*The date the guest elected to receive extended care services (used by Religious Nonmedical*

Code	***Title***	***Definition***
		Health Care Institutions only).
35	*Date Treatment Started for Physical Therapy*	*The date the provider initiated services for physical therapy.*
36	*Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)*	*The date of discharge for a hospital stay in which the patient received a covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs.* ***NOTE:*** *When the patient received a covered and a non-covered transplant, the covered transplant predominates.*
37	*Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant*	*The date of discharge for an inpatient hospital stay during which the patient received a non-covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs.*
38	*Date treatment started for Home IV Therapy*	*Date the patient was first treated at home for IV therapy (Home IV providers - bill type 85X).*
39	*Date discharged on a continuous course of IV therapy*	*Date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers- bill type 85X).*
40	*Scheduled Date of Admission*	*The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)*
41	*Date of First Test for Pre-admission Testing*	*The date on which the first outpatient diagnostic test was performed as a part of a PAT program. This code may be used only if a date of admission was scheduled prior to the administration of the test(s).*
42	*Date of Discharge*	*(Hospice claims only.) The date on which a beneficiary terminated their election to receive hospice benefits from the facility rendering the bill. The frequency digit should be 1 or 4.*
43	*Scheduled Date of Cancelled Surgery*	*The date for which outpatient surgery was scheduled.*
44	*Date Treatment Started for Occupational Therapy*	*The date the provider initiated services for occupational therapy.*
45	*Date Treatment Started for Speech Therapy*	*The date the provider initiated services for speech therapy.*
46	*Date Treatment Started for Cardiac Rehabilitation*	*The date the provider initiated services for cardiac rehabilitation.*

Code	***Title***	***Definition***
47	*Date Cost Outlier Status Begins*	*Code indicates that this is the first day the inpatient cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments.*
48-49	*Payer Codes*	*For use by third party payers only. The CMS assigns for FI use. Providers do not report these codes.*
50-69		*Reserved for State Assignment. Discontinued Effective October 16, 2003.*
A1	*Birth Date-Insured A*	*The birth-date of the insured in whose name the insurance is carried.*
A2	*Effective Date-Insured A Policy*	*The first date the insurance is in force.*
A3	*Benefits Exhausted*	*The last date for which benefits are available and after which no payment can be made by payer A.*
A4	*Split Bill Date*	*Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as "Split Bill Date"). Effective 10/1/03.*
A5-AZ		*Reserved for national assignment*
B1	*Birth Date-Insured B*	*The birth-date of the individual in whose name the insurance is carried.*
B2	*Effective Date-Insured B Policy*	*The first date the insurance is in force.*
B3	*Benefits Exhausted*	*The last date for which benefits are available and after which no payment can be made by payer B.*
B4-BZ		*Reserved for national assignment*
C1	*Birth Date-Insured C*	*The birth-date of the individual in whose name the insurance is carried.*
C2	*Effective Date-Insured C Policy*	*The first date the insurance is in force.*
C3	*Benefits Exhausted*	*The last date for which benefits are available and after which no payment can be made by payer C.*
C4-CZ		*Reserved for National Assignment.*
D0-DQ		*Reserved for National Assignment.*
DR		*Reserved for Disaster Related Code*
DS-DZ		*Reserved for National Assignment*
E0		*Reserved for National Assignment*

Code	Title	Definition
E1	Birth Date-Insured D	Discontinued 3/1/07.
E2	Effective Date-Insured D Policy	Discontinued 3/1/07.
E3	Benefits Exhausted	Discontinued 3/1/07.
E4-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Birth Date-Insured E	Discontinued 3/1/07.
F2	Effective Date-Insured E Policy	Discontinued 3/1/07.
F3	Benefits Exhausted	Discontinued 3/1/07.
F4-FZ		Reserved for national assignment
G0		Reserved for national assignment
G1	Birth Date-Insured F	Discontinued 3/1/07.
G2	Effective Date-Insured F Policy	Discontinued 3/1/07.
G3	Benefits Exhausted	Discontinued 3/1/07.
G4-LZ		Reserved for national assignment
M0-MQ		See instructions in FLs 35 and 36 – Occurrence Span Codes and Dates
MR		Reserved for Disaster Related Code
MS-ZZ		Reserved for national assignment

FLs 35 and 36 - Occurrence Span Code and Dates

Required For Inpatient.

The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

Code Structure

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Non-utilization Dates (For Payer Use on Hospital Bills Only)	The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates	(Part A claims only.) The From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6,

Code	Title	Definition
		Statement Covers Period.
74	Non-covered Level of Care	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, but not valid for HHA under PPS.
75	SNF Level of Care	The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLs 24-30). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care.
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability- Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL

Code	Title	Definition
		36.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5-ZZ		Reserved for National Assignment

FL 37 - (Untitled)
Not used. *Data entered will be ignored.*

FL 38 - Responsible Party Name and Address
Not Required*. For claims that involve payers of higher priority than Medicare.*

FLs 39, 40, and 41 - Value Codes and Amounts
Required*. Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.*

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second). ***Note that codes 80-83 are only available for use on the UB-04.***

Code	Title	Definition

Code	***Title***	***Definition***
01	*Most Common Semi-Private Rate*	*To provide for the recording of hospital's most common semi-private rate.*
02	*Hospital Has No Semi-Private Rooms*	*Entering this code requires $0.00 amount.*
03		*Reserved for national assignment*
04	*Inpatient Professional Component Charges Which Are Combined Billed*	*The sum of the inpatient professional component charges that are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component.* ***(Used only by some all-inclusive rate hospitals.)***
05	*Professional Component Included in Charges and Also Billed Separately to Carrier*	*(Applies to Part B bills only.) Indicates that the charges shown are included in billed charges FL 47, but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the carrier processes the bill for physician's services. These charges are also deducted when computing interim payment.* *The hospital uses this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.*
06	*Medicare Part A and Part B Blood Deductible*	*The product of the number of un-replaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each un-replaced pint furnished.* *If all deductible pints have been replaced, this code is not to be used.* *When the hospital gives a discount for un-replaced deductible blood, it shows charges after the discount is applied.*
07		*Reserved for National Assignment*
08	*Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period*	*The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year*

Code	Title	Definition
		of admission.
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. The provider may not use this code on Part B bills. For Part B coinsurance use value codes A2, B2 and C2.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. The provider uses this code only on bills spanning 2 calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. The provider uses this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. It may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other

Code	*Title*	*Definition*
		insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim
15	*Worker's Compensation (WC)*	*That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.*
16	*PHS, Other Federal Agency*	*That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges.* ***NOTE:*** *A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).*
17	*Operating Outlier Amount*	*(Not reported by providers.) The FI reports the amount of operating outlier payment made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.*
18	*Operating Disproportionate Share Amount*	*(Not reported by providers.) The FI reports the operating disproportionate share amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital DSH adjustment in this entry.*
19	*Operating Indirect Medical Education Amount*	*(Not reported by providers.) The FI reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment*

Code	*Title*	*Definition*
		in this entry.
20	*Payer Code*	*(For internal use by third party payers only.)*
21	*Catastrophic*	*Medicaid-eligibility requirements to be determined at State level.*
22	*Surplus*	*Medicaid-eligibility requirements to be determined at State level.*
23	*Recurring Monthly Income*	*Medicaid-eligibility requirements to be determined at State level.*
24	*Medicaid Rate Code*	*Medicaid-eligibility requirements to be determined at State level.*
25	*Offset to the Patient-Payment Amount – Prescription Drugs*	*Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
26	*Offset to the Patient-Payment Amount – Hearing and Ear Services*	*Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
27	*Offset to the Patient-Payment Amount – Vision and Eye Services*	*Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
28	*Offset to the Patient-Payment Amount – Dental Services*	*Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
29	*Offset to the Patient-Payment Amount – Chiropractic Services*	*Chiropractic Services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
31	*Patient Liability Amount*	*The FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.*
32	*Multiple Patient Ambulance Transport*	*If more than one patient is transported in a single ambulance trip, report the total number of patients transported.*
33	*Offset to the Patient-Payment Amount – Podiatric Services*	*Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
34	*Offset to the Patient-Payment Amount – Other Medical Services*	*Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*
35	*Offset to the Patient-Payment Amount – Health Insurance Premiums*	*Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).*

Code	*Title*	*Definition*
36		*Reserved for national assignment.*
37	*Pints of Blood Furnished*	*The total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.*
38	*Blood Deductible Pints*	*The number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.*
39	*Pints of Blood Replaced*	*The total number of pints of blood that were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).*
40	*New Coverage Not Implemented by Managed Care Plan*	*(For inpatient service only.) Inpatient charges covered by the Managed Care Plan. (The hospital uses this code when the bill includes inpatient charges for newly covered services that are not paid by the Managed Care Plan. It must also report condition codes 04 and 78.)*
41	*Black Lung (BL)*	*That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.*
42	*Veterans Affairs (VA)*	*That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this*

Code	***Title***	***Definition***
		bill.
43	*Disabled Beneficiary Under Age 65 With LGHP*	*That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.*
44	*Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received*	*That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due.*
45	*Accident Hour*	*The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.*
46	*Number of Grace Days*	*If a code "C3" or "C4" is in FL 24-30, indicating that the QIO has denied all or a portion of this billing period, the provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient's post discharge. The field contains one numeric digit.*
47	*Any Liability Insurance*	*That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer's payment.*
48	*Hemoglobin Reading*	*The latest hemoglobin reading taken during this billing cycle. The provider reports in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, it uses the position to the right of the delimiter for the third digit. Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken* ***before*** *the start of the billing period.*

Code	***Title***	***Definition***
49	*Hematocrit Reading*	*Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit. Effective January 1, 2006 the definition of value code 49 is changed to indicate the patient's most recent hematocrit reading taken* ***before*** *the start of the billing period.*
50	*Physical Therapy Visits*	*The number of physical therapy visits from onset (at the billing provider) through this billing period.*
51	*Occupational Therapy Visits*	*The number of occupational therapy visits from onset (at the billing provider) through this billing period.*
52	*Speech Therapy Visits*	*The number of speech therapy visits from onset (at the billing provider) through this billing period.*
53	*Cardiac Rehabilitation Visits*	*The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.*
54	*Newborn birth weight in grams*	*Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law.*
55	*Eligibility Threshold for Charity Care*	*Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.*
56	*Skilled Nurse – Home Visit Hours (HHA only)*	*The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.)*
57	*Home Health Aide – Home Visit Hours (HHA only)*	*The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (The number is rounded to the nearest whole hour.)*

NOTE: *Codes 50-57 represent the number of visits or hours of service provided. Entries*

Code	Title	Definition

for the number of visits are right justified from the dollars/cents delimiter as follows:

					1	3		

The FI accepts zero or blanks in the cents position, converting blanks to zero for CWF.

