Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2655

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3604 (Cont) – 3604 (Cont.)	6-29 – 6-32 (4 pp.) 6-35 – 6-44.2 (12 pp.) 6-51 – 6-54.2D (10 pp.) 6-54.19 – 6-54.22 (4 pp.) 6-54.25 – 6-54.26 (2 pp.) 6-57 – 6-64 (8 pp.)	6-29 – 6-32 (4 pp.) 6-35 – 6-44 (10 pp.) 6 –51 – 6-54.2 (6 pp.) 6-54.19 – 6-54.22 (4 pp.) 6-54.25 – 6-54.26 (2 pp.) 6-57 – 6-64 (8 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATES: October 16, 2003, April 1, 2003 and October 1, 2002*
IMPLEMENTATION DATE: October 16, 2003

Section 3604, Review of Form HCFA-1450 for Inpatient and Outpatient Bills, is being updated to include new condition codes for Form Locator FL 24 and new value codes for (FL) 39 approved by the National Uniform Billing Committee (NUBC) with an effective date of October 16, 2003 to coincide with the implementation of the HIPAA 837 institutional guide. The new codes have the 10/16/2003 date in their descriptions. All other redlined items are already in effect, but were not included in the Intermediary Manual and are being updated with this transmittal. All of the updates may not apply to Medicare but because of the HIPAA legislation CMS must accept all valid codes in order to pass the codes on to another payer, for possible coordination of benefits.

Provider Education: Intermediaries shall notify providers of these new codes in their next regularly scheduled bulletin and post them on your Web site within 2 weeks of receiving this instruction. In addition, if you have a list-serv that targets the affected provider communities, you shall use it to notify subscribers that important information about the new codes approved by the NUBC is available on your Web site.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

upon the amount Medicare will pay and enter the utilization days chargeable to the beneficiary in the utilization days on the UB-92 CWF RECORD. (See §§3682 and 3685.)

For discussion of how to determine whether part of a day is covered, see §§3620ff.

If the provider reported an incorrect number of days, report the correct number when you submit the CWF RECORD.

FL 8. Noncovered Days
Required. The total number of noncovered days during the billing period within the "From" and "Through" date that are not claimable as Medicare patient days on the cost report.

FL 9. Coinsurance Days
Required. The number of covered inpatient hospital days occurring after the 60th day and before the 9lst day or the number of covered inpatient SNF days occurring after the 20th day and before the l0lst day of the benefit period are shown for this billing period.

FL 10. Lifetime Reserve Days
Required. The provider enters the number of lifetime reserve days applicable. Change this entry, if necessary, based on data developed by your claims processing system. (See §3106.2 for special considerations in election of lifetime reserve days.)

FL 11. (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 12. Patient's Name
Required. The patient's name is shown with the surname first, first name, and middle initial, if any.

FL 13. Patient's Address
Required. This item shows the patient's full mailing address including street number and name, post office box number or RFD, City, State, and ZIP code. A valid ZIP code is required for PRO purposes on inpatient bills.

FL 14. Patient's Birthdate
Required. The month, day, and year of birth is shown numerically as MMDDYYYY. If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.

FL 15. Patient Sex
Required. A "M" for male or a "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Patient's Marital Status
Not Required.

FL 17. Admission Date
Required. The month, day, and year of admission for inpatient care is shown numerically as MMDDYY. When using Form HCFA-1450 as a hospice admission notice, the facility shows the date the beneficiary elected hospice care.

FL 18. Admission Hour
Not Required.

FL 19. Type of Admission/Visit
Required on inpatient bills only. This is the code indicating priority of this admission/visit.

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 and 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.
9	Information Not Available	The hospital cannot classify the type of admission. This code is used only on rare occasions.

FL 20. Source of Admission
Required. This is the code indicating the source of this admission or outpatient registration.

Code Structure (for Emergency, Elective or Other Type of Admission):

1	Physician Referral	Inpatient: The patient was admitted upon the recommendation of a personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Inpatient: The patient was admitted 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	HMO Referral	Inpatient: The patient was admitted upon the recommendation of an HMO physician.

