

Medicare Claims Processing Manual

Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

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

(Rev. 1104, Issued: 11-03-06, Effective: 03-01-07, Implementation: 03-01-07)

70.1 - Uniform Billing with Form CMS-1450

(Rev. 1104, Issued: 11-03-06, 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. 1104, Issued: 11-03-06, 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. 1104, Issued: 11-03-06, 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	
L69	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. 1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

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 | Used when the Form CMS-1450 is used as a notice |

	Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation 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 or 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*

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

Inpatient: The patient was admitted to this facility

	Enforcement	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 where 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. 1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

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).

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)

Code Structure

Usage note: 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
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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 30 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 30 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

Code	Title	Definition
		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 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	(Sole Community Hospitals only). The

Code	Title	Definition
	Community Hospital for a Diagnostic Laboratory Test	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 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.

Code	Title	Definition
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 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).

Code	Title	Definition
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 <u>while the patient is still a patient of the hospital</u>).
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 product lifecycle	Replacement of a product earlier than the 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

Code	Title	Definition
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)

Code	Title	Definition
		for payment
64	Other Than Clean Claim	(Not reported by providers.) The claim is 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

Code	Title	Definition
		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 Care Plan	The bill is for a newly covered service under Medicare for which a managed 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.

Code	Title	Definition
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
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	For ambulance claims. Specialized treatment/bed unavailable. Transported to

Code	Title	Definition
	Unavailable	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).

Code	Title	Definition
C4	Admission Denied	The patient's need for inpatient services was 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	Self-explanatory

Code	Title	Definition
	Secondary Payer	
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 – FZ		Reserved for national assignment
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 OPSS 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

Code	Title	Definition
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. 1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

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.
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.

Code	Title	Definition
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

Code	Title	Definition
		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 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.

Code	Title	Definition
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 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	Date the patient was discharged from the hospital on a continuous course of IV

Code	Title	Definition
	therapy	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.
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.

Code	Title	Definition
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

Code	Title	Definition
E0		Reserved for National Assignment
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, 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.

Code	Title	Definition
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 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	From/Through dates of a period of inpatient

Code	Title	Definition
	Care	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 alphanumeric 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
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

Code	Title	Definition
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 of admission.

Code	Title	Definition
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	<p>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.</p> <p>For Part B coinsurance use value codes A2, B2 and C2.</p>
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	<p>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.</p>
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	<p>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.</p>
12	Working Aged Beneficiary Spouse With an EGHP	<p>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.</p>
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	<p>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,</p>

Code	Title	Definition
		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 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	(Not reported by providers.) The FI reports the

Code	Title	Definition
	Share Amount	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 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-	Chiropractic Services paid for out of a long term

Code	Title	Definition
	Payment Amount – Chiropractic Services	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).
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.

Code	Title	Definition
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 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.

Code	Title	Definition
		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	<i>The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.</i>
49	Hematocrit Reading	<i>The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the</i>

Code	Title	Definition
		<i>dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.</i>
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 for the number of visits are right justified from the dollars/cents delimiter as follows:

						1	3		
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The FI accepts zero or blanks in the cents position, converting blanks to zero for CWF.

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|----|-------------------------------------|---|
| 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 (O2 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 <u>§1812(a)(3)</u> 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 <u>§1812(a)(3)</u> 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 <u>§1812(a)(3)</u> 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 <u>§1812(a)(3)</u> 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

Code	Title	Definition
68	Number of Units of EPO Provided During the Billing Period	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.) Indicates the number of units of EPO 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		
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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.
73-75	Payer Codes	(For use by third party payers only.)
76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges

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. 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
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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 60 th day and before the 91 st day or inpatient SNF/Swing Bed days occurring after the 20 th and before the

Code	Title	Definition
		101 st 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 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

Code	Title	Definition
		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.

Code	Title	Definition
		For Part A coinsurance amounts use Value Codes 8-11.
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.

Code	Title	Definition
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	Patient Estimated Responsibility	The amount estimated by the provider to be paid by the indicated patient
D4-DQ		Reserved for national assignment
DR		Reserved for disaster related code
DS-DZ		Reserved for national assignment
E0-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

Code	Title	Definition
		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 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. 1104, Issued: 11-03-06, 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))

Revenue Code	Description
	5 - Reserved
	6 - Reserved
	7 - Reserved
	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

Revenue Code	Description
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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
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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
8 - Rehabilitation	REHAB/2BED
9 - Other	OTHER/2BED

013X Semi-private - three and Four Beds (Medical or General)

**Revenue
Code**

Description

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

Revenue Code**Description**

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

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**

Revenue Code	Description
	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 Services	IV THER/PHARM/SVC

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
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0 – General Classification	MED-SUR SUPPLIES
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1 – Non--sterile Supply	NONSTER SUPPLY
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2 - Sterile Supply	STERILE SUPPLY
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3 - Take Home Supplies	TAKEHOME SUPPLY
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4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
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5 - Pace maker	PACE MAKER
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6 - Intraocular Lens	INTR OC LENS
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7 – Oxygen - Take Home	02/TAKEHOME
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8 - Other Implants	SUPPLY/IMPLANTS
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9 - Other Supplies/Devices	SUPPLY/OTHER
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028X Oncology

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

Subcategory	Standard Abbreviations
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0 – General Classification	ONCOLOGY
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9 - Other Oncology	ONCOLOGY/OTHER
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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 - Angiocardiology	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
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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 (Cryoprecipitates)	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
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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
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0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC O2
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 restorative therapy)	OTHER OCCUP THER