58	Arterial Blood Gas (PO2/PA2)	Indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. The provider reports right justified in the cents area. (See note following code 59 for an example.)
59	Oxygen Saturation (02 Sat/Oximetry)	Indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill. The hospital reports right justified in the cents area. (See note following this code for an example.)

NOTE: *Codes 58 and 59 are not money amounts. They represent arterial blood gas or oxygen saturation levels. Round to two decimals or to the nearest whole percent. For example, a reading of 56.5 is shown as:*

						5	7

A reading of 100 percent is shown as:

					1	0	0

Code	Title	Definition
60	HHA Branch MSA	The MSA in which HHA branch is located. (The HHA reports the MSA when its branch location is different than the HHA's main location – It reports the MSA number in dollar portion of the form locator, right justified to the left of the dollar/cents delimiter.)

Code	***Title***	***Definition***
61	*Location Where Service is Furnished (HHA and Hospice)*	*MSA number or Core Based Statistical Area (CBSA) number (or rural State code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.* *For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.*
62	*HH Visits – Part A (Internal Payer Use Only)*	*The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.*
63	*HH Visits – Part B (Internal Payer Use Only)*	*The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.*
64	*HH Reimbursement – Part A (Internal Payer Use Only)*	*The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.*
65	*HH Reimbursement – Part B (Internal Payer Use Only)*	*The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.*
66	*Medicare Spend-down Amount*	*The dollar amount that was used to meet the recipient's spend-down liability for this claim.*
67	*Peritoneal Dialysis*	*The number of hours of peritoneal dialysis provided during the billing period. The provider counts only the hours spent in the home, excluding travel time. It reports in whole hours, right justifying to the left of the dollar/cent delimiter. (Rounded to the nearest whole hour.)*
68	*Number of Units of EPO*	*Indicates the number of units of EPO*

Code	Title	Definition
	Provided During the Billing Period	administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0		

Code	Title	Definition
69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of ESRD Networks	(For third party payer use only.) The FI reports the amount the Medicare payment was reduced to help fund ESRD networks.
72	Flat Rate Surgery Charge	(For third party payer use only.) The standard charge for outpatient surgery where the provider has such a charging structure.
73-74	Payer Codes	(For use by third party payers only.)
75	Gramm/Rudman/Hollings	(For third party payer internal use only.) The contractor reports the amount of sequestration.
76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0

Code	***Title***	***Definition***
77	*Medicare New Technology Add-On Payment*	*Code indicates the amount of Medicare additional payment for new technology.*
78-79	*Payer Codes*	*Codes reserved for internal use only by third party payers. The CMS assigns as needed. Providers do not report payer codes.*
80	*Covered days*	*The number of days covered by the primary payer as qualified by the payer.*
81	*Non-Covered Days*	*Days of care not covered by the primary payer.*
82	*Co-insurance Days*	*The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness.*
83	*Lifetime Reserve Days*	*Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.*
84-99		*Reserved for national assignment.*
A0	*Special Zip Code Reporting*	*Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.*
A1	*Deductible Payer A*	*The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.*
A2	*Coinsurance Payer A*	*The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.*
A3	*Estimated Responsibility Payer A*	*Amount the provider estimates will be paid by the indicated payer.*
A4	*Covered Self-Administrable Drugs - Emergency*	*The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. For use with Revenue Code 0637. See The Medicare Benefit Policy*

Code	Title	Definition
		Manual).
A5	Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05)
A9	Patient Height	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05)
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
AC-B0		Reserved for national assignment.
B1	Deductible Payer B	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.

Code	***Title***	***Definition***
B3	*Estimated Responsibility Payer B*	*Amount the provider estimates will be paid by the indicated payer.*
B4-B6		*Reserved for national assignment*
B7	*Co-payment Payer B*	*The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer.*
B8-B9		*Reserved for national assignment*
BA	*Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer B*	*The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03*
BB	*Other Assessments or Allowances (e.g., Medical Education) Payer B*	*The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated*
BC-C0		*Reserved for national assignment*
C1	*Deductible Payer C*	*The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. (**Note:** Medicare blood deductibles should be reported under Value Code 6.)*
C2	*Coinsurance Payer C*	*The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.*
C3	*Estimated Responsibility Payer C*	*Amount the provider estimates will be paid by the indicated payer.*
C4-C6		*Reserved for national assignment*
C7	*Co-payment Payer C*	*The amount the provider assumes is applied to the patient's co-payment amount involving the indicated payer.*
C8-C9		*Reserved for national assignment*
CA	*Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer C*	*The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03*
CB	*Other Assessments or Allowances (e.g., Medical Education) Payer C*	*The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003*
CC-CZ		*Reserved for national assignment*
D0-D2		*Reserved for national assignment*
D3		*Reserved for national assignment (effective 3/1/07)*
D4-DQ		*Reserved for national assignment*

Code	*Title*	*Definition*
DR		*Reserved for disaster related code*
DS-DZ		*Reserved for national assignment*
E0		*Reserved for national assignment*
E1	*Deductible Payer D*	*Reserved for national assignment (effective 3/1/07)*
E2	*Coinsurance Payer D*	*Reserved for national assignment (effective 3/1/07)*
E3	*Estimated Responsibility Payer D*	*Reserved for national assignment (effective 3/1/07)*
E4-E6		*Reserved for national assignment*
E7	*Co-payment Payer D*	*Reserved for national assignment (effective 3/1/07)*
E8-E9		*Reserved for national assignment*
EA	*Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer D*	*Reserved for national assignment (effective 3/1/07)*
EB	*Other Assessments or Allowances (e.g., Medical Education) Payer D*	*Reserved for national assignment (effective 3/1/07)*
EC-EZ		*Reserved for national assignment*
F0		*Reserved for national assignment*
F1	*Deductible Payer E*	*Reserved for national assignment (effective 3/1/07)*
F2	*Coinsurance Payer E*	*Reserved for national assignment (effective 3/1/07)*
F3	*Estimated Responsibility Payer E*	*Reserved for national assignment (effective 3/1/07)*
F4-F6		*Reserved for national assignment*
F7	*Co-payment Payer E*	*Reserved for national assignment (effective 3/1/07)*
F8-F9		*Reserved for national assignment*
FA	*Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer E*	*Reserved for national assignment (effective 3/1/07)*
FB	*Other Assessments or Allowances (e.g., Medical Education) Payer E*	*Reserved for national assignment (effective 3/1/07)*
FC-FZ		*Reserved for national assignment*
G0		*Reserved for national assignment*
G1	*Deductible Payer F*	*Reserved for national assignment (effective 3/1/07)*
G2	*Coinsurance Payer F*	*Reserved for national assignment (effective 3/1/07)*
G3	*Estimated Responsibility Payer F*	*Reserved for national assignment (effective 3/1/07)*

Code	*Title*	*Definition*
G4-G6		*Reserved for national assignment*
G7	*Co-payment Payer F*	*Reserved for national assignment (effective 3/1/07)*
G8-G9		*Reserved for national assignment*
GA	*Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer F*	*Reserved for national assignment (effective 3/1/07)*
GB	*Other Assessments or Allowances (e.g., Medical Education) Payer F*	*Reserved for national assignment (effective 3/1/07)*
GC-GZ		*Reserved for national assignment*
H0-WZ		*Reserved for national assignment*
X0-Y0		*Reserved for national assignment*
Y1	*Part A Demonstration Payment*	*This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.*
Y2	*Part B Demonstration Payment*	*This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.*
Y3	*Part B Coinsurance*	*This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).*
Y4	*Conventional Provider Payment Amount for Non-Demonstration Claims*	*This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as*

Code	*Title*	*Definition*
		any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ		*Reserved for national assignment*

75.4 - Form Locator 42

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

FL 42 - Revenue Code

Required*. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.*

The biller must provide detail level coding for the following revenue code series:

0290s - Rental/purchase of DME
0304 - Renal dialysis/laboratory
0330s - Radiology therapeutic
0367 - Kidney transplant
0420s - Therapies
0520s - Type or clinic visit (RHC or other)
0550s - 590s - home health services
0624 - Investigational Device Exemption (IDE)
0636 - Hemophilia blood clotting factors
0800s - 0850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

Zero level billing is encouraged for all other services; however, an FI may require detailed breakouts of other revenue code series from its providers.

NOTE: *RHCs and FQHCs, in general, use revenue codes 052X and 091X with appropriate subcategories to complete the Form CMS-1450. The other codes provided are not generally used by RHCs and FQHCs and are provided for informational purposes. Those applicable are: 0025-0033, 0038-0044, 0047, 0055-0059, 0061, 0062, 0064-0069, 0073-0075, 0077, 0078, and 0092-0095.*

NOTE: *Renal Dialysis Centers bill the following revenue center codes at the detailed level:*

0304 - rental and dialysis/laboratory,

0636 - hemophilia blood clotting factors,
0800s thru 0850s - ESRD services.
The remaining applicable codes are 0025, 0027, 0031-0032, 0038-0039, 0075, and 0082-0088.

