Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2848

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3604 (Cont.) – 3604 (Cont.)	6-25 – 6-28 (4 pp.) 6-31 – 6-32 (2 pp.) 6-44.1 – 6-46 (4 pp.) 6-49 – 6-54 (6 pp.) 6-54.2C – 6-54.2D (2 pp.) 6-54.23 – 6-54.26 (4 pp.) 6-55 – 6-56.2A (5 pp.)	6-25 – 6-28 (4 pp.) 6-31 – 6-32 (2 pp.) 6-44.1 – 6-46 (4 pp.) 6-49 – 6-54 (6 pp.) 6-54.2C – 6-54.2D (2 pp.) 6-54.23 – 6-54.26 (4 pp.) 6-55 – 6-56.2 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATES: October 1 2003 and October 16, 2003*
IMPLEMENTATION DATE: January 1, 2004

Section 3604, Review of Form CMS-1450 (previously Form HCFA-1450) for Inpatient and Outpatient Bills, is being updated to include a new Revenue Code (RC), Form Locator (FL) 42 approved by the National Uniform Billing Committee (NUBC). The new Revenue Code, 100X, Behavioral Health Accommodations Code goes into effect October 16, 2003. The NUBC also made changes to several revenue codes subcategories; these include RCs 009X, 079X, 090X and 091X, effective October 16, 2003. Other new codes approved or updated by the NUBC include Patient Status (FL22) with an effective date of October 1, 2003; Occurrence Code (FL 35), Occurrence Span Code (FL36) and Value Code, (FL39) with effective dates of October 16, 2003.

There was a typographic error for RC subcategory 3109, Other Adult Care. The current RC 3106 for Other Adult care in the instruction is incorrect. We are making the change in this instruction to show the correct RC as 3109. This correction is effective upon receipt of this instruction.

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

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

These instructions should be implemented within your current operating budget.

Form CMS-1450

3604. REVIEW OF FORM CMS-1450 FOR INPATIENT AND OUTPATIENT BILLS

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on Form CMS-1450 are described, but detailed information is given only for items required for Medicare claims. The National Uniform Billing Committee (NUBC) maintains a complete list of allowable data elements and codes. You must be able to capture all NUBC-approved input data for audit trail purposes and be able to pass all data to other payers with whom you have a coordination of benefits agreement. Items listed as "Not Required" need not be reviewed although providers may complete them when billing multiple payers. All Medicare claims you process must be billed on Form CMS-1450 billing form or billed using related electronic billing record formats.

If required data is omitted, obtain it from the provider or other sources and maintain it on your history record. It is not necessary to search paper files to annotate missing data unless you do not have an electronic history record. You need not obtain data not needed to process the bill.

Data elements in the CMS uniform electronic billing specifications are consistent with Form CMS-1450 data set to the extent that one processing system can handle both. Definitions are identical. In some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Also, for a few data elements not used by Medicare, conversion may be needed from an alpha code to a numeric, but these do not affect Medicare processing. The revenue coding system for both Form CMS-1450 and the electronic specifications are identical.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the hard copy UB-92 or Form CMS-1450, this simply means you will accept claims of up to 9 pages. For the electronic format, the new requirements are described in Addendum A.

Effective October 16, 2003, all state fields will be discontinued and reclassified as reserved for national assignment.

Form Locator (FL) 1. (Untitled) - Provider Name, Address, and Telephone Number Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 2. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit - Type of Facility
1 - Hospital
2 - Skilled Nursing
3 - Home Health

4 - Religious Non- Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special Facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit - Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).
4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to "nonpatients", and referred diagnostic services).
5 - Intermediate Care - Level I
6 - Intermediate Care - Level II
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement.)
9 - Reserved for National Assignment

2nd Digit - Classification (Clinics Only)
1 - Rural Health Clinic (RHC)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free-Standing Provider-Based Federally Qualified Health Centers (FQHC)
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)
7-8 Reserved for National Assignment
9 - OTHER

2nd Digit - Classification (Special Facilities Only)
1 - Hospice (Nonhospital Based)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6 - Residential Facility (not used for Medicare)
7-8 Reserved for National Assignment
9 - OTHER

3rd Digit - Frequency	Definition
A - Admission/Election Notice	This code is used when a hospice or religious non-medical health care institution is submitting the Form CMS-1450 as an admission notice.
B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/ Revocation Notice	Use when the UB-92 is used as a Termination/ Revocation of a hospice, Medicare coordinated care demonstration, or religious non-medical health care institution election.
C - Hospice Change of Provider	This code is used when the Form CMS-1450 is used as a Notice of Change to the hospice provider.
D - Hospice/Medicare Coordinated Care Demonstration/Religious	This code is used when the UB-92 is used as a Notice of a Void/Cancel of a hospice, Medicare Coordinated