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.
4	Transfer from a Hospital	Inpatient: The patient was admitted as a transfer from an acute care facility 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 another acute care facility.
5	Transfer from a SNF	Inpatient: The patient was admitted 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 is an inpatient.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a SNF. This includes transfers from nursing homes, long-term care facilities, and SNF patients that are at a nonskilled 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 he or she is an inpatient.
7	Emergency Room	Inpatient: The patient was admitted upon the recommendation of this facility's emergency room physician. Outpatient: The patient received services in this facility's emergency department.
8	Court/Law Enforcement	Inpatient: The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency's 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 is not known. Outpatient: For Medicare outpatient bills this is not a valid code.
A	Transfer from a Critical Access Hospital	Inpatient: The patient was admitted to this facility as a transfer from a Critical Access Hospital 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 Critical Access Hospital where he or she is 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-Z		Reserved for national assignment.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. (For all Part A inpatient, SNF, hospice, 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 another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04-ICF.)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
*09	Admitted as an inpatient to this hospital
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility, (e.g., hospital, SNF, ICF or freestanding hospice)
42	Expired - place unknown (hospice claims only)
43-49	Reserved for national assignment
50	Hospice - home
51	Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
62-70	Reserved for national assignment
73-99	Reserved for national assignment

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

Code	Title	Definition
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Code indicates that 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	Code indicates that 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 coverage from a 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 that 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 he/she is enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that he/she enrolled in a cooperative/ work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that he/she is enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that he/she is enrolled as a part-time student.
ACCOMMODATIONS		
35		Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Code indicates the hospital temporarily placed the patient in a special care unit because no general care beds were available.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) Code indicates that the patient was assigned to ward

Code	Title	Definition
		accommodations at his own request. This code must be supported by a written request in the provider's files. (See §3101.1F.)
38	Semi-Private Room Not Available	(Not used by hospitals under PPS.) Code indicates that the patient's assignment to a ward or private room was because there were no semi-private rooms available at admission.

NOTE: If revenue charge codes indicate a ward accommodation was assigned and neither code 37 or 38 apply, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, pay semi-private costs.

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Code indicates patient's assignment to a private room was for medical reasons.
40	Same Day Transfer	Code indicates patient was transferred from one participating provider to another before midnight on the day of admission.
41	Partial Hospitalization	Code indicates claim is for partial hospitalization services. For outpatients this includes a variety of psychiatric programs. (See §§3112.7C and D for a description of coverage.)
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 Postdischarge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the postdischarge window.
55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Code indicates 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	Code indicates the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Medicare+Choice Organization Enrollee	Code indicates that patient is a terminated enrollee in a Medicare+Choice Organization plan whose three-day inpatient hospital stay was waived.
59		Reserved for national assignment

Code	Title	Definition
60	Operating Cost Day Outlier	(Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. Indicate the operating cost outlier portion paid in value code 17.
61	Operating Cost Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. Indicate the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Code indicates bill was paid under PIP. Record this from your system.
63	Payer Only Code	Code reserved for internal use only. CMS assigns as needed. Providers do not report this code.
64	Other Than Clean Claim	(Not reported by providers.) Code indicates the claim is not "clean." Record this from your system.
65	Non-PPS Bill	(Not reported by providers.) Code indicates bill is not a PPS bill. Record this from your system for non-PPS hospital bills.
66	Provider Does Not Wish Cost Outlier Payment	Code indicates a hospital paid under PPS is not requesting additional payment as a cost outlier for this stay.
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary has elected 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 EPO	Code indicates the billing is for a dialysis patient who self-administers EPO.
71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care In Unit	Code indicates the billing is for a patient who managed his/her own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where the patient and his/her helper (if necessary) were learning to perform dialysis.

Code	Title	Definition
74	Home	Code indicates the billing is for a patient who received dialysis services at home.
75	Home 100 percent Payment	(Not to be used for services furnished 4/16/90 or later.) Code indicates the billing is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100 percent program.
76	Back-up In-facility Dialysis	Code indicates the billing 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 a Primary Payer as Payment in Full	Code indicates 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 HMO	Code indicates this bill is for a Medicare newly covered service for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off Site	Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

Special Program Indicator Codes

Code	Title	Definition
A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A3	Special Federal Funding	This code is designed for uniform use by State uniform billing committees.
A5	Disability	This code is designated for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumonia/ Influenza 100% Payment	This code identifies that pneumococcal/influenza vaccine (PPV) services given that are to be paid under a special Medicare program provision.
A7	Induced Abortion-Danger to Life	Code indicates an abortion was performed to avoid danger to woman's life.
A8	Induced Abortion- Victim of Rape/Incest	Self-explanatory. Discontinued 10/01/02
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.