NOTE: *The Hospice uses revenue code 0657 to identify its charges for services furnished to patients by physicians employed by it, or receiving compensation from it. In conjunction with revenue code 0657, the hospice enters a physician procedure code in the right hand margin of FL 43 (to the right of the dotted line adjacent to the revenue code in FL 42). Appropriate procedure codes are available to it from its FI. Procedure codes are required in order for the FI to make reasonable charge determinations when paying the hospice for physician services.*

The Hospice uses the following revenue codes to bill Medicare:

Code	***Description***	***Standard Abbreviation***
*0651**	*Routine Home Care*	*RTN Home*
*0652**	*Continuous Home Care*	*CTNS Home (A minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is 1 hour.*
0655	*Inpatient Respite Care*	*IP Respite*
0656	*General Inpatient Care*	*GNL IP*
0657	*Physician Services*	*PHY Ser (must be accompanied by a physician procedure code.)*

**The hospice must report value code 61 with these revenue codes.*

Below is a complete description of the revenue center codes for all provider types:

Revenue Code	***Description***	
0001	*Total Charge* *For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, FIs report the total charge in the appropriate data segment/field*	
001X	*Reserved for Internal Payer Use*	
002X	*Health Insurance Prospective Payment System (HIPPS)*	
	Subcategory	***Standard Abbreviations***
	0 - Reserved	
	1 - Reserved	
	2 - Skilled Nursing Facility Prospective Payment System	*SNF PPS (RUG)*
	3 - Home Health Prospective Payment System	*HHS PPS (Health Resource Groups (HRG))*
	4 - Inpatient Rehabilitation Facility Prospective Payment System	*IRF PPS (Case-Mix Groups (CMG))*
	5 - Reserved	
	6 - Reserved	
	7 - Reserved	

Revenue Code	***Description***
	8 - Reserved
	9 - Reserved
003X to 006X	*Reserved for National Assignment*
007X to 009X	*Reserved for State Use until October 16, 2003. Thereafter, Reserved for National Assignment*

ACCOMMODATION REVENUE CODES (010X - 021X)

010X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

Subcategory		***Standard Abbreviations***
0	*All-Inclusive Room and Board Plus Ancillary*	*ALL INCL R&B/ANC*
1	*All-Inclusive Room and Board*	*ALL INCL R&B*

011X Room & Board - Private (Medical or General)

Routine service charges for single bedrooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	***Standard Abbreviations***
0 - General Classification	*ROOM-BOARD/PVT*
1 - Medical/Surgical/Gyn	*MED-SUR-GY/PVT*
2 - OB	*OB/PVT*
3 - Pediatric	*PEDS/PVT*
4 - Psychiatric	*PSYCH/PVT*
5 - Hospice	*HOSPICE/PVT*
6 - Detoxification	*DETOX/PVT*
7 - Oncology	*ONCOLOGY/PVT*
8 - Rehabilitation	*REHAB/PVT*
9 - Other	*OTHER/PVT*

012X Room & Board - Semi-private Two Beds (Medical or General)

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

Subcategory	***Standard Abbreviations***
0 - General Classification	*ROOM-BOARD/SEMI*
1 - Medical/Surgical/Gyn	*MED-SUR-GY/2BED*
2 - OB	*OB/2BED*
3 - Pediatric	*PEDS/2BED*
4 - Psychiatric	*PSYCH/2BED*
5 - Hospice	*HOSPICE/2BED*
6 - Detoxification	*DETOX/2BED*
7 - Oncology	*ONCOLOGY/2BED*

Revenue Code	Description	
	8 - Rehabilitation	REHAB/2BED
	9 - Other	OTHER/2BED
013X	Semi-private - three and Four Beds (Medical or General)	
	Routine service charges incurred for accommodations with three and four beds.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ROOM-BOARD/3&4 BED
	1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
	2 - OB	OB/3&4 BED
	3 - Pediatric	PEDS/3&4 BED
	4 - Psychiatric	PSYCH/3&4 BED
	5 - Hospice	HOSPICE/3&4 BED
	6 - Detoxification	DETOX/3&4 BED
	7 - Oncology	ONCOLOGY/3&4 BED
	8 - Rehabilitation	REHAB/3&4 BED
	9 - Other	OTHER/3&4 BED
014X	Private - (Deluxe) (Medical or General)	
	Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ROOM-BOARD/ PVT/DLX
	1 - Medical/Surgical/Gyn	MED-SUR-GY/ PVT/DLX
	2 - OB	OB/ PVT/DLX
	3 - Pediatric	PEDS/ PVT/DLX
	4 - Psychiatric	PSYCH/ PVT/DLX
	5 - Hospice	HOSPICE/ PVT/DLX
	6 - Detoxification	DETOX/ PVT/DLX
	7 - Oncology	ONCOLOGY/ PVT/DLX
	8 - Rehabilitation	REHAB/ PVT/DLX
	9 - Other	OTHER/ PVT/DLX
015X	Room & Board - Ward (Medical or General)	
	Routine service charges incurred for accommodations with five or more beds. Rationale: Most third party payers require ward accommodations to be identified.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ROOM-BOARD/WARD
	1 - Medical/Surgical/Gyn	MED-SUR-GY/ WARD
	2 - OB	OB/ WARD
	3 - Pediatric	PEDS/ WARD
	4 - Psychiatric	PSYCH/ WARD
	5 - Hospice	HOSPICE/ WARD
	6 - Detoxification	DETOX/ WARD
	7 - Oncology	ONCOLOGY/ WARD
	8 - Rehabilitation	REHAB/ WARD

Revenue Code	Description	
	9 - Other	*OTHER/ WARD*

016X *Other Room & Board (Medical or General)*

Any routine service charges incurred for accommodations that cannot be included in the more specific revenue center codes

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviations
0 - General Classification	*R&B*
4 - Sterile Environment	*R&B/STERILE*
7 - Self Care	*R&B/SELF*
9 - Other	*R&B/OTHER*

017X *Nursery Charges for nursing care to newborn and premature infants in nurseries Subcategories 1-4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under State regulations or other statutes supersede the following guidelines. For example, some States may have fewer than four levels of care or may have multiple levels within a category such as intensive care.*

Level I	*Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).*
Level II	*Low birth-weight neonates who are not sick, but require frequent feeding and neonates who require more hours of nursing than do normal neonates (Continuing Care).*
Level III	*Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).*
Level IV	*Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).*

Subcategory	Standard Abbreviations
0 - Classification	*NURSERY*
1 - Newborn - Level I	*NURSERY/LEVEL I*
2 - Newborn - Level II	*NURSERY/LEVEL II*
3 - Newborn - Level III	*NURSERY/LEVEL III*
4 - Newborn - Level IV	*NURSERY/LEVEL IV*
9 - Other	*NURSERY/OTHER*

018X *Leave of Absence*

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

NOTE: *Charges are billable for codes 2 - 5.*

Subcategory	Standard Abbreviations
0 - General Classification	*LEAVE OF ABSENCE OR LOA*
1 - Reserved	

2 - Patient Convenience -Charges billable	*LOA/PT CONV CHGS BILLABLE*
3 - Therapeutic Leave	*LOA/THERAP*
4 – RESERVED	*Effective 4/1/04*
5 - Hospitalization	*LOA/HOSPITALIZATION Effective 4/1/04*
9 - Other Leave of Absence	*LOA/OTHER*

019X *Sub-acute Care*

Accommodation charges for sub acute care to inpatients in hospitals or skilled nursing facilities.

Level I	***Skilled Care**: Minimal nursing intervention. Co-morbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.*
Level II	***Comprehensive Care**: Moderate to extensive nursing intervention. Active treatment of co morbidities. Assessment of vitals and body systems required 2-3 times per day.*
Level III	***Complex Care**: Moderate to extensive nursing intervention. Active medical care and treatment of co morbidities. Potential for co morbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.*
Level IV	***Intensive Care**: Extensive nursing and technical intervention. Active medical care and treatment of co morbidities. Potential for co morbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.*

Subcategory	***Standard Abbreviations***
0 - Classification	*SUBACUTE*
1 – Sub-acute Care - Level I	*SUBACUTE /LEVEL I*
2 – Sub-acute Care - Level II	*SUBACUTE /LEVEL II*
3 – Sub-acute Care - Level III	*SUBACUTE /LEVEL III*
4 – Sub-acute Care - Level IV	*SUBACUTE /LEVEL IV*
9 - Other Sub-acute Care	*SUBACUTE /OTHER*

*Usage Note: Revenue code 019X may be used in multiple types of bills. However, if bill type X7X is used in Form Locator 4, Revenue Code 019X must be used. (**Note:** Bill Type X7X to be DISCONTINUED as of 10/1/05.)*

020X *Intensive Care*

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service be identified.

Subcategory	***Standard Abbreviations***
0 - General Classification	*INTENSIVE CARE or (ICU)*
1 - Surgical	*ICU/SURGICAL*
2 - Medical	*ICU/MEDICAL*

3 - Pediatric	*ICU/PEDS*
4 - Psychiatric	*ICU/PSTAY*
6 - Intermediate ICU	*ICU/INTERMEDIATE*
7 - Burn Care	*ICU/BURN CARE*
8 - Trauma	*ICU/TRAMA*
9 - Other Sub-acute Care	*ICU/OTHER*

021X *Coronary Care*

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

Subcategory	***Standard Abbreviations***
0 - General Classification	*CORONARY CARE or (CCU)*
1 - Myocardial Infarction	*CCU/MYO INFARC*
2 - Pulmonary Care	*CCU/PULMONARY*
3 - Heart Transplant	*CCU/TRANSPLANT*
4 - Intermediate CCU	*CCU/INTERMEDIATE*
9 - Other Coronary Care	*CCU/OTHER*

Code ***Description***

ANCILLARY REVENUE CODES (022X - 099X)

022X *Special Charges*

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services furnished in greater detail and thus break out charges for items that normally would be considered part of routine services.

Subcategory	***Standard Abbreviations***
0 - General Classification	*SPECIAL CHARGES*
1 - Admission Charge	*ADMIT CHARGE*
2 - Technical Support Charge	*TECH SUPPT CHG*
3 - U.R. Service Charge	*UR CHARGE*
4 - Late Discharge, medically necessary	*LATE DISCH/MED NEC*
9 - Other Special Charges	*OTHER SPEC CHG*

023X *Incremental Nursing Care Charges*

Charges for nursing services assessed in addition to room and board.

Subcategory	***Standard Abbreviations***
0 - General Classification	*NURSING INCREM*
1 - Nursery	*NUR INCR/NURSERY*
2 - OB	*NUR INCR/OB*
3 - ICU (includes transitional care)	*NUR INCR/ICU*
4 - CCU (includes transitional care)	*NUR INCR/CCU*
5 - Hospice	*NUR INCR/HOSPICE*

	9 - Other	*NUR INCR/OTHER*

024X *All Inclusive Ancillary*

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	***Standard Abbreviations***
0 - General Classification	*ALL INCL ANCIL*
1 - Basic	*ALL INCL BASIC*
2 - Comprehensive	*ALL INCL COMP*
3 - Specialty	*ALL INCL SPECIAL*
9 - Other All Inclusive Ancillary	*ALL INCL ANCIL/OTHER*

025X *Pharmacy*

Code indicates charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements. Sub code 4 is for hospitals that do not bill drugs used for other diagnostic services as part of the charge for the diagnostic service. Sub code 5 is for hospitals that do not bill drugs used for radiology under radiology revenue codes as part of the radiology procedure charge.

