CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 980 **Date: JUNE 14, 2006**

CHANGE REQUEST 4014

Transmittal 980, CR 4014 rescinds and replaces Transmittal 941 dated May 5, 2006. Information erroneously deleted from prior transmittals in Chapter 1, Section 50.2.2, Chapter 6, Section 20.1.1 and Chapter 26, Section10.4 has been restored. In addition, the following sections have been deleted from this CR as no new information was added: Chapter 4, Section 10.1, Chapter 5, Sections 20 and 100.3, Chapter 25, Section 60, Chapter 26, Section 10.5 and Chapter 27, Section 80.4. In Chapter 25, Sections 60.2, 60.3 and 60.4 have been added to include changes to the language relating to "speech therapy". All other information remains the same.

SUBJECT: Changes Conforming to CR 3648 Instructions for Therapy Services

I. SUMMARY OF CHANGES: Language relating to "speech therapy" is changed to "speech-language pathology services". Also, the requirement that the date last seen by a physician be entered on the 1500 claim form has been deleted due to change in policy previously made in CR 3648 (Pub 100-02, Transmittal 36, dated June 24, 2005). There has been no change to policies related to incident to services.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2006
IMPLEMENTATION DATE: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Table of Contents
R	1/01 - Foreword
R	1/30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for Carrier Processed Claims
R	1/40.4 - Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement
R	1/50.1.6 - When Beneficiary Statement is Not Required for Physician/Supplier Claim
R	1/50.2.2 - Frequency of Billing for Outpatient Services to FIs

R	1/70.8.17 - Time Limitation of Claims for Outpatient Physical Therapy or Speech-Language Pathology Services Furnished by Clinic Providers
R	1/80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services
R	2/05 - Definition of Provider and Supplier
R	2/30.6 - Provider Access to CMS and Carrier or FI Eligibility Data
R	3/110.9 - Nonemergency Part B Medical and Other Health Services
R	3/140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation Hospitals
R	4/240 - Inpatient Part B Hospital Services
R	5/20.2 - Reporting of Service Units With HCPCS - Form CMS-1500 and Form CMS-1450
R	5/40.3 - Applicable Revenue Codes – FIs
R	5/100.5 - Off-Site CORF Services
R	6/10.1 - Consolidated Billing Requirement for SNFs
R	6/10.3 - Types of Services Subject to the Consolidated Billing Requirement for SNFs
R	6/10.4 - Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" With an Outside Entity
R	6/20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement
R	6/110.2.2 - Utilization Edits
R	7/10.1 - Billing for Inpatient SNF Services Paid Under Part B
R	7/40.1 - Audiologic Tests
R	10/10.1.19.1 - Adjustments of Episode Payment - Therapy Threshold
R	10/90 - Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)
R	11/40.2 - Carrier Processing of Claims for Hospice Beneficiaries
R	20/01 - Foreword
R	25/60.2 - Form Locators 21-30
R	25/60.3 - Form Locators 31-41
R	25/60.4 - Form Locator 42
R	26/10.4 - Items 14-33 – Provider of Service of Supplier Information
R	27/80.6 - A/B Crossover Error Codes

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:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 980	Date: June 14, 2006	Change Request 4014

Transmittal 980, CR 4014 rescinds and replaces Transmittal 941 dated May 5, 2006. Information erroneously deleted from prior transmittals in Chapter 1, Section 50.2.2, Chapter 6, Section 20.1.1 and Chapter 26, Section10.4 has been restored. In addition, the following sections have been deleted from this CR as no new information was added: Chapter 4, Section 10.1, Chapter 5, Sections 20 and 100.3, Chapter 25, Section 60, Chapter 26, Section 10.5 and Chapter 27, Section 80.4. In Chapter 25, Sections 60.2, 60.3 and 60.4 have been added to include changes to the language relating to "speech therapy". All other information remains the same.

SUBJECT: Changes Conforming to Change Request 3648 for Therapy Services

I. GENERAL INFORMATION

A. Background: This change was made to update obsolete language in Pubs. 100-03 and 100-04. It changes the term speech therapy to speech-language pathology, as has been appropriate for many years. It also removes the requirements in Pub. 100-04, chapter 1 for therapists to provide information on the 1500 claim form and the UB-92 claim form concerning the date last seen by the physician (to conform to instructions in CR 3648). This instruction conforms to the Health Insurance Portability and Accountability Act guidelines which require the date last seen and the Unique Provider Identification Number of the physician only when it impacts the payer's adjudication process. Medicare payment is not impacted by this information except when therapy services are provided incident to the services of physicians or nonphysician practitioners (NPP), in which case it is required.

These requirements update instructions in CR 3648 related to claims for services incident to a physician's/NPP's service by acknowledging that the "incident to" service can be identified only on prepay or postpay review and manual review of all therapy claims is not required by the instruction. They also acknowledge that incident to policies have not changed and still apply to therapy services. There is further clarification of some of the business requirements of CR3648 to indicate that some contractor actions will occur on pre or postpay review (e.g., 3648.8) and some contractor actions should not be applied to services "incident to." (e.g., 3648.3).

B. Policy: There is no new policy. CR 3648 (Pub 100-02, Transmittal 36, dated June 24, 2005,) omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim. This change does not affect the requirements for services billed incident to a physician. When a therapy service is billed "incident to," requirements for an initial physician visit (date last seen) and identification of the ordering (and supervising) physicians/NPPs remain in effect because they are required by "incident to" policies.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4014.1	Contractors shall update the terms "speech therapy", and "speech-language therapy" to "speech-language pathology" or "speech-language pathology services" in related LCDs and educational materials whenever they modify these documents or issue new documents. It is not necessary to change the documents merely to update this language.	X	X	X	X					
4014.2	Carriers processing claims received after the implementation date of this CR with dates of service on or after June 6, 2005, for outpatient physical therapy, occupational therapy and speech-language pathology services, contractors shall adjust their processing systems to no longer require the UPIN/NPI of an ordering/referring/attending/certifying physician/NPP and/or the date last seen by a physician/NPP. **NOTE:** Do not disallow submission of this information, because it is appropriate when services are also provided "incident to."			X						
4014.3	Fiscal Intermediaries processing claims submitted on types of bills 34X, 74X, and 75X, received after the implementation date of this CR with dates of service on or after June 6, 2005, for outpatient physical therapy, occupational therapy and speech-language pathology services, contractors shall adjust their processing systems to no longer require the UPIN/NPI of an ordering/referring/attending/certifying physician/NPP and/or the date last seen by a	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	physician/NPP. **NOTE:** Do not disallow submission of this information, because it is appropriate when services are also provided "incident to."									
4014.4	For claims received after the implementation date of this CR with dates of service on or after June 6, 2005, for outpatient physical therapy, occupational therapy, and speech-language pathology service claims, contractors shall not require that a patient visit a physician before or during therapy services unless a National Coverage Determination for that service specifically requires a physician visit or on prepay or postpay review it is noted that the service is provided as an incident to a physician's service.	X	X	X						
4014.5	On prepay and postpay review, contractors shall continue to require the date last seen and the ordering physician's and supervising physician's UPIN/NPI for outpatient therapy services billed incident to a physician's/NPP's services.	X	X	X						
4014.6	On prepay or post pay review of outpatient therapy services, for services provided on or after June 6, 2005, contractors shall pay for speech-language pathology services only when the service qualifies as a speech-language pathology service and the service is furnished by qualified professionals, as defined in the appropriate Medicare manuals.	X	X	X						
4014.7	On prepay or post pay review of outpatient therapy claims, for services provided on or after June 6, 2005, contractors shall pay for physical therapy and occupational therapy services only when the services qualify as physical therapy or occupational therapy services.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4014.8	On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for physical therapy and occupational therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals	X	X	X						
4014.9	On prepay or post pay review of outpatient therapy claims, for services provided on or after January 1, 2005, and for services provided by an assistant in a physical therapy (PT) or occupational therapy (OT) private practice, contractors shall allow claims if there is a qualified physical therapist or occupational therapist in the office directly supervising the service for which they are qualified.	X	X	X						
4014.10	On prepay or post pay review of outpatient therapy claims, for claims with dates of service after July 25, 2005, contractors shall deny payment for therapy services provided incident to a physician's/NPP's service if the person who performed the service does not meet the qualifications for qualified therapists as defined in appropriate Medicare manuals, with the exception of the licensure requirement.	X	X	X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4014.11	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	x	x	x						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Dorothy Shannon, (Policy) Yvonne Young, (410) 786-1886, Yvonne.Young@cms.hhs.gov (FI Billing) **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.**

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

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents

(Rev. 980, 06-14-06)

01 - Foreword

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Generally, this chapter describes policy applicable to Medicare fee-for-service claims, or what is known as the original or traditional Medicare program. See the Medicare Managed Care Manual for services to enrollees in managed care plans.

Unless specified otherwise the instructions in this chapter apply to both providers and suppliers, and to the contractors that process their claims.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.202.

- Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-*language* pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
- Supplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare. A supplier must meet certain requirements and enroll as described in Chapter 10 of the Medicare Program Integrity Manual. A provider that meets the applicable conditions may also enroll as a supplier of a particular service and may bill separately for that service where Medicare payment policy allows separate payment for the service.

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for Carrier Processed Claims

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

A General

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses Form CMS-1500 or the current ANSI X12N billing format to submit claims to Medicare carriers. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding ANSI X12N location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For EDI claims a certification can be maintained on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

B Provider Identification Numbers

Carriers assign a provider identification number (group number) to the medical group, or other entity as a whole. The entity's identification number is entered in block 33. Each physician who performs services for a patient must be identified on Form CMS-1500 in block 24k for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician under a reciprocal or locum tenens billing arrangement, the performing physicians is the physician member of the entity for whom the substitute is providing services.)

C Payment Records

Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, carriers transmit the performing physician's UPIN on the Common Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists.

D Outpatient Physical Therapy or Speech-*Language* Pathology Claims

Clinics that have been certified to provide outpatient physical therapy or speech-*language* pathology services to outpatients also use Form CMS-1500 for billing the Part B carrier.

40.4 - Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The CMS RO will inform the FI upon termination, expiration or cancellation of a provider agreement.

Effective with the date a provider agreement under §1866 of the Act (or swing bed approval) terminates, expires, or is cancelled, no payment is made to the provider under such agreement for:

A Termination of Hospital Agreement

Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can continue to be made for up to 30 days of inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B Termination of Swing Bed Approval

Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

C Skilled Nursing Facility Termination

Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (§40.1) or involuntarily terminated by the Secretary for cause (§40.2). However, payment can continue to be made for up to 30 days of posthospital extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

D Expiration SNF

Posthospital extended care services furnished on or after the date which follows the last day of the specified term of the agreement, where such agreement has expired at the close of the last day of its specified term (§40.3), except that where the agreement has not been renewed, payment can be made for up to 30 days of posthospital extended care services furnished on and after the date which follows the last day of the specified term of such agreement to beneficiaries who were admitted on or before such last day.

E HHA and Hospice

Home health and hospice services furnished under a plan which is established on or after the termination date, except that if the plan was established before the termination date, payment is made for services for up to 30 days following the effective date of termination.

F Other

Other items and services, including outpatient physical therapy or speech-*language* pathology and diagnostic services, furnished on or after the effective date of termination or, in the case of an expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement.

50.1.6 - When Beneficiary Statement is Not Required for Physician/Supplier Claim

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Enrollee Signature Requirements

A request for payment signed by the enrollee must be filed on or with each claim for charge basis reimbursement except as provided below. All rules apply to both assigned and unassigned claims unless otherwise indicated.

1. When no enrollee signature required:
    a. Claim submitted for diagnostic tests or test interpretations performed in a medical facility which has no contact with enrollee.
    b. Unassigned claim submitted by a public welfare agency on a bill which is paid.
    c. Enrollee deceased, bill unpaid and the physician or supplier agrees to accept Medicare approved amount as the full charge.
2. When signature by mark is permitted: The enrollee is unable to sign his name because of illiteracy or physical handicap.
3. When another person may sign on behalf of the enrollee:
    a. Enrollee who is resident of a nonprofit retirement home gives power of attorney to the administrator of the home.
    b. Enrollee physically or mentally unable to transact business: The request may be signed by a representative payee, legal representative, relative, friend, representative of an institution providing the enrollee care or support, or of a governmental agency providing him/her assistance.
    c. Enrollee physically or mentally unable to transact business and full documentation is supplied that the enrollee has no one else to sign on his behalf: The physician, supplier, or clinic may sign.
    d. Enrollee deceased and bill paid or liability assumed: Person claiming payment should sign. If Form CMS-1500 was signed before the enrollee dies, claimant should sign separate request for underpayment.
4. When request retained in file may cover extended future period:
    a. Assignment in files of welfare agency covers all services furnished during the period when the enrollee is on medical assistance.
    b. Authorization in files of organization approved under §30.2.8.3 covers all services paid for by that organization under that procedure.
    c. Assignment in the files of group practice prepayment plan covers services furnished by the plan during the period of the enrollee's membership.
    d. Assignment in the files of a participating provider (hospital, SNF, home health agency, outpatient physical *therapy* or speech-*language pathology*

provider or comprehensive rehabilitation facility) or ESRD facility covers physician services for which the provider or facility is authorized to bill, and may cover the physician services furnished in the provider or facility as follows:

- Inpatient services - effective for period of confinement.
- Outpatient services - effective indefinitely.

e. Assignment in files of individual physician, supplier (except in the case of unassigned claims for rental of durable medical equipment) or qualified reassignee under §30.2 is effective indefinitely.

B. Physician (Supplier) Signature Requirement

The rules below apply to both assigned and unassigned claims unless otherwise indicated.

1. In a claim for services furnished by an individual physician (or supplier), the physician may:
   a. In an unassigned claim, provide an itemized bill on his own letterhead - no physician signature required. A Form CMS-1500 on which the name or identification code of the physician has been stamped or preprinted in item 31 is the equivalent of the physician's own letterhead.
   b. Sign item 31 of Form CMS-1500.
   c. Sign one time certification letter for machine-prepared claims submitted on other than paper vehicles.
   d. Authorize an employee (e.g., nurse, secretary) to enter the physician's signature in item 31 of the Form CMS-1500.
      i. Manually
      ii. By stamp-facsimile or block letters
      iii. By computer
   e. Authorize a nonemployee agent, e.g., billing service or association, to enter as in d. above, the physician's signature in item 31 of the Form CMS-1500, followed by the agent's name, title, and organization (e.g., a billing agent might enter by stamp "Dr. Tom Jones by Robert Smith, Secretary, Ajax Billing Service"). Alternatively, the agent may simply enter the physician's signature.
2. In a claim by a clinic, hospital, or other entity authorized to bill and receive payment in its name for the services of the physician, the entity may:
   a. In an unassigned claim, provide an itemized bill on its letterhead-no signature necessary. A Form CMS-1500 on which the name or identification code of the billing entity has been stamped or preprinted in item 8 is the equivalent of the reassignee's own letterhead.
   b. Have authorized official sign in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556).

c. Have authorized official sign one-time certification letter for machine-prepared claims submitted on other than paper vehicles.

d. Have authorized employee, e.g., a secretary, enter authorized official's signature in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556) as in 1d.

e. Have nonemployee agent enter authorized official's signature in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556) as in 1.e.