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

Code	Title	Definition
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-BZ		Reserved for national assignment
M0-M9	Payer Only Codes	
M0	All-Inclusive Rate for Outpatient	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Code indicates the influenza virus vaccine or Pneumococcal Pneumonia Vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.
PRO Approval Indicator Codes		
C1	Approved as Billed	Code indicates claim has been reviewed by the PRO and is fully approved including any day or cost outlier.
C3	Partial Approval	Code indicates the bill has been reviewed by the PRO and some portion (days or services) has been denied. From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. Exclude grace days and any period at a noncovered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	Code indicates patient's need for inpatient services was reviewed by the PRO and none of the stay was medically necessary.
C5	Postpayment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/ Preprocedure	Code indicates that the PRO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	Code indicates the PRO authorized these services for an extended length of time, but has not reviewed the services provided.

Claim Change Reasons

Code	Title	Definition
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	Change in ICD-9-CM Diagnosis and/or Procedure Codes	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in diagnosis (FL67-77) and procedure codes (FL80-81)
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory.
D8	Change to Make Medicare the Primary Payer	Self-explanatory.
D9	Any Other Change	Self-explanatory.
E0	Change in Patient Status	Self-explanatory.
E1-E9		Reserved for national assignment
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue the visits were distinct and constituted independent visits.
G1-G9		Reserved for national assignment
H0	Delayed Filing, Statement Of Intent Submitted specifically	Code indicates that Statement of Intent was submitted within the qualifying period to identify the existence of another third party liability situation.

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 services.

FL 31. (Untitled)
Not Required. This is one of four fields which are not assigned. Use of the field, if any, is assigned by the NUBC.

FLs 32, 33, 34 and 35. Occurrence Codes and Dates
Required. Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36 A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B 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" date 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.

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

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	Code indicates the 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	Code indicates the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicates the date of accident relating to the patient's employment. (See §§3407-3416.)
05	Accident/No Medical or or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury.
11	Onset of Symptoms/Illness	Code indicates the date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	(HHA claims only) Code indicates the date the patient/beneficiary became a chronically dependent

Code	Title	Definition
		individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit
16	Date of Last Therapy	Code indicates the last day of therapy services(e.g. physical, occupational or speech therapy).
17	Date Occupational Therapy Plan Established or Reviewed	Code indicates the date a plan was established or last reviewed for occupational therapy.
18	Date of Retirement Patient/Beneficiary	Code indicates the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code indicates the date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A claims only.) Code indicates date on which the provider began claiming payment under the guarantee of payment provision. (See §3714.)
21	UR Notice Received	(Part A SNF claims only.) Code indicates date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See §3421.1.)
22	Date Active Care Ended	Code indicates 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 Intermediary Use Only. Providers Do Not Report. Code is not required if code “21” is used.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	Code indicates the date on which coverage (including Worker’s Compensation benefits or no-fault coverage) is not longer available to the patient.
26	Date SNF Bed Available	Code indicates 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	Code indicates 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.

Code	Title	Definition
28	Date CORF Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for CORF care. (See §3350.)
29	Date OPT Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for OPT. (See §3350.)
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for outpatient speech pathology. (See §3350.)
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
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) may not be reasonable or necessary under Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	Code indicates 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	Code indicates the date the guest elected to receive extended care services (used by Religious Non-medical Health Care Institution only)
35	Date Treatment Started For Physical Therapy	Code indicates the date the billing provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge For Transplant Procedure	Code indicates the date of discharge for the inpatient hospital stay during which the patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
37	Date of Inpatient Hospital Discharge Non-covered Transplant Patient	Code indicates the date of discharge for inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test, was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the tests (s).
42	Date of Discharge	(Hospice claims only.) Code indicates date on which the beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (See §3648, FLS 32-35, code 42.) The frequency digit (3rd digit, FL 4, Type of Bill) should be 1 or 4.