Subcategory	***Standard Abbreviations***
0 – General Classification	*PHARMACY*
1 – Generic Drugs	*DRUGS/GENERIC*
2 - Non-generic Drugs	*DRUGS/NONGENERIC*
3 - Take Home Drugs	*DRUGS/TAKEHOME*
4 - Drugs Incident to Other Diagnostic Services	*DRUGS/INCIDENT ODX*
5 - Drugs Incident to Radiology	*DRUGS/INCIDENT RAD*
6 - Experimental Drugs	*DRUGS/EXPERIMT*
7 - Nonprescription	*DRUGS/NONPSCRPT*
8 - IV Solutions	*IV SOLUTIONS*
9 - Other DRUGS/OTHER	*DRUGS/OTHER*

026X *IV Therapy*

Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating of the per diem rate.

Subcategory	***Standard Abbreviations***
0 – General Classification	*IV THERAPY*
1 – Infusion Pump	*IV THER/INFSN PUMP*
2 - IV Therapy/Pharmacy	*IV THER/PHARM/SVC*

Services

3 - IV Therapy/Drug/Supply/Delivery	*IV THER/DRUG/SUPPLY DELV*
4 - IV Therapy/Supplies	*IV THER/SUPPLIES*
9 - Other IV Therapy	*IV THERAPY/OTHER*

027X *Medical/Surgical Supplies (Also see 062X, an extension of 027X)*

Code indicates charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	***Standard Abbreviations***
0 – General Classification	*MED-SUR SUPPLIES*
1 – Non--sterile Supply	*NONSTER SUPPLY*
2 - Sterile Supply	*STERILE SUPPLY*
3 - Take Home Supplies	*TAKEHOME SUPPLY*
4 - Prosthetic/Orthotic Devices	*PROSTH/ORTH DEV*
5 - Pace maker	*PACE MAKER*
6 - Intraocular Lens	*INTR OC LENS*
7 – Oxygen - Take Home	*02/TAKEHOME*
8 - Other Implants	*SUPPLY/IMPLANTS*
9 - Other Supplies/Devices	*SUPPLY/OTHER*

028X *Oncology*

Code indicates charges for the treatment of tumors and related diseases.

Subcategory	***Standard Abbreviations***
0 – General Classification	*ONCOLOGY*
9 - Other Oncology	*ONCOLOGY/OTHER*

029X *Durable Medical Equipment (DME) (Other Than Rental)*

Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	***Standard Abbreviations***
0 – General Classification	*MED EQUIP/DURAB*
1 – Rental	*MED EQUIP/RENT*
2 - Purchase of new DME	*MED EQUIP/NEW*
3 - Purchase of used DME	*MED EQUIP/USED*
4 - Supplies/Drugs for DME Effectiveness (HHA's Only)	*MED EQUIP/SUPPLIES/DRUGS*
9 - Other Equipment	*MED EQUIP/OTHER*

030X *Laboratory*

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	***Standard Abbreviations***
0 – General Classification	*LABORATORY or (LAB)*
1 - Chemistry	*LAB/CHEMISTRY*
2 - Immunology	*LAB/IMMUNOLOGY*
3 - Renal Patient (Home)	*LAB/RENAL HOME*

4 – Non-routine Dialysis	*LAB/NR DIALYSIS*
5 - Hematology	*LAB/HEMATOLOGY*
6 - Bacteriology & Microbiology	*LAB/BACT-MICRO*
7 – Urology	*LAB/UROLOGY*
9 - Other Laboratory	*LAB/OTHER*

031X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.
Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	***Standard Abbreviations***
0 - General Classification	*PATHOLOGY LAB or (PATH LAB)*
1 - Cytology	*PATHOL/CYTOLOGY*
2 - Histology	*PATHOL/HYSTOL*
4 – Biopsy	*PATHOL/BIOPSY*
9 – Other	*PATHOL/OTHER*

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting radiographs and fluorographs.
Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	***Standard Abbreviations***
0 - General Classification	*DX X-RAY*
1 - Angiocardiography	*DX X-RAY/ANGIO*
2 - Arthrography	*DX X-RAY/ARTH*
3 - Arteriography	*DX X-RAY/ARTER*
4 - Chest X-Ray	*DX X-RAY/CHEST*
9 – Other	*DX X-RAY/OTHER*

033X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify. Chemotherapy - IV was added at the request of Ohio.

Subcategory	***Standard Abbreviations***
0 - General Classification	*RX X-RAY*
1 - Chemotherapy - Injected	*CHEMOTHER/INJ*
2 - Chemotherapy - Oral	*CHEMOTHER/ORAL*
3 - Radiation Therapy	*RADIATION RX*
5 - Chemotherapy - IV	*CHEMOTHERP-IV*
9 – Other	*RX X-RAY/OTHER*

034X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.
Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify.

Subcategory	***Standard Abbreviations***
0 - General Classification	*NUCLEAR MEDICINE or (NUC MED)*
1 – Diagnostic Procedures	*NUC MED/DX*
2 – Therapeutic Procedures	*NUC MED/RX*
3 – Diagnostic Radiopharmaceuticals	*NUC MED/DX RADIOPHARM Effective 10/1/04*
4 – Therapeutic Radiopharmaceuticals	*NUC MED/RX RADIOPHARM Effective 10/1/04*
9 – Other	*NUC MED/OTHER*

035X *Computed Tomographic (CT) Scan*
Charges for CT scans of the head and other parts of the body.
Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	***Standard Abbreviations***
0 - General Classification	*CT SCAN*
1 - Head Scan	*CT SCAN/HEAD*
2 - Body Scan	*CT SCAN/BODY*
9 - Other CT Scans	*CT SCAN/OTHER*

036X *Operating Room Services*
Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment.
Rationale: Permits identification of particular services.

Subcategory	***Standard Abbreviations***
0 - General Classification	*OR SERVICES*
1 - Minor Surgery	*OR/MINOR*
2 - Organ Transplant - Other than Kidney	*OR/ORGAN TRANS*
7 - Kidney Transplant	*OR/KIDNEY TRANS*
9 - Other Operating Room Services	*OR/OTHER*

037X *Anesthesia*
Charges for anesthesia services in the hospital.
Rationale: Provides additional identification of services. In particular, acupuncture was identified because some payers, including Medicare, do not cover it. Subcode 1 is for providers that do not bill anesthesia used for radiology under radiology revenue codes as part of the radiology procedure charge. Subcode 2 is for providers that do not bill anesthesia used for another diagnostic service as part of the charge for the diagnostic service.

Subcategory	***Standard Abbreviations***

	0 - General Classification	*ANESTHESIA*
	1 - Anesthesia Incident to RAD	*ANESTHE/INCIDENT RAD*
	2 - Anesthesia Incident to Other Diagnostic Services	*ANESTHE/INCIDENT ODX*
	4 - Acupuncture	*ANESTHE/ACUPUNC*
	9 - Other Anesthesia	*ANESTHE/OTHER*
038X	*Blood*	
	Rationale: Charges for blood must be separately identified for private payer purposes.	
	Subcategory	***Standard Abbreviations***
	0 - General Classification	*BLOOD*
	1 - Packed Red Cells	*BLOOD/PKD RED*
	2 - Whole Blood	*BLOOD/WHOLE*
	3 – Plasma	*BLOOD/PLASMA*
	4 – Platelets	*BLOOD/PLATELETS*
	5 - Leucocytes	*BLOOD/LEUCOCYTES*
	6 - Other Components	*BLOOD/COMPONENTS*
	7 - Other Derivatives Cryopricipitates)	*BLOOD/DERIVATIVES*
	9 - Other Blood	*BLOOD/OTHER*
039X	*Blood Storage and Processing*	
	Charges for the storage and processing of whole blood	
	Subcategory	***Standard Abbreviations***
	0 - General Classification	*BLOOD/STOR-PROC*
	1 - Blood Administration (e.g., Transfusions	*BLOOD/ADMIN*
	9 - Other Processing and Storage	*BLOOD/OTHER STOR*
040X	*Other Imaging Services*	
	Subcategory	***Standard Abbreviations***
	0 - General Classification	*IMAGE SERVICE*
	1 - Diagnostic Mammography	*MAMMOGRAPHY*
	2 - Ultrasound	*ULTRASOUND*
	3 - Screening Mammography	*SCR MAMMOGRAPHY/GEN MAMMO*
	4 - Positron Emission Tomography	*PET SCAN*
	9 - Other Imaging Services	*OTHER IMAG SVS*

NOTE: *Medicare will require the hospitals to report the ICD-9 diagnosis codes (FL 67) to substantiate those beneficiaries considered high risks. These high-risk codes are as follows:*

ICD-9 Codes	***Definitions***	***High Risk Indicator***
V10.3	*Personal History - Malignant neoplasm breast cancer*	*A personal history of breast cancer*
V16.3	*Family History - Malignant neoplasm breast cancer*	*A mother, sister, or daughter who has had breast cancer*

V15.89	*Other specified personal history representing hazards to health*	*Has not given birth before age 30 or a personal history of biopsy-proven benign breast disease*

041X *Respiratory Services*

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	***Standard Abbreviations***
0 - General Classification	*RESPIRATORY SVC*
2 - Inhalation Services	*INHALATION SVC*
3 - Hyperbaric Oxygen Therapy	*HYPERBARIC 02*
9 - Other Respiratory Services	*OTHER RESPIR SVS*

042X *Physical Therapy*

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	***Standard Abbreviations***
0 – General Classification	*PHYSICAL THERP*
1 - Visit Charge	*PHYS THERP/VISIT*
2 - Hourly Charge	*PHYS THERP/HOUR*
3 - Group Rate	*PHYS THERP/GROUP*
4 - Evaluation or Re-evaluation	*PHYS THERP/EVAL*
9 - Other Physical Therapy	*OTHER PHYS THERP*

043X *Occupational Therapy*

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	***Standard Abbreviations***
0 – General Classification	*OCCUPATION THER*
1 - Visit Charge	*OCCUP THERP/VISIT*
2 - Hourly Charge	*OCCUP THERP/HOUR*
3 - Group Rate	*OCCUP THERP/GROUP*
4 - Evaluation or Re-evaluation	*OCCUP THERP/EVAL*
9 - Other Occupational Therapy (may include	*OTHER OCCUP THER*

restorative therapy)

044X *Speech-Language Pathology*

Charges for services provided to persons with impaired functional communications skills.

