CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 199 **Date: JUNE 10, 2004**

CHANGE REQUEST 3337

I. SUMMARY OF CHANGES: This CR requires rejecting any outpatient claim containing a range of dates in the line item date of service (LIDOS) field. Transmittal 107, CR 3031, issued on February 24, 2004, required FIs to edit ALL outpatient claims, to ensure that each claim contains a line item date or dates of service for each revenue code. This does not support Medicare business rules for OPPS billing or inpatient hospital and inpatient SNF bundling of services. In order to prevent duplicate payment for bundled inpatient services, Medicare needs to compare the LIDOS for each outpatient service to the inpatient stay dates. Also, to correctly attribute the costs of packaged services and items to the procedure for which they are used for outpatient services subject to OPPS, a specific LIDOS is required. These data are also used to recalibrate OPPS payments for future years. For all of these reasons, Medicare needs to reject ALL outpatient claims containing a range of dates in the LIDOS field.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 24/40.7.1/X12N 837 Institutional Implementation Guide (IG) Edits
R	Chapter 25/70/Form CMS-1450 Consistency Edits

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - One-Time Notification

Pub. 100-04	Transmittal: 199	Date: June 10, 2004	Change Request 3337

SUBJECT: Medicare Need for a Specific Line Item Date of Service (LIDOS) for Each Revenue Code on ALL Outpatient and Inpatient Part B Claims

I. GENERAL INFORMATION

A. Background: The HIPAA Implementation Guide (IG) contains directions for submitting Line Item Date of Service (LIDOS) information. The IG requires a single service date or a range of service dates (e.g., from/through dates) for each revenue code on all outpatient claims. Medicare has always required a LIDOS when there is a HCPCS, but not when there is only a revenue code. CMS's COB trading partners complained that we were sending them COB records with no LIDOS on revenue lines. Transmittal 107, CR 3031 will remedy this; as of July 1, claims with no LIDOS will be returned to providers.

- During the extensive provider education CMS has been doing about this CR (there are other requirements as well), providers asked about using a range of dates, rather than a single date. We believe that HIPAA allows payers the discretion to accept a date range for any type of service or a single date of service.

- CMS's internal systems cannot process a range of service dates at the line level. Transmittal 107, CR 3031 instructs that if a service date range is submitted, Medicare will take only the "from" date and store the "through" date for possible coordination of benefits transaction creation. Currently, some contractors reject claims that contain a range of dates, and some contractors accept the claims but drop the "through" date before processing the claim.

- This CR will add an edit to the FI shared system to reject as unprocessable claims containing a LIDOS consisting of a range of dates.

B. Policy:

- In determining the national payment rates under the outpatient prospective payment system (OPPS), CMS uses dates of service in order to correctly attribute the costs of packaged services and items to the procedure for which they are used.

- In order to ensure that CMS does not pay for services on a separate claim that were paid as part of a bundle on another claim, we edit outpatient claims on LIDOS. This applies to all services on inpatient hospital claims and all but a few specified exceptions on an inpatient SNF claim.

- In order to support existing Medicare business rules and facilitate OPPS recalibration for future years, FIs will reject as unprocessable outpatient claims and inpatient Part B claims containing a range of dates in the LIDOS field. With this transmittal, Medicare is establishing a business rule that all bills containing a date range in the LIDOS will be rejected. This is necessary to avoid duplicate payments in hospital inpatient and SNF services and to facilitate correct rate setting under the hospital OPPS.

C. Provider Education: "A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin."

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3337.1	FIs shall not accept outpatient or inpatient Part B claims, types of bills (TOBs) 12x, 13x, 14x, 22x, 23x, 24x, 32x, 33x, 34x, 71x, 72x, 73x, 74x, 75x, 76x, 81x, 82x, 83x, and 85x, into the FI's system unless there is a single date in the LIDOS field.	FIs, SSM
3337.2	The FI's SSM shall reject as unprocessable claims with TOBs 12x, 13x, 14x, 22x, 23x, 24x, 32x, 33x, 34x, 71x, 72x, 73x, 74x, 75x, 76x, 81x, 82x, 83x, and 85x if there is a date range in the LIDOS field.	FIs, SSM
3337.3	FIs shall inform providers they are to list each LIDOS on a separate line, repeating the revenue code and/or HCPCS code if necessary. That is, if a service, such as chemotherapy, occurs on 5 different dates, the revenue code and HCPCS must be listed 5 times on the claim, once for each date.	FIs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3031.1	FIs shall edit 13X, 14X, 22X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date or dates of service for each revenue code.
3264.17	Business requirement 3031.1 has been changed to remove bill type 22X. Contractor shall adjust the edit.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3337.1	This edit must be installed in FISS, since it is a Medicare business rule.