50.2.2 - Frequency of Billing for Outpatient Services to FIs

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

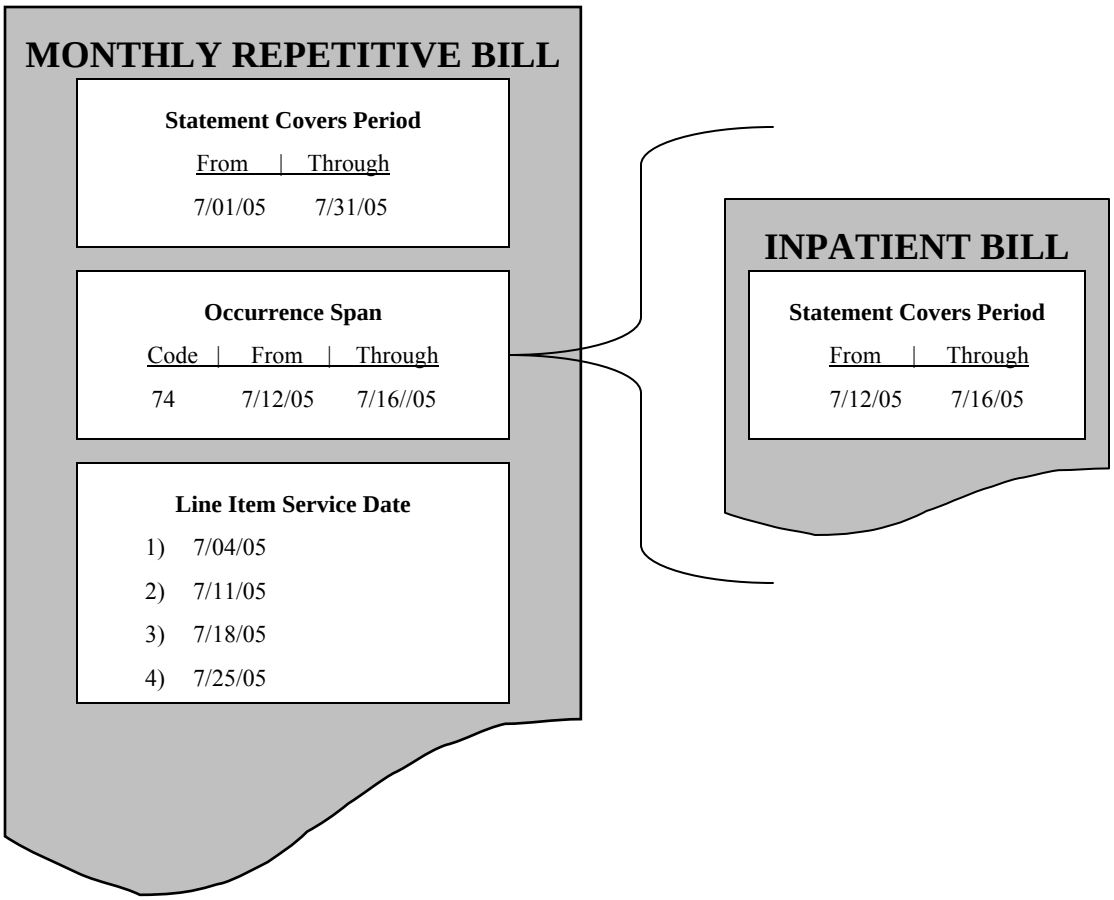
Repetitive Part B services furnished to a single individual by providers that bill FIs shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply to hospice services billed under Part A, though they do not apply to home health services. Consolidating repetitive services into a single monthly claim reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

Type of Service	**Revenue Code(s)**
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech-*Language* Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill for repetitive services shall nonetheless be submitted for the entire month as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive non-repetitive services while receiving repetitive services, and consequently, is on leave of absence from the repetitive services. This permits submitting a single, monthly bill for repetitive services and simplifies FI review of these bills. The following is an illustration explaining this scenario:

Leave of Absence "Carve-Out" Example

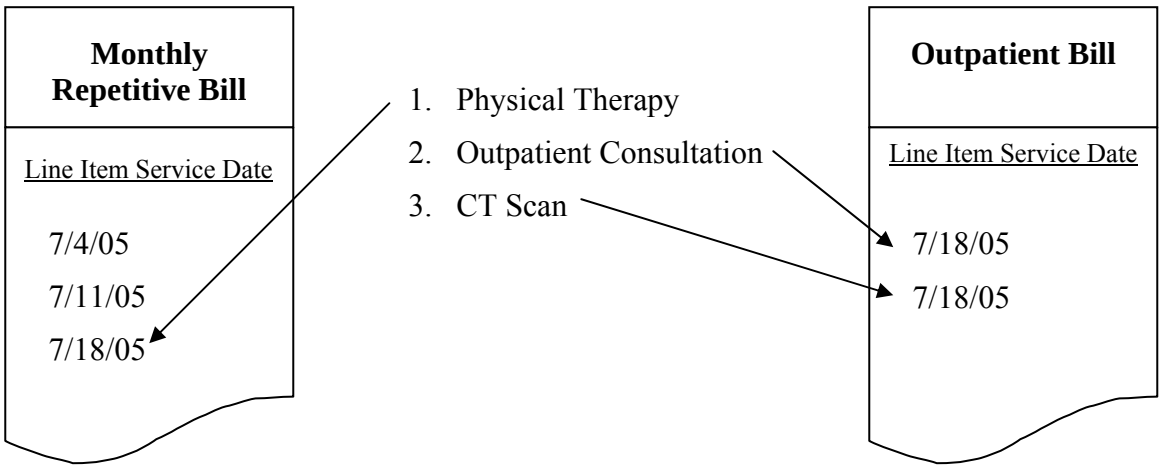


Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).

However, to facilitate APC recalibration, do not report unrelated one-time, non-repetitive services that have the same date of service as a repetitive service (even if both the non-repetitive service and the repetitive service are paid under OPPS). If a non-repetitive OPPS service is provided on the same date as a repetitive service, report the non-repetitive OPPS services, along with any packaged and/or services related to the non-repetitive OPPS service, on a separate OPPS claim. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, report the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the monthly repetitive services claim. Similarly, as shown below in the illustration, "Example: Monthly Repetitive Billing Procedure," a physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service

list) is administered on the same day an outpatient consultation and a CT scan are furnished, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month. Report the visit for the consultation and the CT scan on a separate claim.

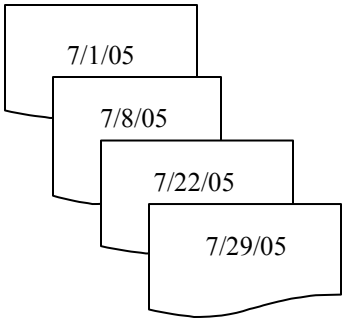
Example: Monthly Repetitive Billing Procedure



Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may all be reported on the same claim or billed separately by date of service as illustrated below:

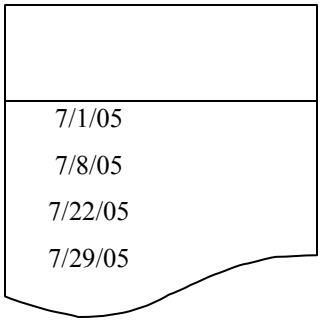
Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):



OR

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):



Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-ASC services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

FIs periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. FIs may rely on informal communications from their medical review staff, and

FIs should educate providers that bill improperly. FIs shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.
- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

70.8.17 – Time Limitation of Claims for Outpatient Physical Therapy or Speech-*Language* Pathology Services Furnished by Clinic Providers

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Effective with respect to claims filed after December 3l, l974, claims for payment for services reimbursable on a reasonable cost basis are subject to the same limitation as claims for payments for services reimbursable on a reasonable charge basis (including a charge-related-to-cost basis). (The only Medicare claims for payments reimbursable strictly on a reasonable cost basis under the carriers' jurisdiction are those relating to outpatient physical therapy or speech-*language* pathology services furnished by clinic providers. There was no time limit on filing for such services for claims submitted before January l, l975.) In the case of services reimbursable on a reasonable cost basis, administrative error of SSA or its agents will not ordinarily extend the time limit beyond the close of the third year following year in which the services were furnished (deeming services furnished in the last quarter of the year to have been furnished in the following year).

EXAMPLE: Mr. G. receives outpatient physical therapy services on January 05, 1995 at Clinic X, a participating provider. For reimbursement for these services, the claim must be submitted to the carrier no later than December 31, 1996. If the services were furnished on October 15, 1995, the services would be deemed to be furnished in l996, and the claim would have to be submitted by December 31, 1997. If the services were furnished on October 15, 1992, the claim must have been submitted by l2/3l/94, the effective date of the time limit. If administrative error prevents the claim for services furnished on October 15, 1992 from being filed until after l996, the fourth year after the fourth quarter of l992, the case should be submitted to BHI for advice.

If an enrollee request for payment is filed with the provider timely (or would have been filed timely had the provider taken action to obtain a request from a patient whom the provider knew or had good reason to believe was an enrollee) but the provider does not file a timely claim, the provider may not charge him for the services except for such deductible and/or coinsurance amounts and noncovered services as would be appropriate if Medicare payment were made.

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Carriers must return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:

   1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.

   2. If the initial date "actual" treatment occurred is not entered in item 14. (Remark code MA122 is used.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, ZIP code, and PIN (or NPI when effective) number is not entered in item 33 or their personal PIN (or NPI number when effective) is not entered in item 24K. (Remark code MA112 is used.)

c. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP code of the location where the order was accepted were not entered in item 32. (Remark code MA114 is used.)

d. For physicians who maintain dialysis patients and receive a monthly capitation payment:

   1. If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's PIN (or NPI when effective) is not entered in item 24K. (Remark code MA112 is used.)

   2. If the name, address, and ZIP code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when effective) is not present in item 19. (Remark code MA104 is used.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 is used.)

g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or

her name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 is used.)

h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP code of the location where services were performed is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

i. For independent laboratory claims:

   1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). (Remark code MA116 is used.)

   2. If the name, address, and ZIP code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code MA102 is used.)

l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when effective) are not entered in items 17 or 17A. (Remark code MA102 is used.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when effective) if appropriate are not entered in items 17 or 17A. (Remark code MA102 is used.)

n. For outpatient physical or occupational *therapy* services provided by a qualified independent physical or occupational therapist, *Medicare policy does not require the date last seen by a physician, or the UPIN/NPI of such physician. Medicare policy does not require identification of the ordering, referring or certifying physician on outpatient therapy claims, including speech-language pathology service claims. However, providers and suppliers are required to comply with applicable HIPAA ASC X12 837 claim completion requirements. See Pub. 100-04, chapter 5, §20 and*

Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies. Deletion of this claim requirement for outpatient therapy services does not apply to the requirements for the date last seen and the UPIN/NPI of the ordering and supervising physician/nonphysician practitioner for therapy services provided incident to the services of a physician, because the incident to policies continue to require them.

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP code, and PIN (or NPI when effective) where the laboratory services were performed in item 32, if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114.)

p. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA51 is used.)

q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23. (Remark code MA50 is used.)

r. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

s. For Competitive Acquisition Program drug and biological claims, in accordance with the instructions found in the Medicare Claims Processing Manual, Chapter 17, Section 100.4.2 through 100.4.4.

Medicare Claims Processing Manual

Chapter 2 - Admission and Registration Requirements

05 - Definition of Provider and Supplier

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

This chapter uses the definition of provider and supplier found in 42 CFR 400.202. These are:

> **Provider** means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-*language* pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
>
> **Supplier** means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Note that while rural health clinics, Federally qualified health centers, and renal dialysis facilities are suppliers under the regulation, they submit most claims to FIs.

30.6 - Provider Access to CMS and Carrier or FI Eligibility Data

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The contractor will allow only Medicare certified providers as defined in §§1861 and 1866(e) of the Social Security Act (the Act) and their billing agents automated access to beneficiary eligibility data. Disclosure of CWF eligibility data is restricted under provisions of the Privacy Act of 1974, 5 U.S.C §552a. Under limited circumstances, the Privacy Act permits CMS to disclose information without consent of the individual. One circumstance is for "routine uses," that is, disclosure for purposes that are compatible with the purpose for which CMS collects the information. In the case of this provider access, a routine use exists which permits release of data to providers or their authorized billing agents for the purpose of verifying a patient's eligibility for benefits under the Medicare program. The use of the data by a provider in preparing claims for hospital-based physicians would be an example of unauthorized use because the physicians are not Medicare providers as defined in the Act.

FIs and carriers (contractors) will adjust their systems to accept the revised standard HIQA/HUQA records from the CMS CWF. The standard data elements to be made available to providers are listed below:

- HICN;
- Beneficiary:
    - Last name (first six positions)/first initial;
    - Date of birth;
    - Sex;
    - Date of death;
    - Lifetime reserve days remaining;
    - Lifetime psychiatric days remaining (requesting hospital must use a psychiatric provider number to obtain this data);
    - Cross reference HICN;
    - Current and prior A and B entitlements, with start and stop dates for Part A, Part B, ESRD, HMO, and hospice; and
    - Spell of illness (applicable spell based on the date entered by the provider and the next most recent spell):
        - Hospital full days remaining;
        - Hospital coinsurance days remaining;
        - SNF full days remaining;
        - SNF coinsurance days remaining;
        - Part A cash deductible remaining to be met;
        - Date of earliest billing action for indicated spell-of-illness;

- Date of latest billing action for indicated spell-of-illness;
- Blood deductible (combined annual Part A and B remaining to be met for applicable year entered by provider);
- Part B trailer year (applicable year based on date entered by provider);
- Part B cash deductible;
- Physical *therapy*/speech-*language pathology* limit (physical therapy and speech-*language pathology* are applicable to physical therapy limit);
- Occupational therapy limit;
- Hospice data (applicable periods based on the date entered by the provider and the next most recent period);
- ESRD indicator (shows beneficiary is currently entitled);
- REP payee indicator;
- MSP indicator;
- Home Health Benefit Period:
    - Part A visits remaining;
    - Part B visits applied;
    - Date of earliest billing action for home health benefit period;
    - Date of latest billing action for home health benefit period.
- HMO information (applicable periods based on date entered by the provider):
    - Name;
    - Identification number;
    - Zip Code;
    - Option code;
    - Start date;
    - Termination date;
    - Pap smear screening risk indicator, professional date, and technical date;
    - Mammography screening risk indicator (applicable to screening services prior to January 1, 1998), professional date, and technical date;

- Colorectal screening (no risk indicator); procedure code, professional date, and technical date;
- Pelvic screening risk indicator and professional date;
- Pneumococcal pneumonia vaccine (PPV) date;
- Influenza virus vaccine date; and
- Hepatitis B vaccine date.

See Chapter 10 of this manual for a complete discussion of the HIQH (Health Insurance Query for Home Health Agencies).

The contractor will make sure that psychiatric information is not being made available to all hospitals. This information is to be made available **only** to psychiatric hospitals or hospitals that furnish inpatient psychiatric hospital services.

Providers may use direct entry terminals or dial-up terminals to inquire about beneficiary eligibility utilization and deductible status. The FI must use either the HIQA screen display (see §30.6.1.1) or create its own Customer Information Control System (CICS) screens from the HUQA data records (see §§30.6.1.2 and 30.6.1.3). Providers may not have access to any other CWF records, e.g., the health insurance master record (HIMR). The data must be from CWF. The FI will not substitute local history.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

110.9 - Nonemergency Part B Medical and Other Health Services

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A Coverage

Nonemergency services to Medicare beneficiaries may be paid for if the coverage requirements for the services are met, and are not covered as Part A emergency inpatient services.

Program payment may be made for the following Part B medical and other health services furnished by a U.S. nonparticipating hospital on a nonemergency basis:

- Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests. (The hospital must meet the applicable conditions of participation for the services.)
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (The hospital must meet the applicable conditions of participation for these services.)
- Services of residents and interns, nurses, therapists, etc., which are directly related to the provision of x-ray or laboratory or other diagnostic tests, or the provisions of x-ray or radium therapy.
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement of such devices.
- Leg, arm, back, and neck braces, trusses and artificial legs, arms, and eyes, including replacement, if required, because of a change in the patient's physical condition.

B Distinction Between Emergency and Nonemergency Medical and Other Health Services

Emergency coverage, particularly Part B emergency outpatient coverage, is broader than the nonemergency Part B Medical and Other Health Services coverage provisions. When the emergency requirements are met, program payment may be made to the hospital for the full range of outpatient hospital services. In addition to the nonemergency coverage list, emergency coverage includes hospital services (including drugs and biologicals - blood is a biological - which cannot be self-administered), "incident to physicians' services rendered to outpatients," and outpatient physical therapy and speech-*language* pathology. The latter two services are not covered under the nonemergency provisions. Payment for "incident to" services can be only under the emergency rather than the nonemergency provisions.