Subcategory	***Standard Abbreviations***
0 - General Classification	*SPEECH PATHOL*
1 - Visit Charge	*SPEECH PATH/VISIT*
2 - Hourly Charge	*SPEECH PATH/HOUR*
3 - Group Rate	*SPEECH PATH/GROUP*
4 - Evaluation or Re-evaluation	*SPEECH PATH/EVAL*
9 - Other Speech-Language Pathology	*OTHER SPEECH PAT*

045X *Emergency Room*

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers. Under the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA), a hospital with an emergency department must provide, upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).

Subcategory	***Standard Abbreviations***
0 - General Classification	*EMERG ROOM*
1 - EMTALA Emergency Medical screening services	*ER/EMTALA*
2 - ER Beyond EMTALA Screening	*ER/BEYOND EMTALA*
6 - Urgent Care	*URGENT CARE*
9 - Other Emergency Room	*OTHER EMER ROOM*

NOTE: *Observation or hold beds are not reported under this code. They are reported under revenue code 0762, "Observation Room."*

Usage Notes

An "X" in the matrix below indicates an acceptable coding combination.

	0450 [a]	***0451*** [b]	***0452*** [c]	***0456***	***0459***
0450					
0451		*X*	*X*	*X*	
0452		*X*			
0456		*X*			*X*
0459		*X*		*X*	

a. General Classification code 0450 should not be used in conjunction with any subcategory. The sum of codes 0451 and 0452 is equivalent to code 0450. Payers that do not require a breakdown should roll up codes 0451 and 0452 into code 0450.

b. Stand alone usage of code 0451 is acceptable when no services beyond an initial

screening/assessment are rendered.
c. Stand alone usage of code 0452 is ***not acceptable****.*

046X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	***Standard Abbreviations***
0 – General Classification	*PULMONARY FUNC*
9 - Other Pulmonary Function	*OTHER PULMON FUNC*

047X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	***Standard Abbreviations***
0 – General Classification	*AUDIOLOGY*
1 - Diagnostic	*AUDIOLOGY/DX*
2 - Treatment	*AUDIOLOGY/RX*
9 - Other Audiology	*OTHER AUDIOL*

048X Cardiology

Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	***Standard Abbreviations***
0 – General Classification	*CARDIOLOGY*
1 – Cardiac Cath Lab	*CARDIAC CATH LAB*
2 - Stress Test	*STRESS TEST*
3 - Echo cardiology	*ECHOCARDIOLOGY*
9 - Other Cardiology	*OTHER CARDIOL*

049X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by any other category.

Subcategory	***Standard Abbreviations***
0 – General Classification	*AMBUL SURG*
9 - Other Ambulatory Surgical Care	*OTHER AMBL SURG*

NOTE: *Observation or hold beds are not reported under this code. They are reported under revenue code 0762, "Observation Room."*

050X Outpatient Services

Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. This revenue code is no longer used for Medicare.

Subcategory	*Standard Abbreviations*
0 – General Classification	*OUTPATIENT SVS*

	9 - Other Outpatient Services	*OUTPATIENT/OTHER*
051X	*Clinic*	

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	***Standard Abbreviations***
0 – General Classification	*CLINIC*
1 – Chronic Pain Center	*CHRONIC PAIN CL*
2 - Dental Clinic	*DENTAL CLINIC*
3 - Psychiatric Clinic	*PSYCH CLINIC*
4 - OB-GYN Clinic	*OB-GYN CLINIC*
5 - Pediatric Clinic	*PEDS CLINIC*
6 - Urgent Care Clinic	*URGENT CLINIC*
7 - Family Practice Clinic	*FAMILY CLINIC*
9 - Other Clinic	*OTHER CLINIC*

052X *Free-Standing Clinic*

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	***Standard Abbreviations***
0 - General Classification	*FREESTAND CLINIC*
1 - Rural Health-Clinic (Effective 7/1/06 will be changed to: Clinic visit by member to RHC/FQHC)	*RURAL/CLINIC*
2 - Rural Health-Home (Effective 7/1/06 will be changed to: Home visit by RHC/FQHC practitioner)	*RURAL/HOME*
3 - Family Practice	*FR/STD FAMILY CLINIC*
4 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF	
5 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility	
6 - Urgent Care Clinic	*FR/STD URGENT CLINIC*
7 - Effective 7/1/06 - RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area	
8 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to other	

non RHC/FQHC site (e.g. scene of accident)

9 - Other Freestanding Clinic	*OTHER FR/STD CLINIC*

053X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: This is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory	***Standard Abbreviations***
0 - General Classification	*OSTEOPATH SVS*
1 - Osteopathic Therapy	*OSTEOPATH RX*
9 - Other Osteopathic Services	*OTHER OSTEOPATH*

054X Ambulance

Charges for ambulance service usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	***Standard Abbreviations***
0 - General Classification	*AMBULANCE*
1 - Supplies	*AMBUL/SUPPLY*
2 - Medical Transport	*AMBUL/MED TRANS*
3 - Heart Mobile	*AMBUL/HEARTMOBL*
4 – Oxygen	*AMBUL/0XY*
5 - Air Ambulance	*AIR AMBULANCE*
6 - Neo-natal Ambulance	*AMBUL/NEO-NATAL*
7 - Pharmacy	*AMBUL/PHARMACY*
8 - Telephone Transmission EKG	*AMBUL/TELEPHONIC EKG*
9 - Other Ambulance	*OTHER AMBULANCE*

055X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	***Standard Abbreviations***
0 - General Classification	*SKILLED NURSING*
1 - Visit Charge	*SKILLED NURS/VISIT*
2 - Hourly Charge	*SKILLED NURS/HOUR*
9 - Other Skilled Nursing	*SKILLED NURS/OTHER*

056X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be

used at other times as required by hospital.

Subcategory	***Standard Abbreviations***
0 - General Classification	*MED SOCIAL SVS*
1 - Visit Charge	*MED SOC SERV/VISIT*
2 - Hourly Charge	*MED SOC SERV/HOUR*
9 - Other Med. Soc. Services	*MED SOC SERV/OTHER*

057X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	***Standard Abbreviations***
0 - General Classification	*AIDE/HOME HEALTH*
1 - Visit Charge	*AIDE/HOME HLTH/VISIT*
2 - Hourly Charge	*AIDE/HOME HLTH/HOUR*
9 - Other Home Health Aide	*AIDE/HOME HLTH/OTHER*

058X Other Visits (Home Health)

Code indicates charges by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	***Standard Abbreviations***
0 - General Classification	*VISIT/HOME HEALTH*
1 - Visit Charge	*VISIT/HOME HLTH/VISIT*
2 - Hourly Charge	*VISIT/HOME HLTH/HOUR*
3 - Assessment	*VISIT/HOME HLTH/ASSES*
9 - Other Home Health Visits	*VISIT/HOME HLTH/OTHER*

059X Units of Service (Home Health)

This revenue code is used by an HHA that bills on the basis of units of service.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	***Standard Abbreviations***
0 - General Classification	*UNIT/HOME HEALTH*
9 - Home Health Other Units	*UNIT/HOME HLTH/OTHER*

060X Oxygen (Home Health)

Code indicates charges by a home health agency for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary had purchased a stationary oxygen system, oxygen concentrator or portable equipment, current revenue codes 0292 or 0293 apply. DME (other than oxygen systems) is billed under current revenue codes 0291, 0292, or 0293.

Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory	***Standard Abbreviations***
0 - General Classification	*02/HOME HEALTH*
1 - Oxygen - State/Equip/Suppl or Cont	*02/EQUIP/SUPPL/CONT*

2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	*02/STAT EQUIP/UNDER 1 LPM*
3 – Oxygen - Stat/Equip/Over 4 LPM	*02/STAT EQUIP/OVER 4 LPM*
4 – Oxygen - Portable Add-on	*02/STAT EQUIP/PORT ADD-ON*

061X *Magnetic Resonance Technology (MRT)*

Code indicates charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body. Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	***Standard Abbreviations***
0 - General Classification	*MRT*
1 - Brain (including Brainstem)	*MRI - BRAIN*
2 - Spinal Cord (including spine)	*MRI - SPINE*
3 - Reserved	
4 - MRI - Other	*MRI - OTHER*
5 - MRA - Head and Neck	*MRA - HEAD AND NECK*
6 - MRA - Lower Extremities	*MRA - LOWER EXT*
7 - Reserved	
8 - MRA - Other	*MRA - OTHER*
9 - MRT- Other	*MRT - OTHER*

062X *Medical/Surgical Supplies - Extension of 027X*

Code indicates charges for supply items required for patient care. The category is an extension of 027X for reporting additional breakdown where needed. Subcode 1 is for hospitals that do not bill supplies used for radiology revenue codes as part of the radiology procedure charges. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

Subcategory	***Standard Abbreviations***
1 - Supplies Incident to Radiology	*MED-SUR SUPP/INCIDNT RAD*
2 - Supplies Incident to Other Diagnostic Services	*MED-SUR SUPP/INCIDNT ODX*
3 - Surgical Dressings	*SURG DRESSING*
4 - Investigational Device	*IDE*

063X *Pharmacy - Extension of 025X*

Code indicates charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in FL 44.