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date: October 4, 2004** **Pre-Implementation Contact(s):** Cindy Murphy, cmurphy1@cms.hhs.gov, 410-786-5733 **Post-Implementation Contact(s):** Regional Offices	**These instructions shall be implemented within your current operating budget.**

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 199, 06-10-04)

The FI shared system will edit *(via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims, TOBs* 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date of service *(LIDOS)* for each revenue code. *Outpatient* claims not containing a *LIDOS* for each revenue code shall be rejected from the flat file with an appropriate error message.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. These claims containing an ICD-9 procedure shall be rejected by the shared system with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all outpatient claims to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" qualifier are accepted (not just HIPPS skilled nursing facility rate codes).

The FI shared system will edit all outpatient claims to ensure each does not contain Covered Days (QTY Segment). Outpatient claims containing Covered Days shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all claims to ensure each does not contain a NPP000 UPIN. Claims containing a NPP000 UPIN shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system will edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system will edit all claims to ensure each does not contain an invalid E-code. Claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any found shall be subject to on-line edits.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in

the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid E-code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to on-line edits.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be subject to on-line edits.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code, value code, occurrence code, or occurrence span code. These shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs and FI shared system, as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update 2 times per year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and FI shared system will edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 *institutional* IG, and are contained in the approved list of HPTCs. HPTCs are not required data elements. Claims received with invalid HPTCs shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all outpatient claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of “ZZ”, along with a compliant “Patient Reason for Visit” diagnosis code. Outpatient claims containing an invalid “Patient Reason for Visit” code (a “Patient Reason for Visit” code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected

from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound HIPAA X12N 837 COB transaction, the FI shared system shall ensure a “ZZ” qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and FI shared system will be responsible for editing to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.

For bill types 12X and 22X, the FI shared system will edit to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via *DDE* (these are already required for other inpatient bill types). Claims not containing this data shall be subject to an appropriate on-line error message.

70 - Form CMS-1450 Consistency Edits

(Rev. 199, 06-10-04)

In order to be paid correctly and promptly, a bill must be completed accurately. The hospital (**but not other provider types**) must edit all Medicare required fields for alphabetic or numeric characters as shown below. In addition, it must apply the MCE edits described in Chapter 3, "Inpatient Part A Hospital" on diagnoses and procedures to its bills before submission. If the hospital's bill fails these edits, the FI returns it to the hospital for correction. If the FI edits bill data online as the hospital keys and transmits bills, the edits are included in FI software and the hospital need not duplicate them. If the hospital prepares magnetic tape or paper bills, either directly or through a billing service, it must ensure that these edits are made before forwarding the bill to the FI. Otherwise, the FI returns the bill and the hospital experiences delay in receiving payment until the bill is properly completed. Depending upon special services the hospital may provide, its FI may require additional edits.

FL 4 - Type of Bill

a. Must not be spaces.

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

First Digit - Type of Facility

1. Hospital

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

2. Skilled Nursing

3. Home Health

4. Religious Nonmedical Health Care Facility (Hospital)

5. Religious Nonmedical Health Care Facility (Extended Care)

7. Clinic (see special coding for second digit below)

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

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

First digit is 1-5

1. Inpatient (Part A)

2. Inpatient (Part B) - (For non PPS HHA claims, Includes HHA visits under a Part B plan of treatment, for HHA PPS claims, indicates a Request for Anticipated Payment - RAP.) **Note:** For HHA PPS claims, CMS determines from which Trust Fund payment is made. Therefore, there is no need to indicate Part A or Part B on the bill.

3. Outpatient (For HHA non-PPS claims, includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment). For home health agency claims paid under PPS, CMS determines from which Trust Fund, Part A or Part B. Therefore, there is no need to indicate Part A or Part B on the bill.