Whether Part B payment is made under the emergency or nonemergency provisions, it may be made for diagnostic laboratory tests furnished by an emergency hospital only if the hospital meets the conditions of participation relating to hospital laboratories. It may be made only for radiology services furnished by an emergency hospital if the hospital meets the conditions of participation relating to radiology departments. Part B payment may be made for diagnostic laboratory tests furnished by a nonparticipating hospital which is not an emergency hospital only if the hospital laboratory meets the conditions of coverage of independent laboratories and for radiology services furnished by it, only if it meets the conditions of participation relating to radiology departments.

C Claims Processing

The hospital enters the annotation "nonemergency-hospital accepts assignment" in Remarks of the Form CMS-1450. If it is determined that some or all of the services are not covered under the nonemergency provisions, the claim is returned to it (if hospital-filed) or to the beneficiary (if patient-filed) to determine whether the services might be covered as emergency services.

140.1.1-Criteria That Must Be Met By Inpatient Rehabilitation Hospitals

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A rehabilitation hospital is excluded from the acute care hospital PPS if it meets all of the following criteria.

A. The hospital has in effect an agreement to participate as a hospital.

B. During a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) the hospital treated an inpatient population that met or exceeded the following percentages:

1. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the hospital must have served an inpatient population of whom at least 50 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

2. For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2007, the hospital must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

3. For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, the hospital must have served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at §140.1.1C.

4. For cost reporting periods beginning on or after July 1, 2008, the hospital must have served an inpatient population of whom of at least 75 percent required intensive rehabilitative services for the treatment of one or more of the medical conditions specified below at §140.1.1C.

(a) Section 140.1.4B3(a) specifies that in certain situations some inpatients will not be considered part of the IRF's total inpatient population when the determination is being made regarding compliance with the requirements specified above in §140.1.1B1 to 140.1.1B4.

C. List of Medical Conditions:

1. Stroke.
2. Spinal cord injury.
3. Congenital deformity.
4. Amputation.
5. Major multiple trauma.
6. Fracture of femur (hip fracture).
7. Brain injury.

8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

9. Burns.

10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days

immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

For the medical conditions specified above in subsections 10, 11, and 12, the FI has the discretion to review documentation in order to assure that an inpatient has completed an appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings. We expect that the IRF will obtain copies of the therapy notes from the outpatient therapy or therapy in another less intensive setting and place it in the patient's inpatient chart (in a section for prior records). We believe that these prior records will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available to FI staff who reviews the medical records for compliance with the requirements specified above in §140.1.1B.

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:

a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

c. The patient is age 85 or older at the time of admission to the IRF.

D. A hospital that seeks classification as an IRF for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the requirements specified above in §140.1.1B, instead of showing that it has treated the inpatient population specified above in §140.1.1B during its most recent 12-month cost reporting period. The written certification is also effective for a cost reporting period of not less than 1 month and not more than 11 months occurring between the dates the hospital began participating in Medicare, and the start of the hospital's regular 12-month cost reporting period. However, if the hospital does not actually meet the requirements specified above in §140.1.1B during any cost reporting period that it has certified it would meet the requirements specified above in §140.1.1B, then CMS will adjust the payments associated with that cost reporting period as described below in §140.1.8.

E. The hospital has in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program or assessment.

F. The hospital ensures that patients receive close medical supervision and furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-*language pathology*, social or psychological services, and orthotic and prosthetic services.

G. The hospital has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

H. The hospital uses a coordinated multi-disciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical

record, to note the patient's status in relationship to goal attainment, and ensures that team conferences are held at least every 2 weeks to determine the appropriateness of treatment.

I. The hospital has a director of rehabilitation who provides services to the hospital and its inpatients on a full time basis, is a Doctor of Medicine or Osteopathy, is licensed under state law to practice medicine or surgery, and has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

240 - Inpatient Part B Hospital Services

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Inpatient Part B services which are paid under OPPS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)
- Bone Mass measurements;
- Prostate screening;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO)

NOTE: Payment for some of these services is packaged into the payment rate of other separately payable services.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back and neck braces; trusses and artificial legs; arms and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; take home surgical

dressings; outpatient physical therapy; outpatient occupational therapy; and outpatient speech-*language* pathology services;

- Ambulance services;
- Screening pap smears, screening colorectal tests, and screening mammography;
- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration;
- Diabetes self-management;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision).

See Chapter 6 of the Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

Medicare Claims Processing Manual

Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

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20.2 - Reporting of Service Units With HCPCS - Form CMS-1500 and Form CMS-1450

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 are required to report the number of units for outpatient rehabilitation and certain audiology services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500. CORFs report their full range of CORF services on the Form CMS-1500. Units are reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in units. Since providers may perform a number of procedures or services during a single visit, the number of units may exceed the number of visits. Visits should not be reported as units for these services.

EXAMPLE

A beneficiary received occupational therapy (HCPCS code 97530 which is defined in 15 minute intervals) for a total of 60 minutes. The provider would then report revenue code 043X in FL 42, HCPCS code 97530 in FL 44, and 4 units in FL 46.

Providers billing on Form CMS-1450 (UB-92) should report Value Code 50, 51, or 52, as appropriate in FLs 39-41, the total number of physical therapy, occupational therapy, or speech-*language pathology* visits provided from start of care through the billing period. This item is visits, not service units. This is not required on the Form CMS-1500.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim Number Minutes

3 units > 38 minutes to < 53 minutes

4 units > 53 minutes to < 68 minutes

5 units > 68 minutes to < 83 minutes

6 units > 83 minutes to < 98 minutes

7 units > 98 minutes to < 113 minutes

8 units > 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than 8 minutes. The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code, should be recorded. (The length of the treatment to the minute could be recorded instead.) **If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time**. For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more units to the service that took the most time.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

40.3 - Applicable Revenue Codes - FIs

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The appropriate revenue codes for reporting outpatient rehabilitation services are

0420 - Physical Therapy Services

0430 - Occupational Therapy Services

0440 – Speech-*language* pathology services

0470 - Audiology

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the FI should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

100.5 - Off-Site CORF Services

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

CORFs may provide physical *therapy*, speech-*language pathology* and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on the Form CMS-1450 (UB-92), in FL 84, Remarks. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

10.1 - Consolidated Billing Requirement for SNFs

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, **except** for certain excluded services described in §§20.1 – 20.3, **and** for all physical, occupational and speech-language pathology services received by residents under Part B. A SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF or the participating, Medicare-certified, distinct part unit (DPU) of a larger institution. When such a beneficiary leaves the facility (or the DPU), the beneficiary's status as a SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends. It may be triggered by any one of the following events:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary dies; or
- The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before midnight of the same day. A "discharge" from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

These requirements apply only to Medicare fee-for-service beneficiaries residing in a participating SNF or DPU.

Claims are submitted to the FI on Form CMS-1450 or its electronic equivalent. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF is required to bill for all physical *therapy*, occupational *therapy*, and/or speech-language *pathology* services provided to a SNF resident under Part B. The consolidated billing provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF.

Thus, SNFs are no longer able to "unbundle" services to an outside supplier that can then submit a separate bill directly to a Part B carrier or DMERC for residents in a Part A stay, or for SNF residents receiving physical *therapy*, occupational *therapy*, and/or speech-language *pathology* services paid under Part B. Instead, the SNF must furnish the

services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than the Medicare carrier or FI or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

NOTE: The requirements for participation at 42 CFR 483.12(a)(2)(i)-(vi) specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include situations in which the resident's health has improved to the point where he or she no longer needs SNF care. However, if a resident has exhausted Part A benefits but nevertheless continues to require SNF care, he or she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those specified in the regulations. For example, the resident cannot be moved to avoid the consolidated billing requirements, or to establish a new benefit period. The determination to move the beneficiary out of the SNF or DPU must not be made on the basis of the beneficiary having exhausted his or her benefits, but rather, on the beneficiary's lack of further need for SNF care. Once a resident of a Medicare-certified DPU ceases to require SNF care, he or she may then be moved from the DPU to the Medicare non-certified area of the institution. As discussed above, such a move would end the beneficiary's status as a SNF "resident" for consolidated billing purposes.

Enforcement of SNF consolidated billing is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from SNF CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to SNF CB. Such transmittals can be found on the CMS Web site at: www.cms.hhs.gov/manuals/

The list of HCPCS codes enforcing SNF CB may be updated each quarter. For the notice on SNF CB for the quarter beginning January, separate instructions are published for FIs and carriers/DMERCs. Since this is usually the only quarter in which new permanent HCPCS codes are produced, this recurring update is referred to as an annual update. Other updates for the remaining quarters of the year will occur as needed prior to the next annual update. In lieu of another update, editing based on the prior list of codes remains in effect. Some non-January quarterly updates may apply to both FIs and carriers/DMERCs, and the applicability of the instruction will be clear in each update. All future updates will be submitted via a Recurring Update Notification form.

- **Effective July 1, 1998**, consolidated billing became effective for those services and items that were not specifically excluded by law from the SNF prospective payment system (PPS) when they were furnished to residents of a SNF in a covered Part A stay and also includes physical *therapy*, occupational *therapy*, and/or speech-language *pathology services* in a noncovered stay. SNFs became subject to consolidated billing once they transitioned to PPS. Due to systems limitations, consolidated billing was not implemented at that time for residents not

in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). Section 313 of the Benefits Improvement and Protection Act (BIPA) of 2000 subsequently repealed this aspect of consolidated billing altogether, except for physical *therapy*, occupational *therapy*, and*/or* speech-language *pathology* services. In addition, for either type of resident, the following requirements were also delayed: (1) that the physicians forward the technical portions of their services to the SNF; and (2) the requirement that the physician enter the facility provider number of the SNF on the claim.

- **Effective July 1, 1998,** under 42 CFR 411.15(p)(3)(iii) published on May 12, 1998, a number of other services are excluded from consolidated billing. The hospital outpatient department will bill these services directly to the FI when furnished on an outpatient basis by a hospital or a critical access hospital. Physician's and other practitioner's professional services will be billed directly to the carrier. Hospice care and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident, are also excluded from SNF PPS consolidated billing.
- **Effective April 1, 2000**, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from consolidated billing that therefore had to be billed directly to the carrier or DMERC by the provider or supplier for payment. As opposed to whole categories of services being excluded, only certain specific services and drugs (identified by HCPCS code) were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services, and certain customized prosthetic devices.
- **Effective January 1, 2001**, §313 of the BIPA, restricted SNF consolidated billing to the majority of services provided to beneficiaries in a Medicare Part A covered stay and only to therapy services provided to beneficiaries in a noncovered stay.
- **Effective for claims with dates of service on or after April 1, 2001**, for those services and supplies that were not specifically excluded by law and are furnished to a SNF resident covered under the Part A benefit, physicians are required to forward the technical portions of any services to the SNF to be billed by the SNF to the FI for payment.

10.3 - Types of Services Subject to the Consolidated Billing Requirement for SNFs

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

As previously discussed, the consolidated billing requirement applies to all services furnished to a SNF resident in a covered Part A stay (other than the excluded service categories described below) and for physical *therapy*, occupational *therapy*, and/or speech-language *pathology* services provided to residents and paid under Part B. Examples of services that are subject to consolidated billing include:

- Physical *therapy*, occupational *therapy*, and*/or* speech-language *pathology* services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional (see §1888(e)(2)(A)(ii) of the Act). Physical *therapy*, occupational *therapy*, and*/or* speech-language *pathology* services (other than audiology services, which are considered diagnostic tests rather than therapy services) furnished to a SNF resident during a noncovered stay must still be billed by the SNF itself.
- Psychological services furnished by a clinical social worker; and
- Services furnished as an "incident to" the professional services of a physician or other excluded category of health care professional described in §20.1.1 below.

10.4 - Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" With an Outside Entity

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

As discussed in §10.1 and §10.3, the skilled nursing facility (SNF) consolidated billing provisions (at §1862(a)(18), §1866(a)(1)(H)(ii), and §1888(e)(2)(A) of the Act) place with the SNF itself the Medicare billing responsibility for most of its residents' services. "Part A" consolidated billing requires that an SNF must include on its Part A bill almost all of the services that a resident receives during the course of a Medicare-covered stay, other than those services that are specifically excluded from the SNF's global PPS per diem payment for the covered stay. (These "excluded" services, such as the services of physicians and certain other practitioners, remain separately billable to Part B directly by the outside entity that actually furnishes them.) In addition, "Part B" consolidated billing makes the SNF itself responsible for submitting the Part B bills for any for physical *therapy*, occupational *therapy*, *and/*or speech-language *pathology* services that a resident receives during a noncovered stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as a supplier) under an "arrangement," as described in §1861(w) of the Act and in §80.5. Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Since the inception of the SNF PPS, several problematic situations have been identified where the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. (In this context, the term "supplier" can also include those practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.) As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or 2) A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or another individual acting on the beneficiary's behalf) seeks to obtain such services directly from the supplier without the SNF's knowledge.

The absence of a valid arrangement in the situations described above creates confusion and friction between SNFs and their suppliers. Suppliers need to understand which services are subject to consolidated billing to avoid situations where they might improperly attempt to bill Part B (or other payers such as Medicaid and beneficiaries) directly for the services. In addition, when ordering or furnishing services "under arrangements," both parties need to reach a common understanding on the terms of payment; e.g., how to submit an invoice, how payment rates will be determined, and the turn-around time between billing and payment. Without this understanding, it may become difficult to maintain the strong relationships between SNFs and their suppliers that are necessary to ensure proper coordination of care to the Medicare beneficiaries.

Whenever possible, SNFs should document arrangements with suppliers in writing, particularly with suppliers furnishing services on an ongoing basis, such as laboratories, x-ray suppliers, and pharmacies. This also enables the SNF to obtain the supplier's assurance that the arranged-for services will meet accepted standards of quality (under the regulations at 42 CFR 483.75(h)(2), SNFs must ensure that services obtained under an arrangement with an outside source meet professional standards and principles that apply to professionals providing such services).

However, it is important to note that the absence of a valid arrangement does NOT invalidate the SNF's responsibility to reimburse suppliers for services included in the SNF "bundle" of services represented by the SNF PPS global per diem rate. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays. This obligation applies even in cases where the SNF did not specifically order the service; e.g., during a scheduled physician's visit, the physician performs additional diagnostic tests that had not been ordered by the SNF; a family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Finally, while establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties, it is not unreasonable to expect occasional disagreements between the parties that may result in non-payment of a supplier claim. However, it is important to note that there are potentially adverse consequences to SNFs when patterns of such denials are identified. Specifically, all participating SNFs agree to comply with program regulations when entering into a Medicare provider agreement which, as explained below, requires an SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself. Moreover, in receiving a bundled per diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment--and financial responsibility--for the service.

Accordingly, these instructions reiterate and clarify the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.

20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Except for the therapy services, the professional component of physician services and services of certain nonphysician providers listed below are excluded from Part A PPS payment and the requirement for consolidated billing, and must be billed separately by the practitioner to the carrier. See below for Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) instructions.

For this purpose "physician service" means the professional component of the service. The technical component, if any, must be billed by the SNF for its Part A inpatients. The carrier will pay only the professional component to the physician.

- Physician's services other than physical, occupational, and speech-language *pathology* services furnished to SNF residents;
- Physician assistants, not employed by the SNF, working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists, not employed by the SNF, working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists; and
- Certified registered nurse anesthetists.

Providers with the following specialty codes assigned by CMS upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §§1861(q) and (r) of the Act. These providers may bill their carrier directly.