Subcategory	***Standard Abbreviations***
0 - RESERVED (Effective 1/1/98	
1 - Single Source Drug	*DRUG/SNGLE*
2 - Multiple Source Drug	*DRUG/MULT*
3 - Restrictive Prescription	*DRUG/RSTR*
4 - Erythropoietin (EPO) less than 10,000 units	*DRUG/EPO ≤10,000 units*
5 - Erythropoietin (EPO) 10,000 or more units	*DRUG/EPO ≥10,000 units*
6 - Drugs Requiring Detailed	*DRUGS/DETAIL CODE*

Coding (a)

7 - Self-administrable Drugs (b)	*DRUGS/SELFADMIN*

NOTE: *(a) Charges for drugs and biologicals (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) requiring specific identifications as required by the payer (effective 10/1/04). If HCPCs are used to describe the drug, enter the HCPCS code in Form Locator 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).*

064X Home IV Therapy Services

Charge for intravenous drug therapy services that are performed in the patient's residence. For Home IV providers, the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategory	***Standard Abbreviations***
0 - General Classification	*IV THERAPY SVC*
1 – Non-routine Nursing, Central Line	*NON RT NURSING/CENTRAL*
2 - IV Site Care, Central Line	*IV SITE CARE/CENTRAL*
3 - IV Start/Change Peripheral Line	*IV STRT/CHNG/PERIPHRL*
4 – Non-routine Nursing, Peripheral Line	*NONRT NURSING/PERIPHRL*
5 - Training Patient/Caregiver, Central Line	*TRNG/PT/CARGVR/CENTRAL*
6 - Training, Disabled Patient, Central Line	*TRNG DSBLPT/CENTRAL*
7 - Training Patient/Caregiver, Peripheral Line	*TRNG/PT/CARGVR/PERIPHRL*
8 - Training, Disabled Patient, Peripheral Line	*TRNG/DSBLPAT/PERIPHRL*
9 - Other IV Therapy Services	*OTHER IV THERAPY SVC*

NOTE: *Units need to be reported in 1-hour increments. Revenue code 0642 relates to the HCPCS code.*

065X Hospice Services

Code indicates charges for hospice care services for a terminally ill patient if the patient elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care that is provided each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	***Standard Abbreviations***
0 - General Classification	*HOSPICE*
1 - Routine Home Care	*HOSPICE/RTN HOME*
2 - Continuous Home Care	*HOSPICE/CTNS HOME*
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Respite Care	*HOSPICE/IP RESPITE*
6 - General Inpatient Care (non-	*HOSPICE/IP NON RESPITE*

respite)

7 - Physician Services	*HOSPICE/PHYSICIAN*
8 –Hospice Room & Board – Nursing Facility	*HOSPICE/R&B/NURS FAC*
9 - Other Hospice	*HOSPICE/OTHER*

066X Respite Care (HHA Only)

Charge for hours of care under the respite care benefit for services of a homemaker or home health aide, personal care services, and nursing care provided by a licensed professional nurse.

Subcategory	***Standard Abbreviations***
0 - General Classification	*RESPITE CARE*
1 – Hourly Charge/ Nursing	*RESPITE/ NURSE*
2 - Hourly Charge/ Aide/Homemaker/Companion	*RESPITE/AID/HMEMKE/COMP*
3 – Daily Respite Charge	*RESPITE DAILY*
9 - Other Respite Care	*RESPITE/CARE*

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

Subcategory	***Standard Abbreviations***
0 - General Classification	*OP SPEC RES*
1 - Hospital Based	*OP SPEC RES/HOSP BASED*
2 - Contracted	*OP SPEC RES/CONTRACTED*
9 - Other Special Residence Charges	*OP SPEC RES/OTHER*

068X Trauma Response

Charges for a trauma team activation.

Subcategory	***Standard Abbreviations***
0 - Not Used	
1 - Level I	*TRAUMA LEVEL I*
2 - Level II	*TRAUMA LEVEL II*
3 - Level III	*TRAUMA LEVEL III*
4 - Level IV	*TRAUMA LEVEL IV*
9 - Other Trauma Response	*TRAUMA OTHER*

Usage Notes:

1. To be used by trauma center/hospitals as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

2. Revenue Category 068X is used for patients for whom a trauma activation occurred. A trauma team activation/response is a "Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival."

3. Revenue Category 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X revenue code reported.

4. Revenue Category 068X is not limited to admitted patients.

5. Revenue Category 068X must be used in conjunction with FL 19 Type of Admission/Visit code 05 ("Trauma Center"), however FL 19 Code 05 can be used alone.

*Only patients for who there has been **pre-hospital** notification, who meet either local, State or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are "drive-by" or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.*

6. Levels I, II, III or IV refer to designations by the State or local government authority or as verified by the American College of Surgeons.

7. Subcategory 9 is for sate or local authorities with levels beyond IV.

069X Not Assigned

070X Cast Room

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service, if necessary.

Subcategory	***Standard Abbreviations***
0 - General Classification	*CAST ROOM*
9 - Other Cast Room	*OTHER CAST ROOM*

071X Recovery Room

Rationale: Permits identification of particular services, if necessary.

Subcategory	***Standard Abbreviations***
0 - General Classification	*RECOVERY ROOM*
9 - Other Recovery Room	*OTHER RECOV RM*

072X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because not all third party payers cover it.

Subcategory	***Standard Abbreviations***
0 - General Classification	*DELIVROOM/LABOR*
1 – Labor	*LABOR*
2 - Delivery	*DELIVERY ROOM*
3 - Circumcision	*CIRCUMCISION*
4 - Birthing Center	*BIRTHING CENTER*
9 - Other Labor Room/Delivery	*OTHER/DELIV-LABOR*

073X Electrocardiogram (EKG/ECG)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	***Standard Abbreviations***

0 - General Classification	*EKG/ECG*
1 – Holter Monitor	*HOLTER MONT*
2 - Telemetry	*TELEMETRY*
9 - Other EKG/ECG	*OTHER EKG-ECG*

074X *Electroencephalogram (EEG)*

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	***Standard Abbreviations***
0 - General Classification	*EEG*
9 - Other EEG	*OTHER EEG*

075X *Gastro-Intestinal Services*

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	***Standard Abbreviations***
0 - General Classification	*GASTR-INTS SVS*
9 - Other Gastro-Intestinal	*OTHER GASTRO-INTS*

076X *Treatment or Observation Room*

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 0762 should be used for observation services.

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. The reason for observation must be stated in the orders for observation. Payer should establish written guidelines that identify coverage of observation services.

Subcategory	***Standard Abbreviations***
0 - General Classification	*TREATMENT/OBSERVATION RM*
1 - Treatment Room	*TREATMENT RM*
2 - Observation Room	*OBSERVATION RM*
9 – Other Treatment Room	*OTHER TREATMENT RM*

077X *Preventative Care Services*

Charges for the administration of vaccines.

Subcategory	***Standard Abbreviations***
0 - General Classification	*PREVENT CARE SVS*
1 - Vaccine Administration	*VACCINE ADMIN*
9 – Other	*OTHER PREVENT*

078X *Telemedicine - Future use to be announced - Medicare Demonstration Project*

	Subcategory	Standard Abbreviations
	0 - General Classification	TELEMEDICINE
	9 – Other Telemedicine	TELEMEDICINE/OTHER

079X Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)

Charges related to Extra-Corporeal Shock Wave Therapy (ESWT)..

	Subcategory	**Standard Abbreviations**
	0 - General Classification	ESWT
	9 – Other ESWT	ESWT/OTHER

080X Inpatient Renal Dialysis

A waste removal process performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

	Subcategory	**Standard Abbreviations**
	0 - General Classification	RENAL DIALYSIS
	1 - Inpatient Hemodialysis	DIALY/INPT
	2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
	3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
	4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
	9 – Other Inpatient Dialysis	DIALY/INPT/OTHER

081X Organ Acquisition

The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation.

Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

	Subcategory	**Standard Abbreviations**
	0 - General Classification	ORGAN ACQUISIT
	1 - Living Donor	LIVING/DONOR
	2 - Cadaver Donor	CADAVER/DONOR
	3 - Unknown Donor	UNKNOWN/DONOR
	4 - Unsuccessful Organ Search Donor Bank Charge*	UNSUCCESSFUL SEARCH
	9 – Other Organ Donor	OTHER/DONOR

NOTE: *Revenue code 0814 is used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.

082X *Hemodialysis - Outpatient or Home Dialysis*

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

Subcategory	***Standard Abbreviations***
0 - General Classification	*HEMO/OP OR HOME*
1 - Hemodialysis/Composite or Other Rate	*HEMO/COMPOSITE*
2 – Home Supplies	*HEMO/HOME/SUPPL*
3 – Home Equipment	*HEMO/HOME/EQUIP*
4 - Maintenance/100%	*HEMO/HOME/100%*
5 - Support Services	*HEMO/HOME/SUPSERV*
9 – Other Hemodialysis Outpatient	*HEMO/HOME/OTHER*

083X *Peritoneal Dialysis - Outpatient or Home*

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	***Standard Abbreviations***
0 - General Classification	*PERITONEAL/OP OR HOME*
1 - Peritoneal/Composite or Other Rate	*PERTNL/COMPOSITE*
2 – Home Supplies	*PERTNL/HOME/SUPPL*
3 – Home Equipment	*PERTNL/HOME/EQUIP*
4 - Maintenance/100%	*PERTNL/HOME/100%*
5 - Support Services	*PERTNL/HOME/SUPSERV*
9 – Other Peritoneal Dialysis	*PERTNL/HOME/OTHER*

084X *Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient or Home*

A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	***Standard Abbreviations***
0 - General Classification	*CAPD/OP OR HOME*
1 - CAPD/Composite or Other Rate	*CAPD/COMPOSITE*
2 – Home Supplies	*CAPD/HOME/SUPPL*
3 – Home Equipment	*CAPD/HOME/EQUIP*
4 - Maintenance/100%	*CAPD/HOME/100%*
5 - Support Services	*CAPD/HOME/SUPSERV*
9 – Other CAPD Dialysis	*CAPD/HOME/OTHER*

085X *Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient*

A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	***Standard Abbreviations***
0 - General Classification	*CCPD/OP OR HOME*
1 - CCPD/Composite or Other Rate	*CCPD/COMPOSITE*
2 – Home Supplies	*CCPD/HOME/SUPPL*

3 – Home Equipment	*CCPD/HOME/EQUIP*
4 - Maintenance/100%	*CCPD/HOME/100%*
5 - Support Services	*CCPD/HOME/SUPSERV*
9 – Other CCPD Dialysis	*CCPD/HOME/OTHER*

086X *Reserved for Dialysis (National Assignment)*

087X *Reserved for Dialysis (National Assignment)*

088X *Miscellaneous Dialysis*

Charges for dialysis services not identified elsewhere.