Non-Medical Health Care Institution-Void/Cancel	Care Demonstration Entity, or Religious Non-medical Health Care Institution election.
E - Hospice Change of Ownership	This code is used when the Form CMS-1450 is used a Notice of Change in Ownership for the hospice.
F - Beneficiary Initiated Adjustment Claim	This code is used to identify adjustments initiated by the beneficiary. For intermediary use only.
G - CWF Initiated Adjustment Claim	This code is used to identify adjustments initiated by CWF. For intermediary use only.
H - CMS Initiated Adjustment Claim	This code is used to identify adjustments initiated by CMS. For intermediary use only.
I - Int. Adjustment Claim (Other Than PRO or Provider)	This code is used to identify adjustments initiated by you. For intermediary use only.
J - Initiated Adjustment Claim-Other	This code is used to identify adjustments initiated by other entities. For intermediary use only.
K - OIG Initiated Adjustment Claim	This code is used to identify adjustments initiated by OIG. For intermediary use only.
M - MSP Initiated Adjustment Claim	This code is used to identify adjustments initiated by MSP. For intermediary use only.

NOTE: MSP takes precedence over other adjustment sources.

P - PRO Adjustment Claim	This code is used to identify an adjustment initiated as a result of a PRO review. For intermediary use only.
0 - Nonpayment/zero claims	This code is used when the provider does not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. 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	This code is used for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which the provider 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	This code is used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment.
3 - Interim - Continuing Claims (Not valid for PPS Bills)	This code is used 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 date for this confinement or course of treatment.
5 - Late Charge Only	This code is used only for outpatient claims. Late charge bills are not accepted for Medicare inpatient or ASC claims.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or new bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also submitted by the provider 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 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period included on this bill are shown in numeric fields (MMDDYY). Days before the patient's entitlement are not shown. Use the "From" date to determine timely filing. (See §§3307ff.)

FL 7. Covered Days
Required. The total number of covered days during the billing period applicable to the cost report including lifetime reserve days elected for which Medicare payment is requested, is entered. This should be the total of accommodation units reported in FL 46. Covered days exclude any days classified as noncovered, as defined in FL 8, leave of absence days, and the day of discharge or death.

If you made an adverse coverage decision, enter the number of covered days through the last date for which program payment can be made. If waiver of liability provisions apply, see §344l.

The provider does not deduct any days for payment made in the following instances:

- o WC;
- o Automobile medical, no-fault, liability insurance;
- o An EGHP for an ESRD beneficiary;
- o Employed beneficiaries and spouses age 65 or over; or
- o An LGHP for disabled beneficiaries.

Enter the number of days shown in this FL in the cost report days field on the UB-92 CWF RECORD. However, when the other insurer has paid in full (see §§3682, and 3685), enter zero days in utilization days on the UB-92 CWF RECORD. For MSP cases only, calculate utilization based

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

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the critical access hospital where he or she is an inpatient.
B	Transfer From Another Home Health Agency	The patient was admitted to this home health agency as a transfer from another home health agency.
C	Readmission to Same Home Health Agency	The patient was readmitted to this home health agency within the same home health episode period.
D-Z		Reserved for national assignment.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. (For all Part A inpatient, SNF, hospice, HHA and outpatient hospital services.) This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04-ICF.)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
*09	Admitted as an inpatient to this hospital
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility, (e.g., hospital, SNF, ICF or freestanding hospice)
42	Expired - place unknown (hospice claims only)
43	Discharged/transferred to a federal hospital. (Effective 10/1/03)
44-49	Reserved for national assignment
50	Hospice - home
51	Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
62-70	Reserved for national assignment
73-99	Reserved for national assignment

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

Code	Title	Definition
43	Scheduled Date of Canceled Surgery	The date for which ambulatory surgery was scheduled.
44	Date Treatment Started For Occupational Therapy	Code indicates the date the billing provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	Code indicates the date the billing provider initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	Code indicates the date the billing provider initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	Code indicates that this is the first day the inpatient cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments.
48-49	Payer Codes	Codes reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers do not report them.
A1	Birthdate-Insured A	Code indicates the birth date of the insured in whose name the insurance is carried.
A2	Effective Date- Insured A Policy	Code indicates the first date the insurance is in force.
A3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer A.
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as "Split Bill Date"). Effective 10/16/03.
B1	Birthdate- Insured B	Code indicates the birth date of the individual in whose name the insurance is carried.
B2	Effective Date- Insured B Policy	Code indicates the first date the insurance is in force.
B3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate- Insured C	Code indicates the birth date of the individual in whose name the insurance is carried.
C2	Effective Date- Insured C policy	Code indicates the first date the insurance is in force.