Code	Title	Definition
43	Scheduled Date of Canceled Surgery	The date for which ambulatory surgery was scheduled.
44	Date Treatment Started For Occupational Therapy	Code indicates the date the billing provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	Code indicates the date the billing provider initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	Code indicates the date the billing 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	Codes reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers do not report them.
A1	Birthdate-Insured A	Code indicates the birth date of the insured in whose name the insurance is carried.
A2	Effective Date- Insured A Policy	Code indicates the first date the insurance is in force.
A3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer A.
B1	Birthdate- Insured B	Code indicates the birth date of the individual in whose name the insurance is carried.
B2	Effective Date- Insured B Policy	Code indicates the first date the insurance is in force.
B3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate- Insured C	Code indicates the birth date of the individual in whose name the insurance is carried.
C2	Effective Date- Insured C policy	Code indicates the first date the insurance is in force.
C3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer C.
C4-C9		Reserved for national assignment.

Code	Title	Definition
D0-D9		Reserved for national assignment.

FL 36. Occurrence Span Code and Dates.
Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

Code Structure (only the codes used for Medicare are shown).

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) Code indicates the dates shown are for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Nonutilizaton Dates (For Payer Use On Hospital Bills Only)	Code indicates a period of time during a PPS inlier stay for which the beneficiary had exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Prior Stay Dates	(Part A claims only.) Code indicates from/through dates given by the patient for any hospital stay that ended within 60 days of this hospital or SNF admission.

Code	Title	Definition
42	Veterans Affairs	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. (See §3153.1A.)
43	Disabled Beneficiary Under Age 65 With LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
44	Amount Provider Agreed Accept From Primary Payer When this Amount is Less Than Charges But Higher than Payment Received	Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due. (See §3682.1.B.6 for an explanation.)
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, (Condition Code) indicating that the PRO has denied all or a portion of this billing period, the number of days determined by the PRO to be covered while arrangements are made for the patient's post discharge are shown. The field contains one numeric digit.
47	Any Liability Insurance	Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. (See §§3419ff.) If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.
48	Hemoglobin Reading	Code indicates the latest hemoglobin reading taken during this billing cycle. This is usually reported in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.
49	Hematocrit Reading	Code indicates the latest hematocrit reading taken during this billing cycle. This is usually reported in two positions(a percentage) to the left of the dollar cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Code	Title	Definition
50	Physical Therapy Visits	Code indicates the number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	Code indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	Code indicates the number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	Code indicates 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 of admission of 4 and on other claims as required by state law.
55		Reserved for national assignment.
56	Skilled Nurse- Home Visit Hours (HHA only)	Code indicates the number of hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour.)
57	Home Health Aide- Home Visit Hours (HHA only)	Code indicates the number of hours of home health aide services provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour).

NOTE: Codes 50-57 and 60 are not money amounts but represent the number of visits. Entries for the number of visits are right justified to the left of the dollars/cents delimiter as shown.

					1	3		

Accept zero or blanks in cents position. Convert blanks to zero for CWF.

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

Code	Title	Definition
		Report 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

60	HHA Branch MSA	Code indicates MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's - Report the MSA number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.)
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
62-65	Payer Codes	THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
66		Reserved by NUBC for Medicaid client spend down liability.
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justify to the left of the dollar/cent delimiter. (Round to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing	Code indicates the number of units of EPO administered and/or supplied relating to the Period billing period and is reported in whole units to the left of the dollar/cents delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

				3	1	0	6	0

70	Interest Amount	(For internal use by third party payers only.) Report the amount of interest applied to this claim.

Code	Title	Definition
71	Funding of ESRD Networks	(For internal use by third party payers only.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
72	Flat Rate Surgery Charge	Code indicates the amount of the standard charge for outpatient surgery where the hospital has such a charging structure.
75	Gramm/Rudman/Hollings	(For internal use by third party payers only.) Report the amount of sequestration.
76	Provider's Interim Rate	(For internal use by third party payers only.) Report the provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. Report to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0

77-79	Payer Codes	Codes reserved for internal use only by third party payers. HCFA assigns as needed. Providers do not report payer codes.
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 assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount assumed by the provider to be applied to the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	The amount estimated by the provider to be paid by 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 (e.g., diabetic coma). For use with Revenue Code 0637.
A5	Covered Self-Administrable Drugs – Not Self-Administrable In Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.