Physician Specialty Codes

01 General Practice	02 General Surgery
03 Allergy/Immunology	04 Otolaryngology
05 Anesthesiology	06 Cardiology
07 Dermatology	08 Family Practice
10 Gastroenterology	11 Internal Medicine
12 Osteopathic Manipulative Therapy	13 Neurology
14 Neurosurgery	16 Obstetrics Gynecology
18 Ophthalmology	19 Oral Surgery (Dentists only)
20 Orthopedic Surgery	22 Pathology

Physician Specialty Codes

24 Plastic and Reconstructive Surgery	25 Physical Medicine and Rehabilitation
26 Psychiatry	28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease	30 Diagnostic Radiology
33 Thoracic Surgery	34 Urology
35 Chiropractic	36 Nuclear Medicine
37 Pediatric Medicine	38 Geriatric Medicine
39 Nephrology	40 Hand Surgery
41 Optometry	44 Infectious Disease
46 Endocrinology	48 Podiatry
66 Rheumatology	69 Independent Labs
70 Multi specialty Clinic or Group Practice	76 Peripheral Vascular Disease
77 Vascular Surgery	78 Cardiac Surgery
79 Addiction Medicine	81 Critical Care (Intensivists)
82 Hematology	83 Hematology/Oncology
84 Preventive Medicine	85 Maxillofacial Surgery
86 Neuropsychiatry	90 Medical Oncology
91 Surgical Oncology	92 Radiation Oncology
93 Emergency Medicine	94 Interventional Radiology
98 Gynecological/Oncology	99 Unknown Physician Specialty

Nonphysician Provider Specialty Codes

42 Certified Nurse Midwife	43 Certified Registered Nurse Anesthetist, Anesthesia Assistants (effective 1/1/89)
50 Nurse Practitioner	62 Clinical Psychologist (billing

Physician Specialty Codes

independently)

68 Clinical Psychologist

89 Certified Clinical Nurse Specialist

97 Physician Assistant

NOTE: Some HCPCS codes are defined as all professional components in the fee schedule. Fee schedule definitions apply for this purpose.

Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) established payment method II, in which CAHs can bill and be paid for physician services billed to their intermediary. CAHs must bill the professional fees using revenue codes 96x, 97x, or 98x on an 85x type of bill (TOB). Like professional services billed to the carrier, the specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing.

RHC/FQHC Instructions:

Effective January 1, 2005, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from a RHC or a Federally Qualified Health Center FQHC, those services are not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC. Accordingly, under section 410 of the MMA of 2003, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay. Use TOBs 71x and 73x, respectively, to bill for these RHC/FQHC services.

110.2.2 - Utilization Edits

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Effective April 1, 2002, CWF implemented the following utilization edits for carrier submitted claims. Carriers implemented automated processes for the resolution of these edits based on the codes returned in the trailers from CWF.

A. Edits 7258 and 7259 - Carrier Part B Physical Therapy Claim Against an Inpatient SNF 21x and Inpatient Part B 22x Claim

Reject if a carrier Part B claim is received containing physical therapy (type of service of W), occupational therapy, or speech-*language pathology* and From/Thru Dates overlap or are within the From/Thru Dates on an SNF inpatient claim (21x) or an inpatient Part B claim (22x).

Use separate error codes where (1) dates are within (contractor will reject claim) or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

- The 21x or 22x type of bill contains a cancel date.
- The incoming claim from date equals the SNF 21x or 22x history claim discharge date or incoming through date equals the SNF 21x or 22x history claim admission date.

B. Edits 7260 and 7261 - Carrier Part B Claim Without Therapy Against an Inpatient SNF

Reject if a carrier Part B claim is received with From/Thru Dates overlapping or are within the From/Thru Dates on an SNF Inpatient claim (21x). If the SNF 21x claim on history has patient status 30 and occurrence code 22 (Date Active Care Ended), use occurrence 22 date instead of the through date.

Use separate error codes where (1) dates are within (contractor will reject claim); or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

- The 21x history claim contains a cancel date.
- The incoming Part B claim from date equals the SNF 21x history claim discharge date. The incoming Part B claim through date equals the SNF 21x history claim admission date.
- A diagnosis code in any position on the incoming claim is for renal disease.
- The Part B claim contains ambulance codes per the files supplied to CWF in the annual and quarterly updates with modifiers other than N (SNF) in both the origin and destination on the same claim.
- The Part B claim is a CANCEL ONLY (Action Code 4) claim.
- The Part B claim is denied.
- The Part B service has a Payment Process Indicator other than A (allowed).

- The Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.

Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

10.1 - Billing for Inpatient SNF Services Paid Under Part B

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

When the beneficiary in a Medicare-certified SNF is not entitled to Part A benefits, limited benefits are provided under Part B. Reasons for not being entitled to have payment made under Part A are that:

- The beneficiary does not have Medicare Part A Health Insurance;
- The beneficiary is not in a Medicare-certified bed;
- The inpatient stay is not at a covered level of care and no Part A program payment is possible; or
- The inpatient stay is not covered because the beneficiary did not have a 3-day qualifying stay.

When no Part A program payment is possible, some or all services may be medically necessary and can be covered as ancillary services under Part B. The following services may be billed by the SNF or the rendering provider or supplier under an arrangement with the SNF:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech-*language* pathology services, and outpatient occupational therapy (see Pub. 100-02 Medicare Benefit Policy Manual, chapter 15, "Covered Medical and Other Health Services," §220 *and 230.*
- Screening mammography services;

- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision);
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).

See chapter 6 of Pub. 100-02, Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

Coverage rules for these services are described in Pub. 100-02, Medicare Benefit Policy Manual, Chapters 10, 14, or 15. Specific billing instructions are found in the Medicare Claims Processing Manual, Chapters 13, 15, 16, 18, 20, or 23.

Outpatient physical therapy, outpatient speech-*language* pathology services, and outpatient occupational therapy (see Chapter 10, §§60) are billable services for SNF inpatients not in a Part A stay. However, they must be billed by the SNF even when another entity renders the services under an arrangement with the SNF.

The determination of whether to use TOB 22x or 23x is a function of the type of facility in which the beneficiary resides. If the facility is not Medicare-certified, it is not a SNF, although it may have a Medicare-certified distinct part unit (DPU). If the beneficiary is in a SNF or SNF DPU, Part B services must be billed on TOB 22x.

All services rendered to SNF patients residing in the non-Medicare-certified portion of an institution that is not primarily engaged in the provision of skilled services must be billed on TOB 23x. Beneficiaries residing in such portions of the facility are considered outpatients of the SNF for Medicare purposes.

If the entire facility qualifies as a Medic are-certified SNF, all Part B services rendered to residents are billed on TOB 22x.

40.1 - Audiologic Tests

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Audiologic tests will generally be billed to the carrier by the provider of service. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component to the intermediary, but is not required to bill the service. *See Pub 100-02 chapter 15, section 80.3 for further information on audiology.*

Payment to SNFs for audiologic tests are bundled into the PPS payment amount for beneficiaries in a covered SNF Part A stay, whether provided directly by the SNF or under arrangements by an independent provider based on a contract with the SNF. Independent audiologists may bill the carrier directly for services rendered to beneficiaries **not** in a SNF Part A covered stay. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic tests are payable under Part B when billed by the SNF as type of bill 22X, or when billed directly to the carrier by the provider of the service. Payment is based on the Medicare Physician Fee Schedule (MPFS), whether by the carrier or the intermediary.

Since audiologic tests are **not** bundled with speech *-language pathology* services, payment is made to the provider of service or to the SNF where the services are provided under arrangements with the SNF for SNF outpatients.

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

10.1.19.1 - Adjustments of Episode Payment - Therapy Threshold

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted in line-item detail on the claim for the episode. Because the advent of 15 minute increment reporting on home health claims only recently preceded HH PPS, therapy hours will be proxied from visits at the start of HH PPS episodes, rather than constructed from increments. Ten visits will be proxied to represent eight hours of therapy.

Each HIPPS code is formulated with anticipation of a projected range of hours of therapy service (physical, occupational, or speech-*language pathology* combined). Logic is inherent in HIPPS coding so that there are essentially two HIPPS codes representing the same payment group; one if a beneficiary does not receive the therapy hours projected, and another if they do meet the "therapy threshold." Therefore, when the therapy threshold is not met and the HIPPS code output by the Grouper indicated it would be, there is an automatic "fall back" HIPPS code, and Pricer software in Medicare claims processing systems will correct payment without access to the full OASIS data set.

The electronic remittance advice will show both the HIPPS code submitted on the claim and the HIPPS code that was used for payment, so such cases can be clearly identified. If the HHA later submits an adjustment claim on the episode that brings the therapy visit total above the utilization threshold, such as may happen in the case of services provided under arrangement which were not billed timely to the primary agency, Medicare claims processing systems would pay the full episode payment based on the HIPPS code. Note that HIPPS codes may also be changed based on the medical review of claims, but Pricer software enforces the therapy threshold. Pricer will automatically change the HIPPS to the fallback code if the threshold is not met, but providers must adjust the HIPPS on their own claims if instead they originally billed the fallback code and then unexpectedly met or exceeded the threshold.

90 - Medical and Other Health Services Not Covered Under the Plan of Care (Bill Type 34X)

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Form CMS-1450 is submitted for certain Part B medical and other health services for which the HHA may receive payment outside of the prospective payment system. (See the Medicare Benefit Policy Manual, Chapter 7). Refer to instructions in Chapter 20 of this manual and §90.1 in this chapter for submitting claims under arrangement with suppliers.

A Patient Not Under A Home Health Plan Of Care

The HHA uses a Form CMS-1450 (TOB 34X) to bill for certain Part B "medical and other health services" when there is no home health plan of care. Specifically the HHA may bill using TOB 34X for the following services. (There must be a physician's certification on file.):

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations. (See Chapter 20 for billing enteral and parenteral supplies and equipment.)
- Rental or purchase of DME. (See Chapter 20 for billing enteral and parenteral supplies and equipment.)
- Prosthetic devices. (See Chapter 20 for billing enteral and parenteral supplies and equipment.)
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.
- Outpatient physical therapy services. (See the Medicare Benefit Policy Manual, Chapter 15 and the Medicare Claims Processing Manual, Chapter 5.)
- Outpatient speech-*language* pathology services. (See the Medicare Benefit Policy Manual, Chapter 15 and the Medicare Claims Processing Manual, Chapter 5.)
- Outpatient occupational therapy services. (See the Medicare Benefit Policy Manual, Chapter 15 and the Medicare Claims Processing Manual, Chapter 5.)

Bills for services not under a home health plan of care should be submitted only after services are delivered. They should be submitted on a periodic basis, e.g., monthly, without regard to an episode of care. These items are not reimbursed under HH PPS.

B The Patient is Under a Home Health Plan of Care

If a patient is receiving home health services under a plan of care, the agency may bill for the following services on Form CMS-1450 (Bill Type 34X). All other services are home health services and should be billed as a HH PPS episode with Bill Type 32X.

- A covered osteoporosis drug, and
- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines.

DME, orthotic, and prosthetics can be billed as a home health service or as a medical and other health service on bill types 32X, 33X, and 34X as appropriate.

C Billing Spanning Two Calendar Years

The agency should not submit a Part B medical and other health services bill (bill type 34X only) for an inclusive period beginning in 1 calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits the FI to apply the appropriate deductible for both years. HH PPS claims (TOB 32X or 33X) may span the calendar year since they represent 60-day episodes, and episodes should be attributed to the Federal fiscal year or calendar year in which they end.

D Billing For Laboratory Services

HHAs may provide laboratory services only if issued a CLIA number and/or having a CLIA certificate of waiver. HHAs do not report laboratory services, even when on the HH plan of care, on the PPS claim to the RHHI. These services are billed to Medicare carriers using the HHAs carrier number on the Form CMS-1500 claim. To submit such claims to the carrier, the HHA must have a CLIA number and a billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate carrier to obtain a billing number. The survey process is used to validate that laboratory services in an HHA facility are being provided in accordance with the CLIA certificate.

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

40.2 - Carrier Processing of Claims for Hospice Beneficiaries

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Professional services of attending physicians, who may be nurse practitioners, furnished to hospice beneficiaries are coded with modifier GV. Attending physician not employed or paid under arrangement by the patient's hospice provider. This modifier must be retained and reported to CWF.

Local Part B carriers shall presume that hospice benefits are not involved unless the biller codes services on the claim to indicate that the patient is a hospice enrollee (e.g. the GV modifier is billed by the attending physician, who may be a nurse practitioner, or the GW modifier is billed for services unrelated to the terminal illness) or the trailer information on the CWF reply shows a hospice election. The carrier shall use the hospice enrollment trailer information on the CWF reply to examine and validate the claim information.

For beneficiaries enrolled in hospice, carriers shall deny any services furnished on or after January 1, 2002, that are submitted without either the GV or GW modifier. For services furnished to a hospice patient prior to January 1, 2002, the attending physician is to include an attestation statement that is the written equivalent of the GV modifier and carriers are responsible for determining whether or not a service is related to the patient's terminal condition.

Deny claims for all other services related to the terminal illness furnished by individuals or entities other than the designated attending physician, who may be a nurse practitioner. Such claims include bills for any DME, supplies or independently practicing speech-*language pathologists* or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the FI.

See §110 for MSN and Remittance Advice (RA) coding.

Medicare Claims Processing Manual

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

01 - Foreword

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

42 CFR 400.202

This chapter provides general instructions on billing and claims processing for durable medical equipment (DME), prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), and supplies. Coverage requirements are in the Medicare Benefit Policy Manual and the National Coverage Determinations Manual.

These instructions are applicable to services billed to the carrier, durable medical equipment regional carrier (DMERC), intermediary (FI), and regional home health intermediary (RHHI) unless otherwise noted.

The DME, prosthetic/orthotic devices (except customized devices in a SNF), supplies and oxygen used during a Part A covered stay for hospital and skilled nursing facility (SNF) inpatients are included in the inpatient prospective payment system (PPS) and are not separately billable.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.202.

- Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-*language* pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

  Of these provider types only hospitals, CAHs, SNFs, and HHAs would be able to bill for DMEPOS; and for hospitals, CAHs, and SNFs usually only for outpatients. Any exceptions to this rule are discussed in this chapter.

- Supplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

  A DMEPOS supplier must meet certain requirements and enroll as described in Chapter 10 of the Program Integrity Manual. A provider that enrolls as a supplier is considered a supplier for DMEPOS billing. However, separate payment remains restricted to those items that are not considered included in a PPS rate.

Unless specified otherwise the instructions in this chapter apply to both providers an suppliers, and to the contractors that process their claims.

Medicare Claims Processing Manual

Chapter 25 - Completing and Processing UB-92 Data Set

60.2 - Form Locators 21-30

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

FL 21 – Discharge Hour

Not Required.

FL 22 – Patient Status

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

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care.
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
04	Discharged/transferred to an ICF
05	Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05). Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions.
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider. To be DISCONTINUED effective 10/1/05.
*09	Admitted as an inpatient to this hospital
10-19	Reserved for National Assignment
20	Expired (or did not recover - Religious Non Medical Health Care Patient)

Code	Structure
21-29	Reserved for National Assignment
30	Still patient or expected to return for outpatient services
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a federal health care facility. (effective 10/1/03) Usage note: Discharges and transfers to a government operated health care facility.
44-49	Reserved for national assignment
50	Discharged/transferred to Hospice - home
51	Discharged/transferred to Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)
67-70	Reserved for national assignment
71	Discharged/transferred to another institution for outpatient services (discontinued effective October 1, 2003)

Code	Structure
72	Discharged/transferred to this institution for outpatient services (discontinued effective October 1, 2003)
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 diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.

FL 23 - Medical Record Number

Required. The provider enters the number assigned to the patient's medical/health record. The FI must carry the medical record number through the FI system and return it to the provider.

FLs 24, 25, 26, 27, 28, 29, 30 - Condition Codes

Required. The provider enters the corresponding code to describe any of the following conditions or events that apply to this billing period.

Code	Title	Definition
02	Condition is Employment Related	Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment. (See Chapter 28.)
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan (such as Medicare+Choice) and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed	The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.