Code	Title	Definition
C3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer C.
C4-C9		Reserved for national assignment.
D0-D9		Reserved for national assignment.

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

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

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

Code	Title	Definition
72	First/Last Visit	Code indicates 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	Noncovered Level of Care	Code indicates the From/Through dates for a period at a noncovered level of care in an otherwise covered stay excluding any period reported with occurrence span code 76, 77, or 79. Codes 76 and 77 apply to most noncovered care. Used for leave of absence. This code is also used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A.
75	SNF Level of Care	Code indicates the From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since Pros 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 which transfer patients from the hospital to a SNF level of care.
76	Patient Liability	Code indicates the From/Through dates for a period of noncovered care for which the hospital is permitted to charge the beneficiary. Code is to be used only where you or the PRO approve such charges in advance and the patient is 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	Code indicates the From/Through dates for a period of noncovered care for which the provider is liable (other than for lack of medical necessity or as 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 Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) Code indicates the From/Through dates given by the patient for a 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 is not shown in FL 36. (See §3035.B.2.)
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.

Code	Title	Definition
M0	PRO/UR Stay Dates	If a code "C3" is in FLS 24-30, the "From" and "Through" dates of the approved billing period are here.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	Code indicates 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 hospital stay.
M5-WZ		Reserved for national assignment.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. Providers enter the control number assigned to the original bill here. Utilized by all provider types on adjustment requests (Bill Type, FL4 = XX7). All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must 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 Hospice claims only, the name, address, and provider number of a transferring Hospice is shown by the new Hospice on its Form CMS-l450 admission notice. (See §3648, FL 38.) For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLS 39, 40, and 41. Value Codes and Amounts
Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending alphanumeric sequence. There are four lines of data, line "A" through line "D." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used before the second line is used and so on).

04	Inpatient Professional Component Charges Which are Combined Billed	Code indicates the amount shown is the sum of the inpatient professional component charges which 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.)

Code	Title	Definition
		reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
15	Worker's Compensation (WC)	Code indicates the amount shown is that portion of a higher priority WC payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in the other payer's payment. (See §§3407-3416.4.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
16	PHS, Other Federal Agency	Code indicates the amount shown is 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. (See §§3153ff.)
17	Operating Outlier Amount	(Not reported by providers.) Report the amount of operating outlier payment made (either cost or day) in CWF with this code. (Do not include any capital outlier payment in this entry.)
18	Operating Disproportionate Share Amount	(Not reported by providers.) Report the operating disproportionate share amount applicable with this code. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry.)
19	Operating Indirect Medical Education Amount	(Not reported by providers.) Report operating indirect medical education amount applicable with this code. Use the amount provided by the indirect medical education field in PRICER. (Do not include any PPS capital IME adjustment in this entry.)
31	Patient Liability Amount	Code indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered 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.

Code	Title	Definition
37	Pints of Blood Furnished	Code indicates the total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced, is shown. 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	Code indicates the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of Blood Replaced	Code indicates the total number of pints of blood which 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 §3235.4A.) Where the provider charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).
40	New Coverage Not Implemented by HMO	(For inpatient service only.) Code indicates the amount shown for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO.) Condition Codes 04 and 78 must also be reported.
41	Black Lung	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment. (See §§3415ff.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)

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

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

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

					1	3		

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

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

Code	Title	Definition
		Report right justified in the cents area. (See note following this code for an example.)

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

							5	7

A reading of 100 percent is shown as:

						1	0	0

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

				3	1	0	6	0

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.

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

					5	0	0	0

77-79	Payer Codes	Codes reserved for internal use only by third party payers. CMS assigns as needed. Providers do not report payer codes.
A0	Special Zip Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount assumed by the provider to be applied to the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	The amount estimated by the provider to be paid by by the indicated payer.
A4	Covered Self-Administrable Drugs-Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation (e.g., diabetic coma). For use with Revenue Code 0637.
A5	Covered Self-Administrable Drugs – Not Self-Administrable In Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.

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

0290s - rental/purchase of DME
0304 - rental and dialysis/laboratory
0330s - radiology therapeutic
0367 - kidney transplant
0420s - therapies
0520s - type of clinic visit (RHC or other)
0550s-0590s - home health services
0624 - Investigational Device Exemption (IDE)
0636 - hemophilia blood clotting factors
0800s-0850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

Zero level billing is encouraged for all services which do not require HCPC codes.

0001 Total Charge
For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, report the total charge in the appropriate data segment/field.