Code	Title	Definition
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 reason (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 coinsurance amount involving the indicated payer.
A8-A9		Reserved for national assignment
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 10/16/03
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 10/16/03
AC-AZ		Reserved for national assignment
B1	Deductible Payer B	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11
B3	Estimated Responsibility Payer B	The amount estimated by the provider to be paid by the indicated payer.
B5-B6		Reserved for national assignment
B7	Co-insurance Payer B	The amount assumed by the provider to 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 Health Care 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 payer. Effective 10/16/03
BC-C0		Reserved for national assignment

Code	Title	Definition
C1	Deductible Payer C	The amount assumed by the provider to 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 assumed by the provider to 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	The amount estimated by the provider to be paid by the indicated payer.
C4-C6		Reserved for national assignment
C7	Co-payment Payer C	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
C8-C9		Reserved for national assignment
CA	Regulatory Surcharges, Assessments, Allowances or Health Care 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 10/16/03
CC-CZ		Reserved for national assignment
D0-D2		Reserved for national assignment
D3	Estimated Responsibility Patient	The amount estimated by the provider to be paid by the indicated patient.
D4-DZ		Reserved for national assignment
E0		Reserved for national assignment
E1	Deductible Payer D	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
E2	Coinsurance Payer D	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Vale Codes 8-11.
E3	Estimated Responsibility Payer D	The amount estimated by the provider to be paid by the indicated payer.

Code	Title	Definition
E4-E6		Reserved for national assignment
E7	Co-payment Payer D	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
E8-E9		Reserved for national assignment
EA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer D	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
EB	Other Assessments or Allowances (e.g., Medical Education) Payer D	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
EC-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Deductible Payer E	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
F2	Coinsurance Payer E	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Vale Codes 8-11.
F3	Estimated Responsibility Payer E	The amount estimated by the provider to be paid by the indicated payer.
F4-F6		Reserved for national assignment
F7	Co-payment Payer E	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
F8-F9		Reserved for national assignment
FA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer E	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
FB	Other Assessments or Allowances (e.g., Medical Education) Payer E	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
FC-FZ		Reserved for national use

Code	Title	Definition

G0		Reserved for national assignment
G1	Deductible Payer F	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
G2	Coinsurance Payer F	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Vale Codes 8-11.
G3	Estimated Responsibility Payer F	The amount estimated by the provider to be paid by the indicated payer.
G4-G6		Reserved for national assignment
G7	Co-payment Payer F	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
G8-G9		Reserved for national assignment
GA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer F	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
GB	Other Assessments or Allowances (e.g., Medical Education) Payer F	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
GC-GZ		Reserved for national use
H0-WZ		Reserved for national use
X0-ZZ		Reserved for national use

FL 42. Revenue Code

Required. For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered 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. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry in FL 47 is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48 are summed.

To assist in bill review, revenue codes are listed in ascending numeric sequence to the extent possible. To limit the number of line items on each bill, revenue codes are summed at the "zero" level to the extent possible.

Providers have been instructed to provide detailed level coding for the following revenue code

series:

0290s - rental/purchase of DME
0304 - rental and dialysis/laboratory
0330s - radiology therapeutic
0367 - kidney transplant
0420s - therapies
0520s - type of clinic visit (RHC or other)
0550s-0590s - 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 services which do not require HCPC codes.

0001 Total Charge
For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, 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 Abbreviation
0 - Reserved	
1 - Reserved	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HH PPS (HRG)
4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (CMG)
5 - Reserved	
6 - Reserved	
7 - Reserved	
8 - Reserved	
9 - Reserved	

003X to 006X Reserved for National Assignment

007X to 009X Reserved for State Use

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 bed rooms.

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

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT

	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 Abbreviation
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

060X Oxygen (Home Health)

Charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary had purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply. DME (other than oxygen systems) is billed under current revenue codes 291, 292, or 293.