Code	Title	Definition
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance	Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 18 month of end stage renal disease entitlement.
07	Treatment of Non-terminal Condition for Hospice Patient	The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	The beneficiary would not provide information concerning other insurance coverage. The FI develops to determine proper payment. (See Chapter 28 for development guidelines.)
09	Neither Patient Nor Spouse is Employed	In response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no Large Group Health Plan (LGHP)	In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. The CMS will assign as needed for FI use. Providers will not report.
15	Clean Claim Delayed in CMS's Processing System (Medicare Payer Only Code)	The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to CPEP/CPT standards. (See Chapter 1.)
16	SNF Transition Exemption (Medicare Payer Only Code)	An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.

Code	Title	Definition
17	Patient is Homeless	The patient is homeless.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits that does not have its father's last name.
20	Beneficiary Requested Billing	Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)
21	Billing for Denial Notice	The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility	Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is 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.

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

Code	Title	Definition
	Patient's Request	accommodations at their own request. This must be supported by a written request in the provider's files. (See the Benefit Policy Manual, Chapter 1.)
38	Semi-private Room Not Available	(Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private accommodations were not available.

NOTE: If revenue charge codes indicate a ward accommodation was assigned and neither code 37 nor code 38 applies, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, Medicare pays semi-private costs.

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) The patient needed a private room for medical reasons.
40	Same Day Transfer	The patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization	The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol). (See the Benefit Policy Manual, Chapter 6 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 Post Discharge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. Effective

Code	Title	Definition
		April 1, 2004
45		Reserved for national assignment
46	Non-Availability Statement on File	A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.
47		Reserved for TRICARE
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49	Product replacement within product lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product replacement for known recall of a product	Manufacturer or FDA has identified the product for recall and therefore replacement.
51-54		Reserved for national assignment
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	The patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Managed Care Organization Enrollee	Code indicates that patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
59	Non-primary ESRD Facility	Code indicates that ESRD beneficiary

Code	Title	Definition
		received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. Effective 10/01/04
60	Operating Cost Day Outlier	Day Outlier obsolete after FY 1997. (Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. The FI indicates the cost outlier portion paid value code 17.
61	Operating Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI indicates the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Bill was paid under PIP. The FI records this from its system.
63	Payer Only Code	Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment
64	Other Than Clean Claim	(Not reported by providers.) The claim is not "clean." The FI records this from its system.
65	Non-PPS Bill	(Not reported by providers.) Bill is not a PPS bill. The FI records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Cost Outlier Payment	The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	The beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	The beneficiary elects to use LTR days when charges are less than LTR coinsurance

Code	Title	Definition
		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 Epoetin (EPO)	The billing is for a home dialysis patient who self-administers EPO.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis services at home.
75	Home 100-percent	(Not to be used for services Payment furnished 4/16/90, or later.) The bill 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	The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	The bill is for a newly covered service under Medicare for which an HMO does not pay. (For outpatient bills, condition code 04

Code	Title	Definition
		should be omitted.)
79	CORF Services Provided Off-Site	Physical therapy, occupational therapy, or speech-*language* pathology services were provided off-site.
80	Home Dialysis-Nursing Facility	Home dialysis furnished in a SNF or Nursing Facility.
81-99		Reserved for State assignment. Discontinued Effective October 16, 2003.

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

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 for uniform use by State uniform billing committees.
A5	Disability	This code is for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment	Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services.
A7		Reserved for national assignment (Discontinued 10/1/02)
A8	Induced Abortion - Victim of Rape/Incest	Self-explanatory. Discontinued 10/01/02 Reserved for national assignment
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
AA	Abortion Performed due to Rape	Self-explanatory – Effective 10/1/02
AB	Abortion Performed due to Incest	Self-explanatory – Effective 10/1/02

Code	Title	Definition
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 facility. – Effective 10/16/03
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective 10/16/03
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening. Effective 1/1/04
AO-AZ		Reserved for national assignment

Code	Title	Definition
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.
B1	Beneficiary is Ineligible for Demonstration Program	Full definition pending
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the Ambulance Fee Schedule
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable Law. – Effective 10/16/03
B4	Admission Unrelated to Discharge	Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004. Effective January 1, 2005
B5-BZ		Reserved for national assignment
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.
QIO Approval Indicator Codes		
C1	Approved as Billed	Claim has been reviewed by the QIO and has been fully approved including any outlier.
C3	Partial Approval	The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as code “M0” in FL 36.

Code	Title	Definition
		The hospital excludes grace days and any period at a non-covered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	The patient's need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.
C5	Post-payment Review Applicable	Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/Pre-procedure	The QIO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
Claim Change Reasons		
D0	Changes to Service Dates	Self explanatory
D1	Changes to Charges	Self explanatory
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Changes In ICD-9-CM Diagnosis and/or Procedure Code	Use for inpatient acute care hospital, long-term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF).
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a	Cancel only to repay a duplicate payment or

Code	Title	Definition
	Duplicate or OIG Overpayment	OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory
DA – DQ		Reserved for national assignment
DR	Disaster related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
DS – DZ		Reserved for national assignment
E0	Change in Patient Status	Self-explanatory
E1 – FZ		Reserved for national assignment
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.
G1 – GZ		Reserved for national assignment

Code	Title	Definition
H0	Delayed Filing, Statement Of Intent Submitted	Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
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.
N0-OZ		Reserved for national assignment
P0-PZ		Reserved for national assignment. FOR PUBLIC HEALTH DATA REPORTING ONLY
Q0-VZ		Reserved for national assignment.
W0	United Mine Workers of America (UMWA) Demonstration Indicator	United Mine Workers of America (UMWA) Demonstration Indicator ONLY
W1-ZZ		Reserved for national assignment.

60.3 - Form Locators 31-41

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

FL 31 - (Untitled)

Not Required. Previously reserved for State Use. Discontinued Effective October 16, 2003.

FL 32, 33, 34, and 35 - Occurrence Codes and Dates

Required. The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

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 34 A and B and 35 A 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" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

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

Code	Title	Definition
01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
02	No-Fault Insurance Involved - Including Auto Accident/Other	Date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Date of an accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Date of an accident that relates to the patient's employment. (See Chapter 28.)
05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08		Reserved for national assignment.
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.
11	Onset of Symptoms/Illness	(Outpatient claims only.) Date that the patient first became aware of

Code	Title	Definition
		symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual (CDI)	(HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.
13-15		Reserved for national assignment
16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical, occupational or speech-*language pathology*).
17	Date Outpatient Occupational Therapy Plan Established or Reviewed	The date the occupational therapy plan was established or last reviewed.
18	Date of Retirement Patient/Beneficiary	Date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision. (See the Financial Management Manual, Chapter 3.)
21	UR Notice Received	(Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See Chapter 3.)
22	Date Active Care Ended	(SNF claims only.) Date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period. For FI Use Only. Providers Do	Code is not required if code "21" is used.

Code	Title	Definition
	Not Report.	
24	Date Insurance Denied	Date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available	The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	The date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date CORF Plan Established or Last Reviewed	The date a plan of treatment was established or last reviewed for CORF care. (See Chapter 5).
29	Date OPT Plan Established or Last Reviewed	The date a plan was established or last reviewed for OPT. (See Chapter 5).
30	Date Outpatient Speech-*Language* Pathology Plan Established or Last Reviewed	The date a plan was established or last reviewed for outpatient speech-*language* pathology. (See Chapter 5).
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date the hospital notified the beneficiary that the beneficiary does not (or no longer) require a covered level of inpatient care.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be reasonable or necessary under Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	The first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.

Code	Title	Definition
34	Date of Election of Extended Care Services	The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
35	Date Treatment Started for Physical Therapy	The date the provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)	The date of discharge for a hospital stay in which the patient received a covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. **NOTE:** When the patient received a covered and a non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant	The date of discharge for an inpatient hospital stay during which the patient received a non-covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs.
38	Date treatment started for Home IV Therapy	Date the patient was first treated at home for IV therapy (Home IV providers - bill type 85X).
39	Date discharged on a continuous course of IV therapy	Date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers- bill type 85X).
40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test was performed as a part of a PAT program. This code may be used only if a date of admission was scheduled prior to the administration of the test(s).

Code	Title	Definition
42	Date of Discharge	(Hospice claims only.) The date on which a beneficiary terminated their election to receive hospice benefits from the facility rendering the bill. See Chapter 11. The frequency digit (3rd digit, FL 4, Type of Bill) should be 1 or 4.
43	Scheduled Date of Cancelled Surgery	The date for which outpatient surgery was scheduled.
44	Date Treatment Started for Occupational Therapy	The date the provider initiated services for occupational therapy.
45	Date Treatment Started for Speech-*Language Pathology*	The date the provider initiated services for speech-*language pathology*.
46	Date Treatment Started for Cardiac Rehabilitation	The date the provider initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	Code indicates that this is the first day the inpatient cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments.
48-49	Payer Codes	For use by third party payers only. The CMS assigns for FI use. Providers do not report these codes.
50-69		Reserved for State Assignment. Discontinued Effective October 16, 2003.
A1	Birth Date-Insured A	The birth-date of the insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy	The first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer A.

Code	Title	Definition
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as "Split Bill Date"). Effective 10/1/03.
A5-AZ		Reserved for national assignment
B1	Birth Date-Insured B	The birth-date of the individual in whose name the insurance is carried.
B2	Effective Date-Insured B Policy	The first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer B.
B4-BZ		Reserved for national assignment
C1	Birth Date-Insured C	The birth-date of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	The first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer C.
C4-CZ		Reserved for National Assignment.
D0-DQ		Reserved for National Assignment.
DR		Reserved for Disaster related code
DS-DZ		Reserved for National Assignment
E0		Reserved for national assignment
E1	Birth date-Insured D	The birth date of the individual in whose name the insurance is carried.
E2	Effective Date-Insured D Policy	A code indicating the first date insurance is in force.
E3	Benefits Exhausted	Code indicating the last date for which

Code	Title	Definition
		benefits are available and after which no payment can be made to payer D.
E4-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Birth date-Insured E	The birth date of the individual in whose name the insurance is carried.
F2	Effective Date-Insured E Policy	A code indicating the first date insurance is in force.
F3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer E.
F4-FZ		Reserved for national assignment
G0		Reserved for national assignment
G1	Birth date-Insured F	The birth date of the individual in whose name the insurance is carried.
G2	Effective Date-Insured F Policy	A code indicating the first date insurance is in force.
G3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer F.
G4-GZ		Reserved for national assignment
H0-HZ		Reserved for national assignment
J0-LZ		Reserved for State assignment. Discontinued Effective October 16, 2003.
M0-ZZ		See instructions in Form Locator 36 – Occurrence Span Codes and Dates

FL 36 - Occurrence Span Code and Dates

Required For Inpatient.

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

Code Structure

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Non-utilization Dates (For Payer Use on Hospital Bills Only)	The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates	(Part A claims only.) The From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.
74	Non-covered Level of Care	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, but not valid for HHA under PPS.
75	SNF Level of Care	The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code “60” in FLs 24-30). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care.

Code	Title	Definition
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability- Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36. (See Chapter 1)
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.

Code	Title	Definition
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5-MQ		Reserved for National Assignment
MR		Reserved for Disaster related code
MS-WZ		Reserved for National Assignment
X0-ZZ		Reserved for State assignment. Discontinued, effective October 16, 2003

FL 37 - Internal Control Number (ICN)/Document Control Number (DCN)

Required. The provider enters the control number assigned to the original bill here. This field is used on adjustment requests (Bill Type, FL 4 = XX7). When requesting an adjustment to a previously processed claim, the provider inserts the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN should be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer B and C should be shown on lines B and C respectively, in FL 37.

FL 38 - (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address

Not Required. For claims that involve payers of higher priority than Medicare, as defined in FL 58, the provider enters the address of the other payer in FL 84 (Remarks).

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

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

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider

uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

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

Code	Title	Definition
07		Reserved for national assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission. (See Chapter 3.)
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. (See Chapter 3.) The provider may not use this code on Part B bills. For Part B coinsurance use value codes A2, B2 and C2.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. The provider uses this code only on bills spanning 2 calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. The provider uses this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. It may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)

Code	Title	Definition
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. (See Chapter 28.) If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim
15	Worker's Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. (See Chapter 28.). Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
16	PHS, Other Federal Agency	That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. **NOTE:** A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment

Code	Title	Definition
		requested (000000).
17	Operating Outlier Amount	(Not reported by providers.) The FI reports the amount of operating outlier payment made (either cost or day (day outliers have been obsolete since 1997) in CWF with this code. It does not include any capital outlier payment in this entry.
18	Operating Disproportionate Share Amount	(Not reported by providers.) The FI reports the operating disproportionate share amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital DSH adjustment in this entry.
19	Operating Indirect Medical Education Amount	(Not reported by providers.) The FI reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.
20	Payer Code	(For internal use by third party payers only.)
21	Catastrophic	Medicaid-eligibility requirements to be determined at State level.
22	Surplus	Medicaid-eligibility requirements to be determined at State level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at State level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at State level.
25	Offset to the Patient-Payment Amount – Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount – Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-	Vision and eye services paid for out of a long-

Code	Title	Definition
	Payment Amount – Vision and Eye Services	term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount – Dental Services	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount – Chiropractic Services	Chiropractic Services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
31	Patient Liability Amount	The FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount – Podiatric Services	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount – Other Medical Services	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount – Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36		Reserved for national assignment.
37	Pints of Blood Furnished	The total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.
38	Blood Deductible Pints	The number of un-replaced deductible pints of blood supplied. If all deductible pints furnished

Code	Title	Definition
		have been replaced, no entry is made.
39	Pints of Blood Replaced	The total number of pints of blood that were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. (See Chapter 3.) Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by HMO	(For inpatient service only.) Inpatient charges covered by the HMO. (The hospital uses this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO. It must also report condition codes 04 and 78.)
41	Black Lung (BL)	That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)
42	Veterans Affairs (VA)	That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. (Any payment must conform to Chapter 28.)
43	Disabled Beneficiary Under Age 65 With LGHP	That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the

Code	Title	Definition
		amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)
44	Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received	That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due. (See Chapter 28.)
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, indicating that the QIO has denied all or a portion of this billing period, the provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient's post discharge. The field contains one numeric digit.
47	Any Liability Insurance	That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer's payment. (See Chapter 28.)
48	Hemoglobin Reading	The latest hemoglobin reading taken during this billing cycle. The provider reports in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, it uses the position to the right of the delimiter for the third digit. Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken **before** the start of the billing period.

Code	Title	Definition
50	Physical Therapy Visits	The number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	The number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech-*Language Pathology* Visits	The number of speech-*language pathology* visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.
54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law.
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse – Home Visit Hours (HHA only)	The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.)
57	Home Health Aide – Home Visit Hours (HHA only)	The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (The number is rounded to the nearest whole hour.)

NOTE: Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits are right justified from the dollars/cents delimiter as follows:

					1	3		

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

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

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

						5	7

A reading of 100 percent is shown as:

					1	0	0

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

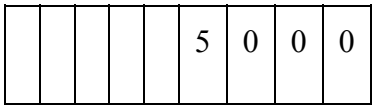
Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number or Core Based Statistical Area (CBSA) number (or rural State code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified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

Code	Title	Definition
		provider counts only the hours spent in the home, excluding travel time. It reports in whole hours, right justifying to the left of the dollar/cent delimiter. (Rounded to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Indicates the number of units of EPO administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0		

Code	Title	Definition
69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of ESRD Networks	(For third party payer use only.) The FI reports the amount the Medicare payment was reduced to help fund ESRD networks.
72	Flat Rate Surgery Charge	(For third party payer use only.) The standard charge for outpatient surgery where the provider has such a charging structure.
73-74	Payer Codes	(For use by third party payers only.)
75	Gramm/Rudman/Hollings	(For third party payer internal use only.) The contractor reports the amount of sequestration.

76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:



Code	Title	Definition
77	Medicare New Technology Add-On Payment	Code indicates the amount of Medicare additional payment for new technology.
78-79	Payer Codes	Codes reserved for internal use only by third party payers. The CMS assigns as needed. Providers do not report payer codes.
80-99		Reserved for State use. Discontinued, Effective October 16, 2003.
A0	Special Zip Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.