001X Reserved for Internal Payer Use

002X Health Insurance Prospective Payment System (HIPPS)

Subcategory	Standard Abbreviation
0 - Reserved	
1 - Reserved	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HH PPS (HRG)
4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (CMG)
5 - Reserved	
6 - Reserved	
7 - Reserved	
8 - Reserved	
9 - Reserved	

003X to 006X Reserved for National Assignment

007X to 009X Reserved for State Use To be discontinued effective October 16, 2003.
009X effective October 16, 2003 Reserved for National Assignment

ACCOMMODATION REVENUE CODES (010X - 021X)

010X All Inclusive Rate

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

Subcategory		Standard Abbreviations
0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All-Inclusive Room and Board	ALL INCL R&B

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

Routine service charges for single bed rooms.

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

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

Subcategory	Standard Abbreviation
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 EKG/ECG (Electrocardiogram)

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 Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

074X EEG (Electroencephalogram)

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 Abbreviation
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 Abbreviation
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 762 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 which identify coverage of observation services.

Subcategory	Standard Abbreviation
0 - General Classification	TREATMENT/OBSERVATION RM
1 - Treatment Room	TREATMENT RM
2 - Observation Room	OBSERVATION RM
9 - Other Treatment Room	OTHER TREATMENT RM

077X Preventative Care Services

Charges for the administration of vaccines.

Subcategory	Standard Abbreviation
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 Abbreviation
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 Abbreviation
0 - General Classification	ESWT
9 - Other ESWT	ESWT/OTHER

080X Inpatient Renal Dialysis

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

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
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

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

NOTE: Revenue code 814 is used only when costs incurred for an organ search does not result in an eventual organ acquisition and transplantation.

082X Hemodialysis - Outpatient or Home Dialysis

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

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

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

083X Peritoneal Dialysis - Outpatient or Home

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

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

084X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient

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

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

086X Reserved for Dialysis (National Assignment)

087X Reserved for Dialysis (State Assignment)

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

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

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

089X Reserved for National Assignment

090X Behavior Health Treatments/Services (also see 091X, and extension of 090X)

Subcategory	Standard Abbreviation
0 - General Classification	BH
1 - Electroshock Treatment	BH/ELECTRO SHOCK
2 - Milieu Therapy	BH/MILIEU THERAPY
3 - Play Therapy	BH/PLAY THERAPY
4 - Activity Therapy	BH/ACTIVITY THERAPY
5 – Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
6 – Intensive Outpatient Services-Chemical Dependency	BH/INTENS OP/CHEM DEP
7 – Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY
8 – Reserved for National Use	
9 – Reserved for National Use	

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

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

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

Subcategory	Standard Abbreviation
0 - Reserved for National Use	
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 912 and 913 services under its partial hospitalization program.

092X Other Diagnostic Services

Code indicates charges for other diagnostic services not otherwise categorized.

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

093X Medical Rehabilitation Day Program

Medical rehabilitation services as contracted with a payer and/or certified by the State. Services may include physical therapy, occupational therapy, and speech therapy. The subcategories of 93X 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 therapy revenue codes as normal.

Subcategory	Standard Abbreviation
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
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	RTN 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
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fees	OTHER PRO FEE

097X Professional Fees-Extension of 096X

Subcategory	Standard Abbreviations
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCUPA
9 - Speech Pathology	PRO FEE/SPEECH

098X Professional Fees-Extension of 096X & 097X

Subcategory	Standard Abbreviation
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

099X Patient Convenience Items

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

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
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 - Nonpatient 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 Abbreviation
0 – General Classification	BH R&B
1 – Residential Treatment – Psychiatric	BH R&B RES/PSYCH
2 – Residential Treatment – Chemical Dependency	BH R&B RES/CHEM DEP
3 – Supervised Living	BH R&B SUP LIVING
4 – Halfway House	BH R&B HALFWAY HOUSE
5 – Group Home	BH R&B GROUP HOME

101X to 209X Reserved for National Assignment

210X Alternative Therapy Services

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

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

Subcategory	Standard Abbreviation
0 - General Classification	ALTTHERAPY
1 – Acupuncture	ACUPUNCTURE
2 – Accupressure	ACCUPRESSURE
3 - Massage	MASSAGE
4 – Reflexology	REFLEXOLOGY
5 – Biofeedback	BIOFEEDBACK
6 – Hypnosis	HYPNOSIS
9 – Other Alternative Therapy Services	OTHER ALTTHERAPY

211X to 300X Reserved for National Assignment

310X Adult Care Effective April 1, 2003

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

Subcategory	Standard Abbreviation
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 DAY
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 to 9099 Reserved for National Assignment