4. Other (Part B) - Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. For HHA PPS claims, indicates an osteoporosis claim.

5. Intermediate Care - Level I

6. Intermediate Care - Level II

7. Subacute Inpatient (Revenue Code 019X required)

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

Second Digit - Classification (Clinics Only - if first digit is 7)

1. Rural Health Clinic (RHC)

2. Hospital Based or Independent Renal Dialysis Facility

3. Free Standing Provider-Based Federally Qualified Health Center (FQHC)

4. Other Rehabilitation Facility (ORF)

5. Comprehensive Outpatient Rehabilitation Facility (CORF)

6. Community Mental Health Center (CMHC)

2nd Digit-Classification - Special Facilities Only (if first digit is 8)

1. Hospice (Nonhospital based)

2. Hospice (Hospital based)

3. Ambulatory Surgical Center Services to Hospital Outpatients

4. Free Standing Birthing Center

5. Critical Access Hospital

Third Digit – Frequency

A	Hospice Admission Notice	Used when the hospice or Religious Nonmedical Health Care Institution is submitting Form CMS-1450 as an Admission Notice.
B	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation Notice	Used when the Form CMS-1450 is used as a notice of termination/revocation for a previously posted Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution election.
C	Hospice Change of Provider Notice	Used when Form CMS-1450 is used as a Notice of Change to the hospice provider.
D	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel	Used when Form CMS-1450 is used as a Notice of a Void/Cancel of Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution election.
E	Hospice Change of Ownership	Used when Form CMS-1450 is used as a Notice of Change in Ownership for the hospice.
F	Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For FI use only.
G	CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For FI use only.
H	CMS Initiated Adjustment Claim	Used to identify adjustments initiated by CMS. For FI use only.

I	FI Adjustment Claim (Other than QIO or Provider	Used to identify adjustments initiated by the FI. For FI use only.
J	Initiated Adjustment Claim-Other	Used to identify adjustments initiated by other entities. For FI use only.
K	OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For FI use only.
M	MSP Initiated Adjustment Claim	Used to identify adjustments initiated by MSP. For FI use only. **Note:** MSP takes precedence over other adjustment sources.
P	QIO Adjustment Claim	Used to identify an adjustment initiated as a result of a QIO review. For FI use only.
0	Nonpayment/Zero Claims	Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to the provider.
1	Admit Through Discharge Claim	The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2	Interim-First Claim	Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. For HHAs, used for the submission of original or replacement RAPs.

3	Interim-Continuing Claims (Not valid for PPS Bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4	Interim-Last Claim (Not valid for PPS Bills)	This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL 6) is the discharge for this treatment.
5	Late Charge Only	Used for outpatient claims only. Late charges are not accepted for Medicare inpatient, home health, or Ambulatory Surgical Center (ASC) claims.
7	Replacement of Prior Claim	This is used to correct a previously submitted bill. The provider applies this code to the corrected or "new" bill.
8	Void/Cancel of a Prior Claim	The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.
9	Final Claim for a Home Health PPS Episode	This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

FL 6 - Statement Covers Period (From-Through)

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

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

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

d. The number of days represented by this period must equal the sum of the covered days (FL 7) and noncovered days (FL 8), if the type of bill is 11X, 18X, 21X, 41X, or 51X.

FL 7 - Covered Days

No edit. The FI determines the number of covered days in its bill process.

FL 8 - Noncovered Days

No edit. The FI determines the number of noncovered days in its bill process.

FL 9 - Coinsurance Days

No edit. The FI determines the number of coinsurance days in its bill process.

FL 10 - Lifetime Reserve Days
No edit. The FI determines the number of lifetime reserve days in its bill process.

FL 13 - Patient's Address

a. The address of the patient must include:
   City
   State (P.O. Code)
   ZIP

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

c. Cannot exceed 62 positions.

FL 14 - Birth Date

a. Must be valid if present.

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

FL 15 – Sex

a. One alpha position.

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

c. Must be present.

FL17 - Admission Date

a. Must be valid if present.

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

c. Present only if the type of bill is 11X, 21X, 32X, 33X, 41X, 51X, 81X, or 82X.

d. Cannot be later than the “From” portion of FL 6.