Rationale: Ultra-filtration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is used only when the procedure is not performed as part of a normal dialysis session.

Subcategory	***Standard Abbreviations***
0 - General Classification	*DIALY/MISC*
1 – Ultra-filtration	*DIALY/ULTRAFILT*
2 - Home Dialysis Aid Visit	*HOME DIALYSIS AID VISIT*
9 - Other Miscellaneous Dialysis	*DIALY/MISC/OTHER*

089X *Reserved for National Assignment*

090X *Behavior Health Treatments/Services (Also see 091X, an extension of 090X)*

Subcategory	***Standard Abbreviations***
0 - General Classification	*BH*
1 - Electroshock Treatment	*BH/ELECTRO SHOCK*
2 - Milieu Therapy	*BH/MILIEU THERAPY*
3 - Play Therapy	*BH/PLAY THERAPY*
4 - Activity Therapy	*BH/ACTIVITY THERAPY*
5 – Intensive Outpatient Services-Psychiatric	*BH/INTENS OP/PSYCH*
6 – Intensive Outpatient Services-Chemical Dependency	*BH/INTENS OP/CHEM DEP*
7 – Community Behavioral Health Program (Day Treatment)	*BH/COMMUNITY*
8 – Reserved for National Use	
9 – Reserved for National Use	

091X *Behavioral Health Treatment/Services-Extension of 090X*

Code indicates charges for providing nursing care and professional services for emotionally disturbed patients. This includes patients admitted for diagnosis and those admitted for treatment.

Subcategories 0912 and 0913 are designed as zero-billed revenue codes (no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract.

Subcategory	***Standard Abbreviations***
0 – Reserved for National Assignment	
1 - Rehabilitation	*BH/REHAB*
2 - Partial Hospitalization - Less Intensive*	*BH/PARTIAL HOSP*
3 - Partial Hospitalization - Intensive*	*BH/PARTIAL INTENSIVE*

4 - Individual Therapy	*BH/INDIV RX*
5 - Group Therapy	*BH/GROUP RX*
6 - Family Therapy	*BH/FAMILY RX*
7 - Bio Feedback	*BH/BIOFEED*
8 - Testing	*BH/TESTING*
9 – Other Behavior Health Treatments/Services	*BH/OTHER*

NOTE: **Medicare does not recognize codes 0912 and 0913 services under its partial hospitalization program.*

092X *Other Diagnostic Services*

Code indicates charges for other diagnostic services not otherwise categorized.

Subcategory	***Standard Abbreviations***
0 - General Classification	*OTHER DX SVS*
1 - Peripheral Vascular Lab	*PERI VASCUL LAB*
2 - Electromyelogram	*EMG*
3 - Pap Smear	*PAP SMEAR*
4 - Allergy test	*ALLERGY TEST*
5 - Pregnancy test	*PREG TEST*
9 - Other Diagnostic Service	*ADDITIONAL DX SVS*

093X *Medical Rehabilitation Day Program*

Medical rehabilitation services as contracted with a payer and/or certified by the State. Services may include physical therapy, occupational therapy, and speech therapy. The subcategories of 093X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable revenue codes as normal.

Subcategory	***Standard Abbreviations***
1 – Half Day	*HALF DAY*
2 – Full Day	*FULL DAY*

094X *Other Therapeutic Services (also See 095X, an extension of 094X)*

Code indicates charges for other therapeutic services not otherwise categorized.

Subcategory	***Standard Abbreviations***
0 - General Classification	*OTHER RX SVS*
1 - Recreational Therapy	*RECREATION RX*
2 - Education/Training (includes diabetes related dietary therapy)	*EDUC/TRAINING*
3 - Cardiac Rehabilitation	*CARDIAC REHAB*
4 - Drug Rehabilitation	*DRUG REHAB*
5 - Alcohol Rehabilitation	*ALCOHOL REHAB*
6 - Complex Medical Equipment Routine	*COMPLX MED EQUIP-ROUT*
7 - Complex Medical Equipment Ancillary	*COMPLX MED EQUIP-ANC*

	9 - Other Therapeutic Services	*ADDITIONAL RX SVS*

095X *Other Therapeutic Services-Extension of 094X*

Charges for other therapeutic services not otherwise categorized

Subcategory	***Standard Abbreviations***
0 - Reserved	
1 - Athletic Training	*ATHLETIC TRAINING*
2 - Kinesiotherapy	*KINESIOTHERAPY*

096X *Professional Fees*

Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	***Standard Abbreviations***
0 - General Classification	*PRO FEE*
1 - Psychiatric	*PRO FEE/PSYCH*
2 - Ophthalmology	*PRO FEE/EYE*
3 - Anesthesiologist (MD)	*PRO FEE/ANES MD*
4 - Anesthetist (CRNA)	*PRO FEE/ANES CRNA*
9 - Other Professional Fees	*OTHER PRO FEE*

097X *Professional Fees - Extension of 096X*

Subcategory	***Standard Abbreviations***
1 - Laboratory	*PRO FEE/LAB*
2 - Radiology - Diagnostic	*PRO FEE/RAD/DX*
3 - Radiology - Therapeutic	*PRO FEE/RAD/RX*
4 - Radiology - Nuclear Medicine	*PRO FEE/NUC MED*
5 - Operating Room	*PRO FEE/OR*
6 - Respiratory Therapy	*PRO FEE/RESPIR*
7 - Physical Therapy	*PRO FEE/PHYSI*
8 - Occupational Therapy	*PRO FEE/OCUPA*
9 - Speech Pathology	*PRO FEE/SPEECH*

098X *Professional Fees - Extension of 096X & 097X*

Subcategory	***Standard Abbreviations***
1 - Emergency Room	*PRO FEE/ER*
2 - Outpatient Services	*PRO FEE/OUTPT*
3 - Clinic	*PRO FEE/CLINIC*
4 - Medical Social Services	*PRO FEE/SOC SVC*
5 – EKG	*PRO FEE/EKG*
6 – EEG	*PRO FEE/EEG*
7 - Hospital Visit	*PRO FEE/HOS VIS*
8 - Consultation	*PRO FEE/CONSULT*
9 - Private Duty Nurse	*FEE/PVT NURSE*

099X *Patient Convenience Items*

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	***Standard Abbreviations***

0 - General Classification	*PT CONVENIENCE*
1 - Cafeteria/Guest Tray	*CAFETERIA*
2 - Private Linen Service	*LINEN*
3 - Telephone/Telegraph	*TELEPHONE*
4 - TV/Radio	*TV/RADIO*
5 – Non-patient Room Rentals	*NONPT ROOM RENT*
6 - Late Discharge Charge	*LATE DISCHARGE*
7 - Admission Kits	*ADMIT KITS*
8 - Beauty Shop/Barber	*BARBER/BEAUTY*
9 - Other Patient Convenience Items	*PT CONVENCE/OTH*

100X Behavioral Health Accommodations

Routine service charges incurred for accommodations at specified behavior health facilities.

Subcategory	***Standard Abbreviations***
0 - General Classification	*BH R&B*
1 – Residential Treatment - Psychiatric	*BH – R&B RES/PSYCH*
2 – Residential Treatment – Chemical Dependency	*BH R&B RES/CHEM DEP*
3 – Supervised Living	*BH R&B SUP LIVING*
4 – Halfway House	*BH R&B HALFWAY HOUSE*
5 – Group Home	*BH R&B GROUP HOME*

101X TO 209X Reserved for National Assignment

210X Alternative Therapy Services

Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042X, 043X, 044X, 091X, 094X, 095X) or services such as anesthesia or clinic (0374, 0511).

Alternative therapy is intended to enhance and improve standard medical treatment. The following revenue codes(s) would be used to report services in a separately designated alternative inpatient/outpatient unit.

Subcategory	***Standard Abbreviations***
0 - General Classification	*ALTTHERAPY*
1 - Acupuncture	*ACUPUNCTURE*
2 - Accupressure	*ACCUPRESSURE*
3 - Massage	*MASSAGE*
4 - Reflexology	*REFLEXOLOGY*
5 - Biofeedback	*BIOFEEDBACK*
6 - Hypnosis	*HYPNOSIS*
9 - Other Alternative Therapy Service	*OTHER THERAPY*

211X to 300X Reserved for National Assignment

310X Adult Care - Effective April 1, 2003

Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADLs)

Subcategory	***Standard Abbreviations***

0 - Note Used	
1 - Adult Day Care, Medical and Social - Hourly	*ADULT MED/SOC HR*
2 - Adult Day Care, Social - Hourly	*ADULT SOC HR*
3 - Adult Day Care, Medical and Social - Day	*ADULT MED/SOC DAY*
4 - Adult Day Care, Social - Daily	*ADULT SOC DAY*
5 - Adult Foster Care - Daily	*ADULT FOSTER CARE*
9 – Other Adult Care	*Other Adult*

311X to 899X	*Reserved for National Assignment*
9000 to 9044	*Reserved for Medicare Skilled Nursing Facility Demonstration Project*
9045 - 9099	*Reserved for National Assignment*

75.5 - Form Locators 43-81

(Rev.1018, Issued: 07-28-06, Effective: 03-01-07, Implementation: 03-01-07)

FL 43 - Revenue Description

Not Required*. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill. The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces). HHAs identify the specific piece of DME or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also see FL 80, Remarks.)*

FL 44 - HCPCS/Rates/HIPPS Rate Codes

Required. *When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.*

Health Insurance Prospective Payment System (HIPPS) Rate Codes

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a casemix group and assigns the correct RUG code. The AIs were developed by CMS. The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot

put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HCPCS Modifiers (Level I and Level II)

The UB-04 accommodates up to four modifiers, two characters each. See AMA publication CPT 200x (x= to current year) Current Procedural Terminology Appendix A - HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

Claims for home health (HH), inpatient skilled nursing facility (SNF), swing bed providers and inpatient rehabilitation facilities (IRF) enter the HIPPS code here where applicable. RHC/FQHC encounters billed on TOBs 071x or 073x do not require HCPCS coding. The complete list of HIPPS codes for use on SNF, swing bed, IRF and HH claims can be accessed at the following Web site: http://new.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp.