Code	Title	Definition
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.
A4	Covered Self-Administrable Drugs - Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. For use with Revenue Code 0637. See The Medicare Benefit Policy Manual, Chapter 6.)
A5	Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05)
A9	Patient Height	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05)

Code	Title	Definition
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
AC-AZ		Reserved for national assignment.
B1	Deductible Payer B	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.
B3	Estimated Responsibility Payer B	Amount the provider estimates will be paid by the indicated payer.
B4-B6		Reserved for national assignment
B7	Co-payment Payer B	The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer.
B8-B9		Reserved for national assignment
BA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer B	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
BC-C0		Reserved for national assignment

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

Code	Title	Definition
E0		Reserved for national assignment
E1	Deductible Payer D	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
E2	Coinsurance Payer D	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
E3	Estimated Responsibility Payer D	Amount the provider estimates will be paid by the indicated payer.
E4-E6		Reserved for national assignment
E7	Co-payment Payer D	The amount the provider assumes will 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 HealthCare 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 10/16/2003
EC-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Deductible Payer E	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
F2	Coinsurance Payer E	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
F3	Estimated Responsibility Payer E	Amount the provider estimates will be paid by the indicated payer.

Code	Title	Definition
F4-F6		Reserved for national assignment
F7	Co-payment Payer E	The amount the provider assumes will 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 HealthCare 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 10/16/2003
FC-FZ		Reserved for national assignment
G0		Reserved for national assignment
G1	Deductible Payer F	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
G2	Coinsurance Payer F	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
G3	Estimated Responsibility Payer F	Amount the provider estimates will be paid by the indicated payer.
G4-G6		Reserved for national assignment
G7	Co-payment Payer F	The amount the provider assumes will 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 HealthCare 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

Code	Title	Definition
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 10/16/2003
GC-GZ		Reserved for national assignment
H0-WZ		Reserved for national assignment
X0-Y0		Reserved for national assignment
Y1	Part A Demonstration Payment	This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
Y2	Part B Demonstration Payment	This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass

Code	Title	Definition
		through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ		Reserved for national assignment

60.4 - Form Locator 42

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

FL 42 - Revenue Code

Required. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed.

To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.

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

0290s - Rental/purchase of DME

0304 - Renal dialysis/laboratory

0330s - Radiology therapeutic

0367 - Kidney transplant

0420s - Therapies

0520s - Type or clinic visit (RHC or other)

0550s - 590s - home health services

0624 - Investigational Device Exemption (IDE)

0636 - Hemophilia blood clotting factors

0800s - 0850s - ESRD services

9000 - 9044 - Medicare SNF demonstration project

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

NOTE: RHCs and FQHCs, in general, use revenue codes 052X and 091X with appropriate subcategories to complete the Form CMS-1450. The other codes provided are not generally used by RHCs and FQHCs and are provided for informational purposes.

Those applicable are: 0025-0033, 0038-0044, 0047, 0055-0059, 0061, 0062, 0064-0069, 0073-0075, 0077, 0078, and 0092-0095.

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

0304 - rental and dialysis/laboratory,

0636 - hemophilia blood clotting factors,

0800s thru 0850s - ESRD services.

The remaining applicable codes are 0025, 0027, 0031-0032, 0038-0039, 0075, and 0082-0088.

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

The Hospice uses the following revenue codes to bill Medicare:

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

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

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

Revenue Code	Description
0001	Total Charge For use on paper or paper facsimile (e.g., “print images”) claims only. For electronic transactions, FIs report the total charge in the appropriate data

Revenue Code	Description
	segment/field
001X	Reserved for Internal Payer Use
002X	Health Insurance Prospective Payment System (HIPPS)

Subcategory	Standard Abbreviations
0 - Reserved	
1 - Reserved	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HHS PPS (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 until October 16, 2003. Thereafter, Reserved for National Assignment

ACCOMMODATION REVENUE CODES (010X - 021X)

010X All Inclusive Rate

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

Subcategory	Standard Abbreviations

Revenue Code		Description	
	0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
	1	All-Inclusive Room and Board	ALL INCL R&B

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

Routine service charges for single bedrooms.

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

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

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

Routine service charges incurred for accommodations with two beds.

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

Subcategory	Standard Abbreviations
0 - General Classification	ROOM-BOARD/SEMI

Revenue Code	Description	
	1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
	2 - OB	OB/2BED
	3 - Pediatric	PEDS/2BED
	4 - Psychiatric	PSYCH/2BED
	5 - Hospice	HOSPICE/2BED
	6 - Detoxification	DETOX/2BED
	7 - Oncology	ONCOLOGY/2BED
	8 - Rehabilitation	REHAB/2BED
	9 - Other	OTHER/2BED
013X	Semi-private - three and Four Beds (Medical or General)	
	Routine service charges incurred for accommodations with three and four beds.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ROOM-BOARD/3&4 BED
	1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
	2 - OB	OB/3&4 BED
	3 - Pediatric	PEDS/3&4 BED
	4 - Psychiatric	PSYCH/3&4 BED
	5 - Hospice	HOSPICE/3&4 BED
	6 - Detoxification	DETOX/3&4 BED
	7 - Oncology	ONCOLOGY/3&4 BED
	8 - Rehabilitation	REHAB/3&4 BED
	9 - Other	OTHER/3&4 BED
014X	Private - (Deluxe) (Medical or General)	

Revenue Code	Description

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

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

015X Room & Board - Ward (Medical or General)

Routine service charges incurred for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviations
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/ WARD
2 - OB	OB/ WARD
3 - Pediatric	PEDS/ WARD
4 - Psychiatric	PSYCH/ WARD
5 - Hospice	HOSPICE/ WARD

Revenue Code	Description	
	6 - Detoxification	DETOX/ WARD
	7 - Oncology	ONCOLOGY/ WARD
	8 - Rehabilitation	REHAB/ WARD
	9 - Other	OTHER/ WARD

016X Other Room & Board (Medical or General)

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

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

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

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

017X Nursery

Charges for nursing care to newborn and premature infants in nurseries

Subcategories 1-4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under State regulations or other statutes supersede the following guidelines. For example, some States may have fewer than four levels of care or may have multiple levels within a category such as intensive care.

Level I Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).

Level II Low birth-weight neonates who are not sick, but require frequent feeding and neonates who require more hours of nursing than do normal neonates (Continuing Care).

Revenue Code	Description
Level III	Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).
Level IV	Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).

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

018X Leave of Absence

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

NOTE: Charges are billable for codes 2 - 5.

Subcategory	Standard Abbreviations
0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - Reserved	
2 - Patient Convenience -Charges billable	LOA/PT CONV CHGS BILLABLE
3 - Therapeutic Leave	LOA/THERAP
4 – RESERVED	Effective 4/1/04
5 - Hospitalization	LOA/HOSPITALIZATION Effective 4/1/04
9 - Other Leave of Absence	LOA/OTHER

Revenue Code	Description

019X Sub-acute Care

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

Level I **Skilled Care:** Minimal nursing intervention. Co-morbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II **Comprehensive Care:** Moderate to extensive nursing intervention. Active treatment of co morbidities. Assessment of vitals and body systems required 2-3 times per day.

Level III **Complex Care:** Moderate to extensive nursing intervention. Active medical care and treatment of co morbidities. Potential for co morbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV **Intensive Care:** Extensive nursing and technical intervention. Active medical care and treatment of co morbidities. Potential for co morbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

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

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

020X Intensive Care

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

Revenue Code	Description

surgical unit.

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

Subcategory	Standard Abbreviations
0 - General Classification	INTENSIVE CARE or (ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU/PEDS
4 - Psychiatric	ICU/PSTAY
6 - Intermediate ICU	ICU/INTERMEDIATE
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Sub-acute Care	ICU/OTHER

021X Coronary Care

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

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

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

Revenue Code	Description
9 - Other Coronary Care	CCU/OTHER

Code	Description

ANCILLARY REVENUE CODES (022X - 099X)

022X Special Charges

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

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

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

023X Incremental Nursing Care Charges

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

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

Revenue Code	Description	
	5 - Hospice	NUR INCR/HOSPICE
	9 - Other	NUR INCR/OTHER

024X All Inclusive Ancillary

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

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

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

025X Pharmacy

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

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

Subcategory	Standard Abbreviations
0 – General Classification	PHARMACY
1 – Generic Drugs	DRUGS/GENERIC
2 - Non-generic Drugs	DRUGS/NONGENERIC

Revenue Code	Description	
	3 - Take Home Drugs	DRUGS/TAKEHOME
	4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
	5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
	6 - Experimental Drugs	DRUGS/EXPERIMT
	7 - Nonprescription	DRUGS/NONPSCRPT
	8 - IV Solutions	IV SOLUTIONS
	9 - Other DRUGS/OTHER	DRUGS/OTHER

026X IV Therapy

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

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

Subcategory	Standard Abbreviations
0 – General Classification	IV THERAPY
1 – Infusion Pump	IV THER/INFSN PUMP
2 - IV Therapy/Pharmacy Services	IV THER/PHARM/SVC
3 - IV Therapy/Drug/Supply/Delivery	IV THER/DRUG/SUPPLY DELV
4 - IV Therapy/Supplies	IV THER/SUPPLIES
9 - Other IV Therapy	IV THERAPY/OTHER

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

Code indicates charges for supply items required for patient care.

Revenue Code	Description

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

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

028X Oncology

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

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

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

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

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviations
0 – General Classification	MED EQUIP/DURAB

Revenue Code	Description	
	1 – Rental	MED EQUIP/RENT
	2 - Purchase of new DME	MED EQUIP/NEW
	3 - Purchase of used DME	MED EQUIP/USED
	4 - Supplies/Drugs for DME Effectiveness (HHA's Only)	MED EQUIP/SUPPLIES/DRUGS
	9 - Other Equipment	MED EQUIP/OTHER

030X Laboratory

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

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

Subcategory	Standard Abbreviations
0 – General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 – Non-routine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMATOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 – Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

031X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Revenue Code	Description

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

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify.

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

033X Radiology - Therapeutic

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

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

Revenue Code	Description

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

034X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify.

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

035X Computed Tomographic (CT) Scan

Charges for CT scans of the head and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the

Revenue Code	Description

specific test be identified.

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

036X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment.

Rationale: Permits identification of particular services.

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

037X Anesthesia

Charges for anesthesia services in the hospital.

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

Revenue Code	Description	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ANESTHESIA
	1 - Anesthesia Incident to RAD	ANESTHE/INCIDENT RAD
	2 - Anesthesia Incident to Other Diagnostic Services	ANESTHE/INCIDENT ODX
	4 - Acupuncture	ANESTHE/ACUPUNC
	9 - Other Anesthesia	ANESTHE/OTHER
038X	Blood	
	Rationale: Charges for blood must be separately identified for private payer purposes.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	BLOOD
	1 - Packed Red Cells	BLOOD/PKD RED
	2 - Whole Blood	BLOOD/WHOLE
	3 – Plasma	BLOOD/PLASMA
	4 – Platelets	BLOOD/PLATELETS
	5 - Leucocytes	BLOOD/LEUCOCYTES
	6 - Other Components	BLOOD/COMPONENTS
	7 - Other Derivatives Cryopricipitates)	BLOOD/DERIVATIVES
	9 - Other Blood	BLOOD/OTHER
039X	Blood Storage and Processing	
	Charges for the storage and processing of whole blood	
	Subcategory	**Standard Abbreviations**

Revenue Code	Description	
	0 - General Classification	BLOOD/STOR-PROC
	1 - Blood Administration (e.g., Transfusions	BLOOD/ADMIN
	9 - Other Processing and Storage	BLOOD/OTHER STOR
040X	Other Imaging Services	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	IMAGE SERVICE
	1 - Diagnostic Mammography	MAMMOGRAPHY
	2 - Ultrasound	ULTRASOUND
	3 - Screening Mammography	SCR MAMMOGRAPHY/GEN MAMMO
	4 - Positron Emission Tomography	PET SCAN
	9 - Other Imaging Services	OTHER IMAG SVS

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

ICD-9 Codes	Definitions	High Risk Indicator
V10.3	Personal History - Malignant neoplasm breast cancer	A personal history of breast cancer
V16.3	Family History - Malignant neoplasm breast cancer	A mother, sister, or daughter who has had breast cancer
V15.89	Other specified personal history representing hazards to health	Has not given birth before age 30 or a personal history of biopsy-proven benign breast disease
041X	Respiratory Services	

Revenue Code	Description

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

Rationale: Permits identification of particular services.

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

042X Physical Therapy

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

Rationale: Permits identification of particular services.

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

043X Occupational Therapy

Revenue Code	Description

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

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

044X Speech-Language Pathology

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

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

045X Emergency Room

Revenue Code **Description**

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

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

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

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

Usage Notes

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

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

Revenue Code **Description**

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

b. Stand alone usage of code 0451 is acceptable when no services beyond an initial screening/assessment are rendered.

c. Stand alone usage of code 0452 **is not acceptable.**

046X Pulmonary Function

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

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

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

047X Audiology

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

Rationale: Permits identification of particular services.

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

048X Cardiology

Revenue Code	Description

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

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

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

049X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by any other category.

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

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

050X Outpatient Services

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

Subcategory	Standard Abbreviations
0 – General Classification	OUTPATIENT SVS
9 - Other Outpatient Services	OUTPATIENT/OTHER

Revenue Code	Description

051X Clinic

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

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

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

052X Free-Standing Clinic

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

Subcategory	Standard Abbreviations
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic (Effective 7/1/06 will be changed to: Clinic visit by member to RHC/FQHC)	RURAL/CLINIC
2 - Rural Health-Home (Effective 7/1/06 will be changed to: Home visit by RHC/FQHC practitioner)	RURAL/HOME

Revenue Code	Description	
	3 - Family Practice	FR/STD FAMILY CLINIC
	4 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF	
	5 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility	
	6 - Urgent Care Clinic	FR/STD URGENT CLINIC
	7 - Effective 7/1/06 - RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area	
	8 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)	
	9 - Other Freestanding Clinic	OTHER FR/STD CLINIC
053X	Osteopathic Services	

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

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

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

Revenue Code	Description

054X Ambulance

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

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

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

055X Skilled Nursing

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

Subcategory	Standard Abbreviations
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT

Revenue Code	Description	
	2 - Hourly Charge	SKILLED NURS/HOUR
	9 - Other Skilled Nursing	SKILLED NURS/OTHER

056X Medical Social Services

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

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

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

057X Home Health Aide (Home Health)

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

Rationale: Necessary for Medicare home health billing requirements.

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

058X Other Visits (Home Health)

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

Revenue Code	Description

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

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

059X Units of Service (Home Health)

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

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

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

060X Oxygen (Home Health)

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

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

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

Subcategory	Standard Abbreviations
0 - General Classification	02/HOME HEALTH

Revenue Code	Description	
	1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
	2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
	3 – Oxygen - Stat/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
	4 – Oxygen - Portable Add-on	02/STAT EQUIP/PORT ADD-ON

061X Magnetic Resonance Technology (MRT)

Code indicates charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

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

062X Medical/Surgical Supplies - Extension of 027X

Revenue Code	Description

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

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

063X Pharmacy - Extension of 025X

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

Subcategory	Standard Abbreviations
0 - RESERVED (Effective 1/1/98	
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythropoietin (EPO) less than 10,000 units	DRUG/EPO $\leq$10,000 units
5 - Erythropoietin (EPO) 10,000 or more units	DRUG/EPO $\geq$10,000 units
6 - Drugs Requiring Detailed Coding (a)	DRUGS/DETAIL CODE
7 - Self-administrable Drugs (b)	DRUGS/SELFADMIN

NOTE: (a) Charges for drugs and biologicals (with the exception of radiopharmaceuticals,

Revenue Code **Description**

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

064X Home IV Therapy Services

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

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

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

065X Hospice Services

Revenue Code	Description

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

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

Subcategory	Standard Abbreviations
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care	HOSPICE/CTNS HOME
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Respite Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (non-respite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYSICIAN
8 –Hospice Room & Board – Nursing Facility	HOSPICE/R&B/NURS FAC
9 - Other Hospice	HOSPICE/OTHER

066X Respite Care (HHA Only)

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

Subcategory	Standard Abbreviations
0 - General Classification	RESPITE CARE
1 – Hourly Charge/ Nursing	RESPITE/ NURSE
2 - Hourly Charge/ Aide/Homemaker/Companion	RESPITE/AID/HMEMKE/COMP

Revenue Code	Description	
	3 – Daily Respite Charge	RESPITE DAILY
	9 - Other Respite Care	RESPITE/CARE

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

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

068X Trauma Response

Charges for a trauma team activation.