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

Subcategory	Standard Abbreviation
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)

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 Abbreviation
0 - General Classification	MRI
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 - Other MRI	MRI - OTHER

062X Medical/Surgical Supplies - Extension of 027X

Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that do not bill supplies used under 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 Abbreviation
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 Abbreviation
0 - RESERVED (Effective 1/1/98)	
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythroepoetin (EPO) less than 10,000 units	DRUG/EPO/≤10,000 units
5 - Erythroepoetin (EPO) 10,000 or more units	DRUG/EPO/≥10,000 units
6 - Drugs Requiring Detailed Coding*	DRUGS/DETAIL CODE
7 - Self-administrable Drugs	DRUGS/SELFADMIN

NOTE: *Revenue code 636 relates to HCPCS code, so HCPCS is the recommended code to be used in FL 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).

NOTE: Value code A4 used in conjunction with Revenue Code 637 indicates the amount included for covered charges for the ordinarily non-covered, self-administered drug insulin administered in an emergency situation to a patient in a diabetic coma. This is the only ordinarily non-covered, self-administered drug covered under Medicare with this value code.

064X Home IV Therapy Services

Charge for intravenous drug therapy services which 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 Abbreviation
0 - General Classification	IV THERAPY SVC
1 - Nonroutine 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/PERIPHAL
4 - Nonroutine 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 642 relates to the HCPCS code.

065X Hospice Services

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

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

Subcategory	Standard Abbreviation
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 (nonrespite)	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)

Charges 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 license professional nurse.

Subcategory	Standard Abbreviation
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

Subcategory	Standard Abbreviation
9 - Other Respite Care	RESPITE/CARE

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

Subcategory	Standard Abbreviation
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 Abbreviation
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

069X Not Assigned

007X Cast Room

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

Rationale: Permits identification of this service, if necessary.

Subcategory	Standard Abbreviation
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 Abbreviation
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 it is not covered by all third party payers.

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 Abbreviation
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 814 is used only when costs incurred for an organ search does 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 Abbreviation
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 Abbreviation
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

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

Subcategory	Standard Abbreviation
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 - Maintanence 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 Abbreviation
0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 - Other CCPD Dialysis	CCPD/HOME/OTHER

086X Reserved for Dialysis (National Assignment)

087X Reserved for Dialysis (State Assignment)

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration 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 only used when the procedure is not performed as part of a normal dialysis session.

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 component 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, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

All revenue codes requiring HCPC codes and paid under a fee schedule are billed as net.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49. (Untitled)
Not Required. This is one of the four fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLS 50A, B, C. Payer Identification
Required. If Medicare is the primary payer, "Medicare" is entered on line A. If Medicare is entered, the provider has developed for other insurance and has 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 lines B or C, as appropriate. (See §§3407-3415, §§3419, and §§3489-3492 to determine when Medicare is not the primary payer.)

FLs 51A, B, and C. Provider Number
Required. This is the six-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 52A, B, and C. Release of Information
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

NOTE: The back of Form HCFA-1450 contains a certification that all necessary release statements are on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments
Required. For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column.

Part A home health DME cost sharing amounts collected from the patient are reported in this item. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as noncovered by Medicare. Thus, for example, if total inpatient hospital charges are $350 including $50 for a deductible pint of blood, $300 is to be apportioned to the Part A deductible and $50 to the blood deductible. Blood is treated the same way in both Part A and Part B.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56 (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 57. (Untitled)
Not Required. This is one of the seven fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

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 enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across that line (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider 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 a conditional payment as described in "3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and their spouses. (See §3491.);
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to 30 months. (See §3490.);
- LGHPs for disabled beneficiaries;
- Automobile medical, no-fault, or liability insurer. (See §§3419 and 3490.); or
- WC, including BL. (See §§3407-3416.)

FLs 59A, B, and C. Patient's Relationship to Insured
Required. If the provider is claiming a payment under any of the circumstances described in the second paragraph of FLs 58A, B, or C, it may enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

I. Effective Until October 16, 2003

Code	Title	Description	Map to List II
01	Patient Is Insured	Self-explanatory	18
02	Spouse	Self-explanatory	01
03	Natural Child/Insured Financial Responsibility	Self-explanatory	19
04	Natural Child/Insured Does not Have Financial Responsibility	Self-explanatory	43
05	Step Child	Self-explanatory	17
06	Foster Child	Self-explanatory	10
07	Ward of the Court	Patient is ward of the insured as a result of a court order.	15
08	Employee	Patient is employed by the insured.	20
09	Unknown	Patient's relationship to the insured is unknown.	None
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as	22

Code	Title	Description	Map to List II
		result of laws or agreements extending coverage.	
11	Organ Donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.	39
12	Cadaver Donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.	40
13	Grandchild	Self-explanatory	05
14	Niece/Nephew	Self-explanatory	07
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.	41
16	Sponsored Dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.	23
17	Minor Dependent of a Minor Dependent	Code is used where patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured.	24
18	Parent	Self-explanatory	None
19	Grandparent	Self-explanatory	04
20	Life Partner	Patient is covered under insurance policy of his/her life partner (or similar designation, e.g., domestic partner, significant other)	29*, 53*
21-99		Reserved for national assignment	None

II. Effective October 16, 2003

Code	Title	Description	Map to List I
01	Spouse		02
04	Grandfather or Grandmother		19
05	Grandson or Granddaughter		13
07	Nephew or Niece		14
10	Foster Child		06
15	Ward	Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order.	07
17	Stepson or Stepdaughter		05
18	Self		01

Code	Title	Description	Map to List I
19	Child		03
20	Employee		08
21	Unknown		09
22	Handicapped Dependent		10
23	Sponsored Dependent		16
24	Dependent of Minor Dependent		17
29	Significant Other		None*
32	Mother		None
33	Father		None
36	Emancipated Minor		None
39	Organ Donor		11
40	Cadaver Donor		12
41	Injured Plaintiff		15
43	Child Where Insured Has No Financial Responsibility		04
53	Life Partner		None*
G8	Other Relationship		None

* No 1:1 map for Significant Other and Life Partner.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number Required. The provider enters the patient's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, EOMB, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the SSO. 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, this information is entered in FL 60A.

If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP coverage for the patient or the spouse or during the first year of ESRD entitlement), the involved claim number for that coverage is shown on the appropriate line.

FLs 61A, B, and C. Group Name
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the name of the insurance group or plan.

FLs 62A, B, and C. Insurance Group Number
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the identification number, control number, or code assigned by such health insurance carrier.

FL 63. Treatment Authorization Code
Required. Whenever PRO review is performed for outpatient preadmission, preprocedure, or inpatient preadmission, the authorization number is required for all approved admissions or services.

FL 64. Employment Status Code
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the code which defines the employment status of the individual identified on the same line in FL 58, if the information is readily available.

Code	Title	Definition
1	Employed Full-Time	Individual stated that he or she is employed full-time
2	Employed Part-Time	Individual stated that he or she is employed part-time
3	Not Employed	Individual states that he or she is not employed full-time or part time
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for National Assignment
9	Unknown	Individual's Employment Status is unknown

FL 65. Employer Name
Required. Where the provider is claiming a 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. Employer Location
Required. Where the provider is claiming a 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 specific location of the employer of the individual identified on the same line in FL 58. A specific location is the city, plant, etc., in which the employer is located.

FL 67. Principal Diagnosis Code
CMS only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in DHHS Publication No. (PHS) 89-l260 or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

Inpatient--Required. The provider reports the principal diagnosis in this field. 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 principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital under PPS.

Outpatient--Required. Hospitals report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. Hospitals report the diagnosis to their 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 is reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0).

If the patient arrives at the hospital for examination or testing without a referring diagnosis and

cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:

- o Routine general medical examination (V70.0);
- o General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); or
- o Examination of ears and hearing (V72.1).

FLs 68-75. Other Diagnoses Codes
Inpatient--Required. The provider reports the full ICD-9-CM 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.

The principal diagnosis entered in FL 67 should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, eliminate it before GROUPER. Proper installation of MCE identifies situations where the principal diagnosis is duplicated.

Outpatient--Required. Hospitals report the full ICD-9-CM codes in FLs 68-75 for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL 67. For instance, if the patient is referred to the hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported here.

FL 76. Admitting Diagnosis/Patient's Reason for Visit
Required. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. (See §3770.1.) Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 76 is a dual use field, Patient's Reason for Visit is not required by Medicare but may be used by providers for non scheduled visits for outpatient bills.