FL 45 - Service Date

Required *Outpatient. Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.*

Inpatient claims for skilled nursing facilities and swing bed providers enter the assessment reference date (ARD) here where applicable.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the

billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date. Assessment Date – used for billing SNF PPS (Bill Type 021X).

FL 46 - Units of Service
***Required**. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable for the following:*

- *Accommodations - 0100s - 0150s, 0200s, 0210s (days)*
- *Blood pints - 0380s (pints)*
- *DME - 0290s (rental months)*
- *Emergency room - 0450, 0452, and 0459 (HCPCS code definition for visit or procedure)*
- *Clinic - 0510s and 0520s (HCPCS code definition for visit or procedure)*
- *Dialysis treatments - 0800s (sessions or days)*
- *Orthotic/prosthetic devices - 0274 (items)*
- *Outpatient therapy visits - 0410, 0420, 0430, 0440, 0480, 0910, and 0943 (Units are equal to the number of times the procedure/service being reported was performed.)*
- *Outpatient clinical diagnostic laboratory tests - 030X-031X (tests)*
- *Radiology - 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS code definition of tests or services)*
- *Oxygen - 0600s (rental months, feet, or pounds)*
- *Drugs and Biologicals- 0636 (including hemophilia clotting factors)*

*The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.*
For RHCs or FQHCs, a "visit" is defined as a face-to-face encounter between a clinic/center patient, and one of the certified RHC or FQHC health professionals. Encounters with more than one health professional, and encounters with the same health professional which take place on the same day and at a single location constitute a single "visit," except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

EXAMPLE 1
A known diabetic visits the provider on the morning on May l and sees the physician assistant. The physician assistant believes an adjustment in current medication is required, but wishes to have the clinic's physician, who will be present in the afternoon, check the determination. The patient returns in the afternoon and sees the physician, who revises the prescribed medication. The physician recommends that the patient return the following week, on May 8, for a fasting blood sugar analysis to check the response to the change in medication. In this situation, the provider bills the Medicare program for one visit. Also, it includes a line item charge for laboratory services for May 1.
EXAMPLE 2
A patient visits the provider on July l complaining of a sore throat, and sees the physician assistant. The physician assistant examines the patient, takes a throat culture and requests that the patient return on July 8 for a follow-up visit to the physician assistant. In this situation, the provider bills the Medicare program for two visits. Also, it includes an entry for laboratory.

FL 47 - Total Charges - Not Applicable for Electronic Billers
Required*. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The FI determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, the FI adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the carrier to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.*

FL 48 - Noncovered Charges
Required*. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.*

FL 49 - (Untitled)
Not used. *Data entered will be ignored.*

Note: the "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A, B, and C - Payer Identification
Required*. If Medicare is the primary payer, the provider must enter "Medicare" on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate. Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on a Home Health Agency Request for Anticipated Payment (RAP). A = Primary Payer, B = Secondary Payer, and*
C = Tertiary Payer. For example: If "Medicare" is entered in Form Locator 50A, this indicates that the provider has determined based on the responses from the patient or the patient's representative or from the insurance enrollment card information that Medicare is the primary payer. In the UB-04, there are a number of value codes to indicate various reasons and amounts associated with insurance or other payers that are primary to Medicare (e.g., Form Locators 39-41, Codes 12, 13, 14, 15, 16, 41, 42, and 43). These value codes are analogous to "Payer Codes" (A, B, D, E, F, H, I, and G respectively). When applicable, use these value codes so they are consistent with the associated payer codes (both are required).

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID
Report the national health plan identifier when one is established;
otherwise report the "number" Medicare has assigned.

FLs 52A, B, and C - Release of Information Certification Indicator
Required*. A "Y" code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An "I" code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.*
NOTE: *The back of Form CMS-1450 contains a certification that all necessary release statements are on file.*

FL 53A, B, and C - Assignment of Benefits Certification Indicator
Not used. *Data entered will be ignored.*

FLs 54A, B, and C - Prior Payments

Situational. *For all services other than inpatient hospital or SNF the provider must enter the sum of any amounts collected from the patient toward deductibles (cash and blood) and/or coinsurance on the patient (fourth/last line) of this column. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as non-covered by Medicare. Thus, for example, if total inpatient hospital charges were $350.00 including $50.00 for a deductible pint of blood, the hospital would apportion $300.00 to the Part A deductible and $50.00 to the blood deductible. Blood is treated the same way in both Part A and Part B. Part A home health DME cost sharing amounts collected from the patient are reported in this item.*

FL 55A, B, and C - Estimated Amount Due From Patient
Not required.

FL 56 – National Provider ID (NPI)
Required, effective May 23, 2007.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)
Situational. *Use this field to report other provider identifiers as assigned by a health plan (as indicated in FL50 lines 1-3) prior to May 23, 2007.*

FLs 58A, B, and C - Insured's Name
Required. *On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider must enter the patient's name as shown on the HI card or other Medicare notice. All additional entries across line A (FLs 59-66) pertain to the person named in Item 58A. The instructions that follow explain when to complete these items.*
The provider must enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and it is requesting payment because:

- *Another payer paid some of the charges and Medicare is secondarily liable for the remainder;*
- *Another payer denied the claim; or*
- *The provider is requesting conditional payment. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:*
- *EGHPs for employed beneficiaries and spouses age 65 or over;*
- *EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period of up to l2 months;*
- *LGHPs for disabled beneficiaries;*
- *An auto-medical, no-fault, or liability insurer; or*

- *WC including BL.*

FL 59A, B, and C - Patient's Relationship to Insured
Required. *If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.*
Effective October 16, 2003

Code	***Title***
01	*Spouse*
18	*Self*
19	*Child*
20	*Employee*
21	*Unknown*
39	*Organ Donor*
40	*Cadaver Donor*
53	*Life Partner*
G8	*Other Relationship*

FLs 60A, B, and C – Insured's Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN))
Required. *On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's HICN, i.e., if Medicare is the primary payer, it enters this information in FL 60A. It shows the number as it appears on the patient's HI Card, Certificate of Award, Medicare Summary Notice, or as reported by the Social Security Office.*
If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP for the patient or the patient's spouse or during the first year of ESRD entitlement), it shows the involved claim number for that coverage on the appropriate line.

FL 61A, B, and C - Insurance Group Name
Situational (required if known). *Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the name of the group or plan through which that insurance is provided.*

FL 62A, B, and C - Insurance Group Number
Situational (required if known). *Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.*

FL 63 - Treatment Authorization Code
Situational. *Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever QIO review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.*

FL 64 – Document Control Number (DCN)
Situational. *The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.*

FL 65 - Employer Name
Situational. *Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.*

FL 66 – Diagnosis and Procedure code Qualifier (ICD Version Indicator)
Required. *The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision.* ***Medicare does not accept ICD-10 codes. Medicare only processes ICD-9 codes.***

FL 67 - Principal Diagnosis Code
Required*. The hospital enters the ICD code for the principal diagnosis. The code* ***must*** *be the full ICD diagnosis code, including all five digits where applicable. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied. The principal diagnosis code will include the use of "V" codes. Where the proper code has fewer than five digits, the hospital may not fill with zeros. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a DRG and cause the hospital to be incorrectly paid under PPS. The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported (7862). If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis (4660). When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:*

- *Routine general medical examination (V700);*
- *General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V709); and*
- *Examination of ears and hearing (V721).*

NOTE: *Diagnosis codes are not required on nonpatient claims for laboratory services where the hospital functions as an independent laboratory.*

FLs 67A-67Q - Other Diagnosis Codes
Inpatient Required. *The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may* ***not*** *duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. If the principal diagnosis is duplicated, the FI will remove the duplicate diagnosis before the record is processed by GROUPER for IPPS claims. The MCE identifies situations where the principal diagnosis is duplicated for IPPS claims.*
Outpatient - Required. *The hospital enters the full ICD codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*
NOTE: Medicare will ignore data submitted in 67I – 67Q.

FL 68
Not used. *Data entered will be ignored.*

FL 69 - Admitting Diagnosis
Required. *For inpatient hospital claims subject to QIO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. This definition is not the same as that for SNF admissions.*

FL70A – 70C - Patient's Reason for Visit
Situational. *Patient's Reason for Visit is required for all un-scheduled outpatient visits for outpatient bills.*

FL71 – Prospective Payment System (PPS) Code
Not used. *Data entered will be ignored.*

FL72 - External Cause of Injury (ECI) Codes
Not used. *Data entered will be ignored.*

FL 73
Not used. *Data entered will be ignored.*

FL 74 - Principal Procedure Code and Date
Situational. *Required on inpatient claims when a procedure was performed. Not used on outpatient claims.*

FL 74A – 74E - Other Procedure Codes and Dates
Situational. *Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.*

FL 75
Not used. *Data entered will be ignored.*

FL 76 - Attending Provider Name and Identifiers (including NPI)
Situational. *Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter.*
Secondary Identifier Qualifiers:
0B - State License Number
1G - Provider UPIN Number
G2 – Provider Commercial Number

FL 77 - Operating Provider Name and Identifiers (including NPI)
Situational. *Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).*
Secondary Identifier Qualifiers:
0B - State License Number
1G - Provider UPIN Number
EI - Employer's Identification Number
SY - Social Security Number

FLs 78 and 79 - Other Provider Name and Identifiers (including NPI)
The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.
Provider Type Qualifier Codes/Definition/Situational Usage Notes:
DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.
ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send.
82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.
Secondary Identifier Qualifiers:
0B - State License Number
1G - Provider UPIN Number
EI - Employer's Identification Number
SY - Social Security Number

FL 80 - Remarks
Situational. *For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's FI may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider*

enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)

FL 81 - Code-Code Field
Situational. *To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.*
Code List Qualifiers:
01-A0 Reserved for National Assignment
A1 National Uniform Billing Committee Condition Codes – not used for Medicare
A2 National Uniform Billing Committee Occurrence Codes – not used for Medicare
A3 National Uniform Billing Committee Occurrence Span Codes – not used for Medicare
A4 National Uniform Billing Committee Value Codes – not used for Medicare
A5 - B0 Reserved for National Assignment
B3 Health Care Provider Taxonomy Code
Code Source: ASC X12 External Code Source 682 (National Uniform Claim Committee)
B4-ZZ Reserved for National Assignment