FL19 - Type of Admission

a. One numeric position.

b. Required only if the type of bill is 11X or 41X.

c. Valid codes are:

1 Emergency

2 Urgent

3 Elective

9 Information unavailable

FL 20 - Source of Admission

a. One numeric position.

b. Required if the type of bill is 11X, 13X, 32X, 33X, 41X or 83X.

c. Valid codes are:

1. Physician referral
2. Clinic referral
3. HMO referral
4. Transfer from a hospital
5. Transfer from a SNF
6. Transfer from another health care facility
7. Emergency room
8. Court/Law enforcement

9. Information not available

   A. Inpatient - Patient admitted to this facility as an inpatient transfer from a CAH.

      Outpatient - Patient referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH where the patient is an inpatient.

   B. Patient admitted to this HHA as a transfer from another HHA.

   C. Patient readmitted to this HHA within the same home health episode period.

FL 22 - Patient Status

a. Two numeric positions.

b. Present only on Part A bills, bill types 11X, 13X 18X, 21X, 32X, 33X, 41X, 51X, 81X, or 82X, and Part B bills, bill types 13X and 83X.

c. Valid codes for hospital, SNF, HHA and RNHCI are:

   01 Discharged to home/self care (routine charge)

   02 Discharged/transferred to a short-term general hospital for inpatient care

   03 Discharged/transferred to SNF-see "Discharged/transferred within this institution to a hospital based Medicare approved swing bed," Code 61 below

   04 Discharged/transferred to ICF

   05 Discharged/transferred to another type of institution (including distinct parts) or referred to another institution

   06 Discharged/transferred to home under care of organized home health service organization

   07 Left against medical advice or discontinued care

   08 Discharged/transferred to home under care of a home IV drug therapy provider

   09 Admitted as an inpatient to this hospital (valid only for outpatient hospital bills for services prior to the third day before admission.)

20 Expired (did not recover - Religious Nonmedical Health Care Institution patient)

30 Still patient or expected to return for outpatient services

d. Valid codes for hospice (81X or 82X) are:

01 Discharged (left this hospice)

30 Still patient (remains a patient)

40 Expired at home

41 Expired in a medical facility such as a hospital, SNF, ICF, or freestanding hospice

42 Expired - place unknown

50 Discharged/transferred to Hospice – home

51 Discharged/transferred to Hospice - medical facility

61 Discharged/transferred within this institution to a hospital based Medicare approved swing bed

71 Discharged/transferred to another institution for outpatient services

72 Discharged/transferred to this institution for outpatient services

FL 23 - Medical Record Number

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

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

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

a. Each code is 2 numeric digits

b. Valid codes for Medicare are:

02	56
04	57
05	60
06	61
07	62

08	63
09	64
10	65
11	66
15	70
16	71
20	72
21	73
26	74
27	75
28	76
29	77
36	78
37	79
38	A5-A9
39	C1-C7
40	D0-D9
41	E0
55	

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

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

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

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

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

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

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alpha-numeric positions.

d. Valid codes are 01-99 and A0-Z9.

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

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

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

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

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

j. If code 20 is entered:

Must either be earlier than “Admission Date” (FL 17) or later than “Through” Date (FL 6).

Must be less than 13 days after the admission date (FL 17) if “From” date is equal to admission date (less than 14 days if billing dates cover the period 12/24 through 1/2).

k. If code 21 is entered:

Cannot be later than “Statement Covers Period” Through date.

Cannot be more than 3 days prior to the “Statement Covers Period” From date.

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

m. If code 34 is entered, the type of bill must be 51X.

FL 36 - Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alpha-numeric positions.

c. Code must be accompanied by dates.

d. Valid codes are:

70
71
72
74
75
76
77

78
79
M0
M1
M2 - If code M2 is present, the bill type must be 81X or 82X.

e. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 51X.

f. If code 71 is entered, the first digit of FL 4 must be “1,” “2,” “4,” or “5” and the second digit must be “1.”

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

h. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 51X, 71X, 72X, 74X, 75X, 81X, or 82X.

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

j. If code 76 is entered, occurrence code 31 or 32 must be present.

k. If code 76 or 77 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 51X, 71X, 72X, 74X, 75X, 81X, or 82X.

l. Code M0 must be present only if FLs 24-30 contains code C3.