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
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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)

2 - Rural Health-Home (Effective 7/1/06 will be changed to: Home visit by RHC/FQHC practitioner)

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 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
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0 - General Classification	SKILLED NURSING
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1 - Visit Charge	SKILLED NURS/VISIT
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2 - Hourly Charge	SKILLED NURS/HOUR
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9 - Other Skilled Nursing	SKILLED NURS/OTHER
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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
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0 - General Classification	MED SOCIAL SVS
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1 - Visit Charge	MED SOC SERV/VISIT
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2 - Hourly Charge	MED SOC SERV/HOUR
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9 - Other Med. Soc. Services	MED SOC SERV/OTHER
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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
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0 - General Classification	AIDE/HOME HEALTH
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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 \leq 10,000 units
5 - Erythropoietin (EPO) 10,000 or more units	DRUG/EPO \geq 10,000 units
6 - Drugs Requiring Detailed Coding (a)	DRUGS/DETAIL CODE
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-respite)	HOSPICE/IP NON 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 state 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
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0 - General Classification	GASTR-INTS SVS
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9 - Other Gastro-Intestinal	OTHER GASTRO-INTS
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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
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0 - General Classification	TREATMENT/OBSERVATION RM
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1 - Treatment Room	TREATMENT RM
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2 - Observation Room	OBSERVATION RM
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9 – Other Treatment Room	OTHER TREATMENT RM
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077X Preventative Care Services

Charges for the administration of vaccines.

Subcategory	Standard Abbreviations
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0 - General Classification	PREVENT CARE SVS
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1 - Vaccine Administration	VACCINE ADMIN
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9 – Other	OTHER PREVENT
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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
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0 - General Classification	CCPD/OP OR HOME
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1 - CCPD/Composite or Other Rate	CCPD/COMPOSITE
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2 – Home Supplies	CCPD/HOME/SUPPL
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3 – Home Equipment	CCPD/HOME/EQUIP
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4 - Maintenance/100%	CCPD/HOME/100%
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5 - Support Services	CCPD/HOME/SUPSERV
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9 – Other CCPD Dialysis	CCPD/HOME/OTHER
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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
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0 - General Classification	DIALY/MISC
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1 – Ultra-filtration	DIALY/ULTRAFILT
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2 - Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
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9 - Other Miscellaneous Dialysis	DIALY/MISC/OTHER
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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
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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 CONVENIENCE/OTH

100X Behavioral Health Accommodations

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

Subcategory	Standard Abbreviations
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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	ALT THERAPY
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. 1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

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 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/PropMedicareFeeSvcPmtGen/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 1 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 1 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 12 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
------	-------

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

G2 – Provider Commercial Number

FLs 78 and 79 - Other Provider Name and Identifiers (including NPI)

Situational. 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

G2 – Provider Commercial 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

80 – Reserved

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1254CP	05/25/2007	National Uniform Billing Committee (NUBC) Update to Chapter 25	06/11/2007	5593
R1104CP	11/03/2006	Uniform Billing (UB-04) Implementation	03/01/2007	5072
R1078CP	10/13/2006	Updating the Medicare Secondary Payer (MSP) Manual for Consistency on Instructing Part A Contactors on Handling MSP Claims with Condition Code (cc) 08	04/02/2007	5266
R1018CP	07/28/2006	Uniform Billing (UB-04) Implementation	03/01/2007	5072
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R901CP	04/07/2006	New National Uniform Billing Committee (NUBC) Codes and Other Chapter 25 Revisions	05/08/2006	4384
R529CP	04/22/2005	Update to Current National Uniform Billing Committee (NUBC) Codes.	07/05/2005	3794
R493CP	03/04/2005	Revision to Chapter 1 and Removal of Section 70 from Chapter 25 of the Medicare Claims Processing Manual	04/04/2005	3671
R368CP	11/12/2004	Instructions for Completion of Form CMS-1450	04/04/2005	3543
R311CP	10/08/2004	Relocation of Sections 20 and 30 to Chapter 24 Clarification of Noncovered Days, Patient Status Codes and Revenue Codes New Condition Codes and Value Codes	1/5/2005	3417

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R303CP</u>	09/24/2004	Relocation of Sections 20 and 30 to Chapter 24 Clarification of Noncovered Days, Patient Status Codes and Revenue Codes New Condition Codes and Value Codes	01/05/2005	3417
<u>R199CP</u>	06/10/2004	Rejection of Any Outpatient Claim Containing a Range of Dates in the Line Item Date of Service (LIDOS) Field	10/04/2004	3337
<u>R167CP</u>	4/30/2004	Replacement of Revenue Code 0910 by Revenue Code 0900 to Report Certain Psychiatric/ Psychological Treatment and Services. Addition of Provider Range 4900-4999 to the Applicable Provider Ranges for Community Mental Health Centers	10/04/2004	3194
<u>R149CP</u>	04/23/2004	Update for New Condition Code, and to Clarify Patient Status Codes and Revenue Code 0910	10/04/2004	3183
<u>R107CP</u>	02/24/2004	Changes in X12N937 Institutional Edits	07/06/2004	3031
<u>R081CP</u>	02/06/2004	New Condition and Value Codes Approved by the National Uniform Billing Committee (NUBC) and Addition of All NUBC Approved Codes that Were Not Previously in Medicare Instructions, to Be Complaint With the HIPAA Requirements	07/06/2004	3012
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA