CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1065	Date: SEPTEMBER 22, 2006
	Change Request 4049

NOTE: Transmittal 717, dated October 21, 2005, is rescinded and replaced with Transmittal 1065, dated September 22, 2006. This CR is being reissued to incorporate information revised in chapter 1, section 80.3.2.2 from CR 4181, Transmittal 771, dated December 2, 2005. This information was inadvertently omitted in CR 4049. All other information remains the same.

SUBJECT: Disabling the Revenue/HCPCS Consistency Edit Codes in the Fiscal Intermediary Shared System (FISS)

I. SUMMARY OF CHANGES: This Change Request will disable the set of consistency edits enforcing revenue/HCPCS codes combinations that were developed to assure accurate payments for outpatient services prior to the implementation of the Outpatient Prospective Payment System (OPPS) in August of 2000.

NEW/REVISED MATERIAL
EFFECTIVE DATE: August 1, 2000
IMPLEMENTATION DATE: April 3, 2006

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED

R/N/D	Chapter / Section / Subsection / Title
R	1/80.3.2.2/FI Consistency Edits

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

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SUBJECT: Disabling the Revenue/HCPCS Consistency Edit Codes in the Fiscal Intermediary Shared System (FISS)

I.   GENERAL INFORMATION

A.   Background: In the past, payments for certain radiology and other diagnostic outpatient services were made based on a blended payment methodology. A set of consistency edits enforcing revenue/HCPCS codes combinations were developed to help assure accurate payments under this methodology. These edits were defined in Chapter 1, Section 80, Subsection 3.2.2 of the Medicare Claims Processing Manual.

The implementation of the Outpatient Prospective Payment System (OPPS) in August of 2000 eliminated the blended payment methodology for the last providers to which it applied. However, due to an oversight the edits remained in effect for some providers to which it did not apply. Therefore, this change request will disable the consistency edits used to enforce it for all providers. The instructions under Form Locator (FL) 44 in Chapter 1, Section 80, Subsection 3.2.2 are being removed.

B.   Policy: No policy changes. The system changes described in this change request are consistent with current policy.

II.   BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4049.1	Medicare systems shall disable the consistency edits related to Revenue/HCPCS code combinations for radiology and other diagnostic services.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4049.1	Disable FISS edits 32925, 32926, 32927, 32928, 32929, 32931, 32932, 32933, 32934, 32935, 32936, 32937, 32938, 32939, and 32940.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: August 1, 2000 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Yvonne Young, (410) 786-1886, Yvonne.Young@cms.hhs.gov, Wil Gehne, (410) 786-6148, Wil.Gehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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80.3.2.2 - FI Consistency Edits
(Rev. 1065, Issued: 09-22-06, Effective: 08-01-00; Implementation: 04-03-06)

In order to be processed correctly and promptly, a bill must be completed accurately. FIs edit all Medicare required fields as shown below. If a bill fails these edits, FIs return it to the provider for correction. If bill data is edited online, the edits are included in the software. When FIs receive magnetic tape or paper bills, either directly or through a billing service, they must ensure that these edits are made. Depending upon special services billed, FIs may require additional edits.

FL 4. Type of Bill

    a. Must not be spaces.

    b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

    1 - Hospital

    NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

    2 - Skilled Nursing

    3 - Home Health

    4 - Religious Non-Medical (Hospital)

    7 - Clinic or Renal Dialysis Facility (requires special information in second digit below)

    8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

    1 - Inpatient (Part A)

    2 - Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)

    3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

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")

8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)

Second Digit - Classification (first digit is 7):

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)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

3 - Ambulatory Surgical Center Service to Hospital Outpatients

4 - Free Standing Birthing Center

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For FI use only)

G - CWF Initiated Adjustment Claim (For FI use only)

H - CMS initiated Adjustment Claim (For FI use only)

I - FI Adjustment Claim (Other than QIO or Provider) (For FI use only)

J - Initiated Adjustment Claim-Other (For FI use only)

K - OIG Initiated Adjustment Claim (For FI use only)

M - MSP Initiated Adjustment Claim (For FI use only)

P - QIO Adjustment Claim (For FI use only)

0 - Nonpayment/zero claims

1 - Admit Through Discharge Claim

2 - Interim - First Claim

3 - Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)

4 - Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either "From" or "Through" portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The "From" date must be a valid date that is not later than the "Through" date.

c. The "Through" date must be a valid date that is not later than the current date.

d. The number of days represented by this period must equal the sum of the covered days (FL 7) and noncovered days (FL 8), if the type of bill is 11X, 18X, 21X, or 41X.

e. With the exception of Home Health PPS claims, the statement covers period may not span *2* accounting years.

FL 7. Covered Days

FIs do not need to edit the provider's bill. They determine the proper number of covered days in their bill process.

FL 8. Noncovered Days

FIs do not need to edit the provider's bill. They determine the proper number of noncovered days in their bill process.

FL 9. Coinsurance Days

FIs do not need to edit the provider's bill. They determine the proper number of coinsurance days in their bill process.

FL 10. Lifetime Reserve Days

FIs do not need to edit the provider's bill. They determine the proper number of lifetime reserve days in their bill process.

FL 13. Patient's Address

a. The address of the patient must include:

City
State (P.O. Code)
ZIP

b. Valid ZIP code must be present if the type of bill is 11X, 13X, 18X, or 83X or 85X.

c. Cannot exceed 62 positions.

FL 14. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL 15. Sex

    a. One alpha position.

    b. Valid characters are "M" or "F."

    c. Must be present.

FL 17. Admission Date

    a. Must be valid if present.

    b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

    c. Present only if the type of bill is 11X, 12X, 18X, 21X, 22X, 32X, 33X, 41X, 81X or 82X.

    d. Cannot be later than the "From" portion of Item 6.

FL 19. Type of Admission/Visit

    a. One numeric position.

    b. Required only if the type of bill is 11X, 12X, 18X, 21X, 22X, or 41X.

    c. Valid codes are *located in Chapter 25*.

FL 20. Source of Admission.

    a. One numeric position

    b. Must be present

    c. Valid codes are *located in Chapter 25*.

FL 22. Patient Status.

    a. Two numeric positions

    b. Present on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

    c. Valid codes *are located in Chapter 25*.

FL 23. Medical Record Number

    a. If provided by the hospital, must be recorded by the FI for the QIO.

    b. Must be left justified in CWF record for QIO.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes.

    a. Each code is two numeric digits.

    b. Valid codes are *located in Chapter 25.*

    c. If code 07 is entered, type of bill must not be hospice 81X or 82X.

    d. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

    e. If code 40 is entered, the "From" and "Through" dates in FL 6 must be equal, and there must be a "0" or "1" in FL 7 (Covered Days).

    f. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

    g. Code C1, C3, C4, C5, or C6 must be present if type of bill is 11X or 18X.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

    a. All dates must be valid.

    b. Each code must be accompanied by a date.

    c. All codes are two alphanumeric positions.

    d. Valid codes are *located in Chapter 25.*

    e. If code 20 or 26 is entered, the type of bill must be 11X or 41X. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

    f. If code 27 is entered, the type of bill must be 81X or 82X.

    g. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit a "5."

    h. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

i. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

j. If code 20 is entered:

- Must not be earlier than "Admission" date (FL 17) or later than "Through" date (FL 6).

- Must be less than 13 days after the admission date (FL 17) if "From" date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

k. If code 21 is entered:

- Cannot be later than "Statement Covers Period" Through date; or

- Cannot be more than 3 days prior to the "Statement Covers Period" From date.

l. If code 22 is entered, the date must be within the billing period shown in FL 6.

m. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

n. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. Valid codes are *located in Chapter 25*.

e. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

f. If code 71 is entered, the first digit of FL 4 must be "1," "2," or "4" and the second digit must be "1."

g. If code 72 is entered, the type of bill must be 13X, 14X, 32X, 33X, 34X, 71X, 73X, 74X, or 75X.

h. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

i. If code 75 is entered, the first digit of FL 4 must be "1" or "4" and the second digit must be "1."

j. If code 76 is entered, occurrence code 31 must be present (inpatient only).

k. If code 76 is entered, occurrence code 32 must be present (outpatient only).

l. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 73X, 74X, 75X, 81X, 82X, or 85X.

m. Neither the "From" nor the "Through" portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

n. If code M2 is present, the bill type must be 81X or 82X.

o. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. Valid codes are *located in Chapter 25*.

e. If code 06 is entered, there must be an entry for code 37.

f. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

g. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

h. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

i. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

j. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. Four numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be "0001" for hardcopy claims only.

c. There must be a revenue code adjacent to each entry in FL 47.

d. For bill types 32X and 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X, 043X, 044X, 055X, 056X, 057X, 0601, 0602, 0603, and 0604.

e. For bill type 34X, the following revenue codes require a 5-position HCPCS code:

0271-0274, 42X, 43X, 44X, and 0601-0604.

f. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

   0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on types of bill *12X,* 13X, 14X, *22X,* 23X, 24X, 32X, 33X, 34X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, *and* 83X.

   Exception: LIDOS *are* not required for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)

c. Accommodation units must equal covered days (FL 7) with the exception of the R No-Pay.

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The "0001" amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare" must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL 51. Medicare Provider Number

a. A 6-position alpha/numeric field *(for CMS use only, effective May 23, 2007, providers are required to submit only their NPI).*

b. Left justified.

FLs 58A, B, and C. Insured's Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 680 or 700 through 728.

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, C, D, E, F, M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code.

a. Must be four or five positions left justified with no decimal points. FIs validate with MCE and OCE programs.

b. Must be valid ICD-9-CM code.

FLs 68-75. Other Diagnosis Codes.

a. If present, must be four or five positions, left justified with no decimal points. FIs validate with MCE and OCE programs.

FL 80. Principal Procedure Code and Date

a. If present, must be valid ICD-9-CM procedure code. FIs validate with MCE program.

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL 81. Other Procedure Codes and Dates.

a. If present, apply edits for FL 80

FL 82. Attending/Referring Physician I.D.

- The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types.

    ° Number, last name, and first initial must be present;

    ° First three characters must be alpha or numeric; and

      ° If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise, the 4th through 6th positions must be numeric.

FL 83. Other Physician I.D

  a. Must be present if:

- Bill type is 11X and a procedure code is shown in FLs 80-81;

- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC payment limitation or is on the list of codes the QIO furnishes that require approval; or

- Bill type is 85X and HCPCS code is in the range of 10000 through 69979.

  b. If required:

- First three characters must be alpha or numeric:

- Number, last name and first initial must be present; and

- Left justified:

      o If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise the 4th through 6th positions must be numeric.