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

FLs 39, 40 and 41 - Value Codes and Amounts

a. Each code must be accompanied by an amount.

b. All codes are two alpha-numeric digits.

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

d. The valid codes are:

04-06	37-44	67-68	A1-A4	D3
08-19	46-53	70-72	B1-B3	
31	56-65	75-76	C1-C3	

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

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

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

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

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

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

FL 42 - Revenue Codes

a. Four numeric positions.

b. Should be listed in ascending numeric sequence except for the final entry, which must be "0001."

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

d. For bill type 13X or 83X, the following revenue codes require a 5-position HCPCS code:

0274, 030X, 031X, 032X, 034X, 035X, 040X, 046X, 0471, 0481, 0482, 061X, 0730, 0732, or 074X

e. For bill type 32X, 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X-044X, 055X-057X, and 0601- 0604

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

0271-0274 and 0601-0604

FL 44 - HCPCS Codes

a. For bill type 13X or 83X the HCPCS codes below must be reported with the specific revenue code shown. These revenue codes can also be reported with other HCPCS codes.

046X	94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620

0471	92504, 92511, 92541, 92542, 92543, 92544, 92545, 92551, 92552, 92553, 92555, 92556, 92557, 92563, 92567, 92568, 92569, 92575, 92584, 92585
0480	93307, 93308, 93320
0482	93017
0636	Revenue code 636 relates to the HCPCS code for drugs requiring detailed coding.
0730	93005, 93024, 93041, 93202, 93208, 93221
0731	93225, 93024, 93041, 93202, 93208, 93221
0732	93012
074X	95819
075X	91010, 91011, 91012, 91020, 91030, 91055
0921	93721, 93731, 93732, 93733, 93734, 93735, 93736
0922	95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, 95900, 95904, 95925, 95935, 95937

For bill type 13X or 83X and revenue codes 0360-0369, a five-position HCPCS code of 10000 - 69979 must be present unless diagnosis code V64.1, V64.2 or V64.3 is present.

FL 45 – Service Date

a. Six numeric positions, MMDDYY.

b. There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X and on inpatient Part B bills (TOBs 12x and 22x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.

FL 46 - Units of Service

a. Up to seven numeric positions.

b. There must be an entry in this column if revenue code series 010X-016X, 020X, 021X, 0262, 0263, 0274, 0291, 030X-031X, 032X, 0333, 034X, 035X, 038X,

0403, 045X, 051X, 052X, 061X, or 080X are entered. Revenue code series 041X, 042X, 043X, 044X, 048X, 091X 0636, and 0943 require an entry only if the first digit of FL 4 is 1-6 and the second digit of FL 4 is "4." Exception: All revenue codes require units for bill types 32X, 33X, 81X, and 82X.

c. Accommodation units must equal covered days (FL 7).

FL 47 - Total Charges

a. Up to ten numeric positions (00000000.00).

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

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

FLs 50 - A, B, and C - Payer Identification

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

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

FL 51 - Medicare Provider Number

a. A 6-position alpha/numeric field.

b. Left-justified.

FLs 58 - A, B, C - Insured's Name

a. Must be present, cannot be all spaces.

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

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position ten, the second in position eleven, etc. The first three numbers must fall within the range of: 001 through 649, and 697 through 729 only.

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

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

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

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

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

FL 67 - Principal Diagnosis Code

a. Must be three to five positions left justified with no decimal points. Validate with MCE program in accordance with Chapter 2, Inpatient Part A Hospital.

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

FLs 68-75 - Other Diagnosis Codes

a. If present, must be three to five positions, left justified with no decimal points. The FI validates this with the MCE.

FL 80 - Principal Procedure Code and Date

a. If present, must be valid. The FI will validate with the MCE.

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

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

FL 81 - Other Procedure Codes and Dates

a. If present, apply edits for FL 80.

FL 82 - Attending/Referring Physician ID

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

Number, last name and first initial must be present;

First 3 characters must be alpha or numeric; and

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

FL 83 - Other Physician ID

a. Must be present if:

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

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

b. If required:

First 3 characters must be alpha or numeric:

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

Left justified:

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