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

Usage Notes:

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

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

Revenue Code	Description

advance of the patient's arrival."

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

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

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

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

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

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

069X Not Assigned

070X Cast Room

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

Rationale: Permits identification of this service, if necessary.

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

071X Recovery Room

Rationale: Permits identification of particular services, if necessary.

Subcategory	Standard Abbreviations
0 - General Classification	RECOVERY ROOM

Revenue Code	Description	
	9 - Other Recovery Room	OTHER RECOV RM
072X	Labor Room/Delivery	

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

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

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

073X Electrocardiogram (EKG/ECG)

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

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

074X Electroencephalogram (EEG)

Revenue Code	Description

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

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

075X Gastro-Intestinal Services

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

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

076X Treatment or Observation Room

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

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

Subcategory	Standard Abbreviations
0 - General Classification	TREATMENT/OBSERVATION RM
1 - Treatment Room	TREATMENT RM

Revenue Code	Description	
	2 - Observation Room	OBSERVATION RM
	9 – Other Treatment Room	OTHER TREATMENT RM

077X Preventative Care Services

Charges for the administration of vaccines.

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

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

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

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

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

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

080X Inpatient Renal Dialysis

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

Rationale: Specific identification required for billing purposes.

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

081X Organ Acquisition

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

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

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

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

Revenue Code **Description**

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

082X Hemodialysis - Outpatient or Home Dialysis

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

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

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

083X Peritoneal Dialysis - Outpatient or Home

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

Subcategory	**Standard Abbreviations**
0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or Other Rate	PERTNL/COMPOSITE
2 – Home Supplies	PERTNL/HOME/SUPPL
3 – Home Equipment	PERTNL/HOME/EQUIP

Revenue Code	Description	
	4 - Maintenance/100%	PERTNL/HOME/100%
	5 - Support Services	PERTNL/HOME/SUPSERV
	9 – Other Peritoneal Dialysis	PERTNL/HOME/OTHER

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

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

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

085X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient

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

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

Revenue Code	Description	
	9 – Other CCPD Dialysis	CCPD/HOME/OTHER
086X	Reserved for Dialysis (National Assignment)	
087X	Reserved for Dialysis (National Assignment)	
088X	Miscellaneous Dialysis	

Charges for dialysis services not identified elsewhere.

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

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

089X Reserved for National Assignment

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

Subcategory	Standard Abbreviations
0 - General Classification	BH
1 - Electroshock Treatment	BH/ELECTRO SHOCK
2 - Milieu Therapy	BH/MILIEU THERAPY
3 - Play Therapy	BH/PLAY THERAPY
4 - Activity Therapy	BH/ACTIVITY THERAPY
5 – Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
6 – Intensive Outpatient Services-	BH/INTENS OP/CHEM DEP

Revenue Code	Description	
	Chemical Dependency	
	7 – Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY
	8 – Reserved for National Use	
	9 – Reserved for National Use	

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

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

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

Subcategory	Standard Abbreviations
0 – Reserved for National Assignment	
1 - Rehabilitation	BH/REHAB
2 - Partial Hospitalization* - Less Intensive	BH/PARTIAL HOSP
3 - Partial Hospitalization* - Intensive	BH/PARTIAL INTENSIVE
4 - Individual Therapy	BH/INDIV RX
5 - Group Therapy	BH/GROUP RX
6 - Family Therapy	BH/FAMILY RX
7 - Bio Feedback	BH/BIOFEED
8 - Testing	BH/TESTING
9 – Other Behavior Health Treatments/Services	BH/OTHER

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

Revenue Code	Description

092X Other Diagnostic Services

Code indicates charges for other diagnostic services not otherwise categorized.

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

093X Medical Rehabilitation Day Program

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

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

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

Code indicates charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS

Revenue Code	Description	
	1 - Recreational Therapy	RECREATION RX
	2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
	3 - Cardiac Rehabilitation	CARDIAC REHAB
	4 - Drug Rehabilitation	DRUG REHAB
	5 - Alcohol Rehabilitation	ALCOHOL REHAB
	6 - Complex Medical Equipment Routine	COMPLX MED EQUIP-ROUT
	7 - Complex Medical Equipment Ancillary	COMPLX MED EQUIP-ANC
	9 - Other Therapeutic Services	ADDITIONAL RX SVS

095X Other Therapeutic Services-Extension of 094X

Charges for other therapeutic services not otherwise categorized

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

096X Professional Fees

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

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSYCH
2 - Ophthalmology	PRO FEE/EYE

Revenue Code	Description	
	3 - Anesthesiologist (MD)	PRO FEE/ANES MD
	4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
	9 - Other Professional Fees	OTHER PRO FEE
097X	Professional Fees - Extension of 096X	
	Subcategory	**Standard Abbreviations**
	1 - Laboratory	PRO FEE/LAB
	2 - Radiology - Diagnostic	PRO FEE/RAD/DX
	3 - Radiology - Therapeutic	PRO FEE/RAD/RX
	4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
	5 - Operating Room	PRO FEE/OR
	6 - Respiratory Therapy	PRO FEE/RESPIR
	7 - Physical Therapy	PRO FEE/PHYSI
	8 - Occupational Therapy	PRO FEE/OCUPA
	9 - Speech-*Language* Pathology	PRO FEE/SPEECH
098X	Professional Fees - Extension of 096X & 097X	
	Subcategory	**Standard Abbreviations**
	1 - Emergency Room	PRO FEE/ER
	2 - Outpatient Services	PRO FEE/OUTPT
	3 - Clinic	PRO FEE/CLINIC
	4 - Medical Social Services	PRO FEE/SOC SVC
	5 - EKG	PRO FEE/EKG
	6 - EEG	PRO FEE/EEG
	7 - Hospital Visit	PRO FEE/HOS VIS

Revenue Code	Description	
	8 - Consultation	PRO FEE/CONSULT
	9 - Private Duty Nurse	FEE/PVT NURSE
099X	Patient Convenience Items	

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

Rationale: Permits identification of particular services as necessary.

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

100X Behavioral Health Accommodations

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

Subcategory	Standard Abbreviations
0 - General Classification	BH R&B
1 – Residential Treatment - Psychiatric	BH – R&B RES/PSYCH

Revenue Code	Description	
	2 – Residential Treatment – Chemical Dependency	BH R&B RES/CHEM DEP
	3 – Supervised Living	BH R&B SUP LIVING
	4 – Halfway House	BH R&B HALFWAY HOUSE
	5 – Group Home	BH R&B GROUP HOME

101X TO 209X Reserved for National Assignment

210X Alternative Therapy Services

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

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

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

211X to 300X Reserved for National Assignment

310X Adult Care - Effective April 1, 2003

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

Revenue Code	Description	
	Subcategory	**Standard Abbreviations**
	0 - Note Used	
	1 - Adult Day Care, Medical and Social - Hourly	ADULT MED/SOC HR
	2 - Adult Day Care, Social - Hourly	ADULT SOC HR
	3 - Adult Day Care, Medical and Social - Day	ADULT MED/SOC DAY
	4 - Adult Day Care, Social - Daily	ADULT SOC DAY
	5 - Adult Foster Care - Daily	ADULT FOSTER CARE
	9 – Other Adult Care	Other Adult
311X to 899X	Reserved for National Assignment	
9000 to 9044	Reserved for Medicare Skilled Nursing Facility Demonstration Project	
9045 - 9099	Reserved for National Assignment	

Medicare Claims Processing Manual

Chapter 26 - Completing and Processing

Form CMS-1500 Data Set

10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;
4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or
5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who

meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. *See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:*

- *Medicare covered services and items that are the result of a physician's order or referral;*
- *Parenteral and enteral nutrition;*
- *Immunosuppressive drug claims;*
- *Hepatitis B claims;*
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- *When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);*
- *When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;*
- *When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;*

Item 17a – Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17. *The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available.*

NOTE: *Field17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.*

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. *All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.*

Item 17b Form CMS-1500 (08-05) – *Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.*

NOTE: *Field17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.*

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 – ***(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)***

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical *therapy,* occupational therapy *or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24K of this section.*

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the pin (or *NPI* when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format

as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. An independent laboratory shall enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number *(or NPI when effective)* of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician shall enter the Medicare facility provider number of the SNF in item 23.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24(Form CMS-1500 (08-05) – *The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. At this time, the shaded area is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.*

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field.

Return as unprocessable if a date of service extends more than one day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in Section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. *The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.*

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H - Leave blank. Not required by Medicare.

Item 24I ***Form CMS-1500 (12-90)*** **-** Leave blank. Not required by Medicare.

Item 24I Form CMS-1500 (08-05) – *Enter the ID qualifier 1C in the shaded portion.*

Item 24J ***Form CMS-1500 (12-90)*** **-** Leave blank. Not required by Medicare.

Item 24J Form CMS-1500 (08-05) *– Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.*

Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than October 1, 2006, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

Item 24K ***Form CMS-1500 (12-90)*** **-** Enter the PIN of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24k.

Item 24K Form CMS-1500 (08-05) – *There is no Item 24K on this version.*

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;

- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 ***Form CMS-1500 (12-90)*** **-** Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.

Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name address, or PIN of the location where the order was accepted must be entered (DMERC only).

This field is required. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed, and the PIN.

Item 32 Form CMS-1500 (08-05) *- Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.*

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a Form CMS-1500 (08-05) – *Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.*

Item 32b Form CMS-1500 (08-05) - *Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Effective May 23, 2007, and later, 32b is not to be reported.*

Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

For durable medical, orthotic, and prosthetic claims, enter the PIN (of the location where the order was accepted) if the name and address was not provided in item 32 (DMERC only).

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Enter the PIN (or NPI when implemented), for the performing provider of service/supplier who is **not** a member of a group practice.

Enter the group PIN (or NPI when implemented), for the performing provider of service/supplier who is a member of a group practice.

Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

Enter the group UPIN, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.

Item 33a Form CMS-1500 (08-05) - *Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006. This is a required field.*

Item 33b Form CMS-1500 (08-05) - *Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item. Enter the PIN for the performing provider of service/supplier who is* ***not*** *a member of a group practice. Enter the group PIN for the performing provider of service/supplier who is a member of a group practice. Enter the group UPIN, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.*

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

80.6 - A/B Crossover Error Codes

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A3-3808, A-02-038, CWF EditXov

http://cms.csc.com/cwf/downloads/docs/pdfs/editabx.pdf

A/B Crossover edit rejects are denoted by a value of CR in the disposition field on the Reply Record. A Trailer 08 containing one crossover error code, will always follow. Also, Trailer 12 will be returned. A/B Crossover alerts are denoted by a value of 01 in the disposition field on the Reply Record. A Trailer 13 containing one crossover Alert Code, will always follow. Listed below are the possible crossover Error and Alert Codes with a general description.

A/B Crossover Error Codes

Error Code	Explanation
7010	Reject • An inpatient, outpatient, or home health bill with dates of service equal to or overlapping a Hospice election period, and Condition Code 07 (Treatment of a non-terminal condition) is not present on the bill; or • An MCCD Notice of Election (89A) From Date overlaps a Hospice election period. **Purpose:** To detect bills during a hospice benefit period when a non-terminal condition is not reported. **Resolution:** Deny the bill, use MSN 27.1 - "This service is not covered because you are enrolled in a hospice."
7020	Reject Claim Bill Type is 12X and the From/Thru dates are equal to the posted outpatient 73X Bill Type service dates or Span Code 72 From/Thru dates. **Purpose:** To detect duplicate billing of inpatient and FQHC services.

Error Code	Explanation
	Resolution: Deny the claim as a duplicate, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7050	Reject • An Outpatient claim (Bill Type 12X, 13X, 14X, 22X, 23X, 24X, 71X, 72X, 73X, 74X, 75X, 83X, or 85X) has From/Thru Dates (or Occurrence Span Code 72 From/Thru Dates), which are equal to, overlap, or are within the From/Thru Dates on a Hospital Inpatient claim (Bill Type 11X, 21X, or 41X) in history. The Provider Number on the incoming claim is the same as the Provider Number on the history claim; or • An Outpatient claim (Bill Type 12X, 13X, 14X, 22X, 23X, 33X, 34X, 74X, or 75X) for physical therapy, occupational therapy, and/or speech *–language pathology* has From/Thru Dates (or Occurrence Span Code 72 From/Thru Dates) which are equal to, overlap, or are within the From/Thru Dates on an SNF Inpatient claim (Bill Type 18X, 21X, or 28X,) for physical therapy, occupational therapy, or speech *–language pathology*. The Provider Number on the incoming claim is the same as the Provider Number on the history claim. **Purpose:** To detect duplicate bills for physical *therapy*, speech-*language pathology* and/or occupational therapy. **Resolution:** Deny the bill as a duplicate, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7055	Reject Outpatient services (Bill Types 13X, 14X, or 83X) billed with From/Thru Dates that are equal to, within, or overlapping the From/Thru Dates on an outpatient ambulatory surgical claim (ASC - Bill type 83X). The Provider Number of both claims are the same. **Purpose:** To ensure that Medicare does not pay for the same services more than once.

Error Code	Explanation
	Resolution: Review claim to ensure both claims are valid and not duplicate billings, deny if duplicate, override error and resubmit if both bills are valid. If denied, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7080	Reject OP, HH • An Outpatient claim has a From/Thru Date that overlaps an Inpatient claim and the Provider Numbers are different; or • A Home Health claim has a detail line item Date of Service that overlaps an Inpatient, SNF, or RNHCI claim on history. **Purpose:** To detect outpatient claims that should have been bundled into the inpatient bill. **Resolution:** Deny the bill, use MSN 21.7 - "This service should be included on your inpatient bill. The provider must review the original (paid) inpatient bill to determine that all charges were included. The hospital pays the supplier."
7108	Alert An outpatient bill for physical therapy (PT), speech *–language pathology (SLP)*, or occupational therapy (OT) for the same or overlapping dates of service (or Occurrence Span Code 72 dates), and a revenue code, HCPCS code, or a revenue to HCPCS code match for PT, S*LP*, or OT bill on history. Billed by the same provider or another provider, physician, or independent therapist. The incoming outpatient bill is matched against both Part A outpatient and Part B carrier claims. **Purpose:** To detect duplicate billings either by the same provider or for a beneficiary receiving the same services from multiple provider specialties that can perform physical *therapy*, speech-*language pathology*, and/or occupational therapy services.

Error Code	Explanation
	Resolution: Deny the bill if the same provider submitted a duplicate claim, use MSN 21.7 - "This service should be included on your inpatient bill." If the services are furnished by a different provider or are not duplicated, refer the bill to medical review for determination of medical necessity. If the claim is denied as a duplicate or as the result of medical review, recover the erroneous payment and process an adjustment to the Host.
7109	Reject An Outpatient claim with the Thru date (or Occurrence Span Code 72 Thru Date) greater than the Inpatient Admission Date minus four days or is equal to the Inpatient Admission Date and one or more diagnostic Revenue Codes or procedure codes are present. **Purpose:** To detect outpatient bills that should be included on an inpatient history bill. **Resolution:** Return the outpatient bill to the provider. The provider may adjust the inpatient bill if charges were omitted. If Part B deductible or coinsurance were collected by the provider, any monies collected must be returned to the beneficiary.
7111	Reject An inpatient PPS bill (type 111, condition code 65 not present) is posted to the Host history and the From date (on the posted bill) is equal to the Through date on the incoming inpatient PPS bill (type 111, condition code 65 not present) and the patient discharge status is 01 (discharged to home or self care). As of October 1, 2002, this edit is bypassed if one of the bills, either history or incoming has an IRF provider number (XX-3025 – XX-3099 or the third position of the provider number is "T"). **Purpose:** To identify transfers between PPS hospitals. This reject prevents incorrect DRG payments. **Resolution:** Change the patient status code to 02 (transferred to another acute care facility) and reprocess the bill.