FL 77. E-Code
Not Required.

FL 78. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 79. Procedure Coding Method
Not Required.

FL 80. Principal Procedure Code and Date
Required for Inpatient Only. The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (FL 67).

For this item, surgery includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation. Review this item against FLs 42-47. It may alert you to noncovered services or omissions.

The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all four digit codes where applicable. See first paragraph under FL 67 for acceptable ICD-9-CM codes.

The date applicable to the principal procedure is shown numerically as MM-DD-YY in the "date" portion.

Transmit to CMS the original codes reported by the provider, unless in the course of the claims development process you restore contradictory correct codes.

FL 81. Other Procedure Codes and Dates
Required for Inpatient Only. The full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 80). The date of each procedure is shown in the date portion of Item 81, as applicable, numerically as MMDDYY.

Transmit to CMS the original codes reported by the provider, unless in the course of the claims development process you restore contradictory correct codes.

FL 82. Attending/Referring Physician ID
Required. Effective January 1, 1992, providers must enter the unique physician identification number (UPIN) and name of the attending/referring physician on inpatient bills or the physician that requested outpatient services. Paper bill specifications are listed below. See Addendum A, record type 80 for electronic tape specifications. Accept data on paper bills that does not strictly adhere to the following, i.e., commas instead of spaces between subfields, or other minor variances if you can process it at no extra cost.

Inpatient Part A.--Hospitals and SNFs must enter the UPIN and name of the attending/referring physician. For hospital services, the Uniform Hospital Discharge Data Set definition for attending physician is used. This is the clinician primarily responsible for the care of the patient from the beginning of the hospital episode. For SNF services, the attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Home Health and Hospice.--HHAs and hospices must enter the UPIN and name of the physician that signs the home health or hospice plan of care. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Outpatient and Other Part B.--All providers must enter the UPIN of the physician that requested the surgery, therapy, diagnostic tests or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial. If the patient is self-referred (e.g., emergency room or clinic visit), SLF000 is entered in the first six positions, and no name is shown.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs, or Public Health Services. Providers must use the following UPINs to report these physicians:

- INT000 for each intern
- RES000 for each resident
- PHS000 for Public Health Service physicians, includes Indian Health Services

- VAD000 for Department of Veterans Affairs physicians
- RET000 for retired physicians
- SLF000 for providers to report that the patient is self-referred
- OTH000 for all other unspecified entities not included above

Accept the SLF entry unless the revenue code or HCPCS code indicates the service can be provided only as a result of physician referral. Accumulate and analyze information on providers that report SLF or OTH. Investigate the five provider types that report the highest percentage of SLF or OTH from January 1, 1992-June 30, 1992. Report your findings on the validity of their use of SLF and OTH to the RO.

If more than one referring physician is involved, the provider enters the UPIN of the physician requesting the service with the highest charge.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

FL 83. Other Physician ID.

Inpatient Part A Hospital.--Required if a procedure is performed. Hospitals must enter the UPIN and name of the physician who performed the principal procedure. If there is no principal procedure, the hospital enters the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, the hospital leaves this item blank. See FL 82 (inpatient) for specifications.

Outpatient Hospital.--Required where the HCPCS code reported is subject to the Ambulatory Surgical Center (ASC) payment limitation or a reported HCPCS code is on the list of codes the PRO furnishes that require approval. Hospitals enter the UPIN and name of the operating physician. They use the format for inpatient reporting.

Other Bills
Not Required.

FL 84. Remarks
Required. For DME billings by HHAs, the rental rate, cost and anticipated months of usage are shown so that you may determine whether to approve the rental or purchase of equipment. In addition, special annotations may be entered where Medicare is not the primary payer because WC, an automobile medical or no-fault insurer, any liability insurer or an EGHP/LGHP is primary to Medicare. (See §§3679, 3680, 3681, and 3682.)

This space is also available to report overflow from other items.

FL 85. Provider Representative Signature.
Not Required. No signature is required for a general care hospital unless a certification is required. (See §3315.2.) A provider representative's signature or facsimile is required on the bill of a psychiatric or tuberculosis hospital.

FL 86. Date
Not Required. This is the date of the provider representative's signature.