Error Code	Explanation
7112	Reject Inpatient claim (HUIP record) From Date or From Date minus 1 day equals the last service date (or Occurrence Span Code 72 First/Last Visit Date) on a posted Part B claim (HUOP record) and the provider numbers are the same. **Purpose:** To detect inpatient bills that have posted Part B bills with charges that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient bill, use MSN 21.7 - "This service should be included on your inpatient bill." Notify the provider why the outpatient bill was canceled. If any beneficiary Part B deductible was collected on the canceled Part B bill, the beneficiary must be paid any amounts collected towards that outpatient bill. Ensure that the inpatient bill has the outpatient charges included. After the outpatient bill is canceled, resubmit the inpatient bill for processing.
7113	Reject An inpatient claim with the Admission Date less than 4 days from the Through Date (or Occurrence Span Code 72 date) on an outpatient history record and the outpatient claim is for diagnostic services only. **Purpose:** To detect outpatient bills for diagnostic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.
7114	Reject An outpatient claim that contains both therapeutic and diagnostic services with the Through date equal to or up to 4 days less than an Inpatient Admission Date.

Error Code	Explanation
	Purpose: To detect therapeutic or diagnostic services on an outpatient bill that should be included on an inpatient claim. **Resolution:** Return the outpatient bill to the provider to re-bill for only the therapeutic services and to determine whether an adjustment to the inpatient bill is needed to include diagnostic services. Use MSN 21.7 - "This service should be included on your inpatient bill."
7115	Reject An Inpatient claim against a posted Outpatient history claim which contains therapeutic and diagnostic services and the Thru Date (or Span Code 72 Thru Date) on the Outpatient claim is greater than the Inpatient Admission Date minus 4 days or is equal to the Inpatient Admission Date. Both claims contain the same provider number. **Purpose:** To detect outpatient diagnostic services that should have been included in the inpatient bill. **Resolution:** Cancel the outpatient claim containing the therapeutic and diagnostic services, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the outpatient diagnostic services have been included on the inpatient bill. Resubmit the inpatient bill for processing. The provider may re-bill the therapeutic services separately.
7119	Reject An Outpatient claim with the Thru Date (or Span Code 72 Thru Date) equal to an Inpatient Admission Date, or 1 day less then the Inpatient Admission Date. One or more diagnostic Revenue Codes are on the Outpatient claim and the Inpatient history claim has a Condition Code of 65. . Both claims contain the same provider number. **Purpose:** To detect outpatient bills that should be included on an inpatient history bill.

Error Code	Explanation
	Resolution: Return the outpatient bill to the provider, use MSN 21.7 - "This service should be included on your inpatient bill." The provider may adjust the inpatient bill if charges were omitted. If Part B deductible or coinsurance were collected by the provider, any monies collected must be returned to the beneficiary.
7120	Reject An Inpatient claim with Condition Code 65, an Admission Date or the Admission Date minus 1 day equal to an Outpatient history Thru date (or Occurrence Span Code 72 Thru Date), and the Outpatient history claim has one or more diagnostic Revenue Codes present. . Both claims contain the same provider number. **Purpose:** To detect outpatient bills for diagnostic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.
7121	Reject An Outpatient claim with the Thru Date (or Occurrence Span Code 72 Date) equal to an Inpatient Admission Date or an Inpatient Admission Date minus one day. One or more therapeutic Revenue Codes are on the Outpatient claim. The Inpatient history claim has a Condition Code of 65. **Purpose:** To detect outpatient bills for therapeutic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.

Error Code	Explanation
7122	Reject An Inpatient claim with Condition Code 65, with the Admission Date or the Admission Date minus one day equal to an Outpatient history Thru Date (or Occurrence Span Code 72 Thru Date), and the Outpatient history claim has one or more therapeutic Revenue Codes present. **Purpose:** To detect outpatient bills for therapeutic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.
7171	Alert Outpatient claim with From/Thru Dates of Service or if present Occurrence Span Code "72" Dates equal or overlap Part B Date of Service. **Purpose:** To detect duplicate billings of physician services for a RHC. **Resolution:** Determine if the physicians charge is a duplicate charge. If the RHC is in error, adjust the claims. If the carrier billing is in error, send all pertinent information to the carrier for necessary action. Use MSN 7.1 - "This is a duplicate of a charge already submitted."
7172	Reject An outpatient bill for a screening pap smear matches an outpatient or Part B history claim for a screening pap smear and the dates of service are equal. **Purpose:** To reject either the hospital outpatient bill or the Part B physician nonprofessional component for billing duplicate services. **Resolution:** Reject the bill and notify the beneficiary and the provider that this service (a screening pap smear) is allowed only once every 3 years. Use MSN 7.1 - "This is a duplicate of a charge already submitted."

Error Code	Explanation
7211	Alert Outpatient, Part B or DMEPOS claim submitted with approved eyewear when no prior bill received indicating cataract or intraocular lens (IOL) insertion on/before the date of the eyewear claim. **Purpose:** To establish an audit trail on the incoming claim. **Resolution:** No action is required.
7220	Reject Outpatient, Part B or DMEPOS claim submitted with eyewear on/after an intraocular lens (IOL) insertion and coverage limitation of one piece of eyewear had already been met by another claim. **Purpose:** To ensure that payment is made for only one eyewear for each cataract surgery with an IOL insertion. **Resolution:** Deny the claim, use MSN 26.3 - "Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant."
7230	Reject Outpatient, Part B or DMEPOS claim submitted with eyewear on/after an intraocular lens (IOL) insertion and more than one piece of eyewear is being billed on the claim. **Purpose:** To ensure that the beneficiary's eyewear benefit is limited to a single eyewear for each cataract surgery with the insertion of an IOL. **Resolution:** Deny the claim, use MSN 26.3 - "Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant."

Error Code	Explanation
7241	Reject • An incoming Outpatient claim with Revenue Code 0274 has the same Date of Service and the same HCPCS code as a paid DME or Outpatient claim in history; or • An incoming DME claim has the same Date of Service and the same HCPCS code as a paid Outpatient claim with Revenue Code 0274 in history. **Purpose:** To ensure that Medicare does not pay for the same service twice. **Resolution:** Deny the claim, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7242	Reject An incoming Outpatient claim with Revenue Code 0623 has the same Date of Service and the same HCPCS code as a paid DME or Outpatient claim in history; or An incoming DME claim has the same Date of Service and the same HCPCS code as a paid Outpatient claim with Revenue Code 0623 in history. **Purpose:** To ensure that Medicare does not pay for the same service twice. **Resolution:** Deny the claim, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7244	Reject A Part B service for physical therapy, occupational therapy, or speech *–language pathology* has From/Thru Dates which are equal to, overlap, or are within the From/Thru Dates on an Inpatient stay in history. **Purpose:** To ensure that physical, occupation, and speech*–language pathology* services are not paid by Part B during hospitalization.

Error Code	Explanation
	Resolution: Deny the claim, use MSN 16.27 - "This service is not covered since our records show you were in the hospital at this time."
7245	Reject Duplicate billing for oral anti-emetic drugs or anti-cancer drugs on the incoming claim, SURG900 file, or in history. An Outpatient or DME claim is submitted with an anti-emetic drug HCPCS code, and there is no "matching" claim for anti-cancer drugs on history, or there is a Duplicate anti-emetic drug claim. **Purpose:** To ensure that anti-emetic drugs are not billed without a matching anti-cancer drug and to ensure that duplicate anti-emetic drugs claims are not paid. **Resolution:** Deny the claim. Use MSN 21.21 - "This service was denied because Medicare covers this service only under certain circumstances;" or MSN 7.1 - "This is a duplicate of a charge already submitted."
7246	Reject • The incoming Part B/DME claim does not contain a CABG demonstration number but there is an Inpatient CABG demonstration claim in history with Covered Service Dates that are equal to, within, or overlapping the service dates on this claim; or • The incoming Inpatient claim contains a CABG demonstration number and there is a Part B/DME claim in history with Service Dates that are equal to, within, or overlapping the Part A Covered Service Dates, but Demonstration Number 06 is not present on the history Part B/DME claim. **Purpose:** To ensure that Medicare does not pay for services not covered for beneficiaries enrolled in a CABG demonstration.

Error Code	Explanation
	Resolution: Investigate claim dates of service if part B/DME claim is for the same date as a transfer in or out of the CABG demonstration and the service was medically necessary pay both the part B/DME and the Inpatient claim. Otherwise, pay the Inpatient claim and deny the part B/DME claim or recoup payment if necessary.
7247	Reject An Outpatient or part B claim containing an anti-emetic drug HCPCS code, and there is a duplicate anti-emetic drug claim on history. **Purpose:** To ensure that Medicare does not pay for the same service twice. **Resolution:** Deny the claim, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7248	Reject Outpatient claims with HCPCS Codes 97504 and 97116 cannot be billed on the same day with the same Provider Number. **Purpose:** To ensure that procedure codes 97504 and 97116 are not paid by Medicare to the same provider on the same day. **Resolution:** Deny the claim, use MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
7249	H Dates of Service during IRF PPS interrupted stay on history. **Purpose:** To ensure Medicare pays only for services that are performed. **Resolution:** Return to provider for verification of Dates of Service.

Error Code	Explanation
7250	Reject OP, HH Duplicate DME billing for Home Health claims (32X, 33X, and 34X), against DMERC, Part B, or Outpatient claims with the same HCPCS code and detail line item for Date of Service October 1, 2000, and after. **Purpose:** To ensure that services are not paid for twice. **Resolution:** Deny the claim, use MSN 7.1 -"This is a duplicate of a charge already submitted."
7530	Alert An outpatient bill (Bill Types 13X, 14X, 34X, 74X, or 75X) is one of three or more in a series of outpatient bills from different providers for the same beneficiary, same revenue and/or HCPCS Code(s), and dates of service within 30 days. **Purpose:** To detect inappropriate utilization of services by beneficiaries. **Resolution:** Forward the bill to medical review. If services are subsequently denied, recover the erroneous payment and process an adjustment to CWF. If denied, use MSN 15.5 - "The information provided does not support the need for similar services by more than one doctor during the same time period."

Error Code	Explanation
7531	Alert The Discharge Date of one PPS Inpatient claim is equal to the Admission Date of another PPS Inpatient claim. An inpatient PPS bill (type 111, condition code 65 not present) is posted to the Host history with a patient discharge status code other than 02 (discharged/transferred to another acute care facility), 05 (discharged/transferred to another type of institution) or 07 (left against medical advice or discontinued care). Condition code 61 (cost outlier) is not present or the DRG is not equal to 385 or 456 and an inpatient PPS bill with a From date equal to the Through date of the posted bill. As of October 1, 2002, this edit is bypassed if one of the bills, either history or incoming has an IRF provider number (XX-3025 – XX-3099 or the third position of the provider number is "T"). **Purpose:** To identify transfers between PPS hospitals. This alert identifies the posted bill that had an inappropriate patient discharge status. **Resolution:** Adjust the original bill using a 11I Bill Type and change the patient status code to 02 (discharged/transferred to another acute care facility). Process the adjustment according to the transfer payment guidelines.
7532	Alert The same provider bills outpatient services monthly or more frequently for the same beneficiary for a period of 6 months or more. The Bill Type(s) is 13X, 23X, 34X, 71X, 74X, 75X. The revenue code(s) is 42X, 43X, 44X, 51X, 52X, 90X, 91X, 94X. **Purpose:** To detect over-utilization of services. **Resolution:** Refer the claim to medical review. If services are subsequently denied, recover the erroneous payment and process an adjustment to CWF. If denied, use MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."

Error Code	Explanation
7533	Alert A home health bill (33X or 34X) for a DME or prosthetic device with dates of service equal to or overlapping a supplier billing for the same DME/prosthetic device. **Purpose:** To detect duplicate billing for DME by an HHA and a DME supplier. **Resolution:** Deny duplicate bills, use MSN 7.1 - "This is a duplicate of a charge already submitted." Recover the erroneous payment from the HHA and process an adjustment to CWF. If the bill is not a duplicate, release the bill.
7534	Alert An outpatient hospital bill (Bill Type 13X) with cardiac rehabilitation revenue code (943) has charges for repeat cardiovascular stress testing (HCPCS Codes 93015, 93017, and/or 93018) in a period of less than 90 days since prior testing. **Purpose:** To detect billing for cardiac rehabilitation where stress testing is performed more frequently than allowed by coverage guidelines. **Resolution:** Determine if stress testing meets the cardiac rehab coverage screens. If tests exceed, deny the charges and recover the inappropriate payment. Process an adjustment to CWF. Use MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
7535	Reject An outpatient hospital bill is for a service for which the related physicians service has been denied. **Purpose:** To detect medically unnecessary Part A services when the related physicians component has been denied.

Error Code	Explanation
	Resolution: Refer the claim to medical review for a determination of the medical necessity of the provider service. If the alerted claim is subsequently denied, recover the erroneous payment and process an adjustment to CWF. Use MSN 15.4 - "The information provided does not support the need for this service or item."
7545	Alert An Inpatient claim (TOB 11x) with From and Thru Dates that equal, or overlap, the From and Thru Dates (or Occurrence Span Code 72 From and Thru Dates) on an Outpatient claim (TOB 12x, 13x, 14x, 32X, 33X, 34X, 72x, 73x, 74x, 75x, 76x, or 83x) in history. **Purpose:** To eliminate outpatient billings for the same services which should have been included in the inpatient claim. **Resolution:** Cancel the outpatient bill. Send a notice to the provider explaining that the charges should have been included on the inpatient bill and they should look to the hospital for payment. Use MSN 21.7 - "This service should be included on your inpatient bill."
7546	Alert HH The Outpatient record (Bill Type 34X) with Revenue Code 0636, HCPCS Code J0630 on history, does not have the same Provider Number as the incoming Home Health claim. **Purpose:** If an open HH episode exists, this service can be billed only by the same provider as is on episode record. **Resolution:** Verify service dates, deny if claim dates overlap. Use MSN 21.18 - "This item or service is not covered when performed or ordered by this provider."

Error Code	Explanation
7547	Alert DME Method II ESRD supplies billed during Inpatient stay. **Purpose:** During an inpatient stay, the hospital or SNF is responsible for providing all supplies and equipment needed for dialysis. In the month following a home dialysis patient's hospitalization, the supplier must reduce the monthly delivery of, and billing for, new supplies to account for the supplies the Method II beneficiary did not use during his or her hospitalization. **Resolution:** If the Inpatient stay was 3 or more days, deny the portion of the claim that coincided with the inpatient stay (do not deny the admission or discharge day), or return to provider for correction. Use MSN 16.27 - "This service is not covered since our records show you were in the hospital at this time."
8100	Alert An inpatient claim (11X), outpatient claim (13X) or ASC claim (83X) for the same beneficiary, having the same one time only surgical procedure performed on different dates of service in the same or a different place of service as a claim on history. **Purpose:** To detect billings for surgical procedures that are not bilateral procedures that had been previously performed. **Resolution:** Review the bill to determine if the correct procedure code(s) was entered into the system. If the corrected code is not a duplicate of the code in the Trailer 13 record, release the claim for processing. If the coding is correct, forward the claim to medical review. If the alerted claim is subsequently denied, recover the erroneous payment and process an adjustment to CWF, use MSN 7.1 - "This is a duplicate of a charge already submitted." If the alerted claim is correct but a prior claim is in error, adjust the prior claim or contact the appropriate servicing FI for the prior claim.