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 1762

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3604 - 3604 (Cont.)	6-25 - 6-46 (22 pp.) 6-51 - 6-54.8 (12 pp.) 6-54.19 - 6-54.22 (4 pp.) 6-55 - 6-58 (6 pp.) 6-61 - 6-62 (2 pp.)	6-25 - 6-46 (22 pp.) 6-51 - 6-54.8 (12 pp.) 6-54.19 - 6-54.22 (4 pp.) 6-55 - 6-58 (6 pp.) 6-61 - 6-62 (2 pp.)
Addendum B	B-1 - B-2 (2 pp.) B-9 - B-20 (12 pp.) B-25 - B-28 (4 pp.) B-31 - B-32 (2 pp.)	B-1 - B-2 (2 pp.) B-9 - B-20 (12 pp.) B-25 - B-28 (4 pp.) B-31 - B-32 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE*:* October 1, 2001
IMPLEMENTATION DATE: October 31, 2001

Section 3604, Review of Form HCFA-1450 for Inpatient and Outpatient Bills, is being updated to include changes that have been made for the coding of the following: FL 4 (Bill Type), FL 22 (Patient Status Code), FL 24-30 (Condition Code), FL 32-35 (Occurrence Codes), FL 36 (Occurrence Span Codes) FL 39-41 (Value Codes), and FL 42 (Revenue Codes). FL 52 (Release of Information) and FL 76 (Admitting Diagnosis/Patient's Reason for Visit) have also been updated. Revenue Code 0024 becomes effective on January 1, 2002. All other codes are already being used.

Addendum B- Alphabetic Listing of Data Elements, adds several data definitions that we previously omitted from this section. Record Type 81 was deleted from Addendum A previously in Change Request 334, Transmittal 1768; however, data definitions pertaining to RT 81 were not deleted from Addendum B and are now being deleted in this transmittal. The deleted definitions are Leads Left In Patient, Manufacturers' ID, Model Number, Leads Left in Patient, Serial Number, and Warranty Expiration Date.

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 HCFA-1450

3604. REVIEW OF FORM HCFA-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 HCFA-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 HCFA-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 HCFA-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 HCFA-1450 and the electronic specifications are identical.

Effective June 5, 2000, HCFA extended the claim size to 450 lines. For the hard copy UB-92 or Form HCFA-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.

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 HCFA-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 HCFA-1450 is used as a Notice of Change to the hospice provider.
D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel	This code is used when the UB-92 is used as a Notice of a Void/Cancel of a hospice, Medicare Coordinated Care Demonstration Entity, or Religious Non-medical Health Care Institution election.

E - Hospice Change of Ownership	This code is used when the Form HCFA-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 - HCFA Initiated Adjustment Claim	This code is used to identify adjustments initiated by HCFA. 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:

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

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

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

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

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

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

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

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

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

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

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

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

FL 16. Patient's Marital Status
Not Required.

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

FL 18. Admission Hour
Not Required.

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

Code Structure:

1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
9	Information Not Available	The hospital cannot classify the type of admission. This code is used only on rare occasions.

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

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

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

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

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

FL 21. Discharge Hour
Not Required.

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

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

FL 23. Medical Record Number
Required. This is the number assigned to the patient's medical/health record by the provider. If the provider enters a number, you must carry the number through your system and return it to the provider.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes
Required. Code(s) identifying conditions related to this bill which may affect processing.

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

Code	Title	Definition
02	Condition is Employment Related	Code indicates patient alleges that the medical condition in this episode of care is due to environment/events resulting from employment. (See §§3415.2ff. for WC and §§3415.3ff. for BL.)
04	Patient is HMO Enrollee	Code indicates bill is submitted for information only and the Medicare beneficiary is enrolled in a risk-based HMO and the hospital expects to receive payment from the HMO.
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the first 30 months of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Code indicates the beneficiary would not provide information concerning other insurance coverage. Develop to determine the proper payer. (See §3686 for development guidelines.)
09	Neither Patient Nor Spouse is Employed	Code indicates that in response to development questions, the patient and spouse have denied employment.

Code	Title	Definition
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Code indicates that in response to development questions, the patient and/ or spouse indicated that one or both are employed but have no group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance that covers the patient.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.
15	Clean Claim Delayed in HCFA's Processing System (Payer Only Code)	Code indicates that the claim is a clean claim in which payment was delayed due to a HCFA processing delay. Interest is applicable, but the claim is not subject to CPEP/CPT standards. (See §3600.1A.3.)
16	SNF Transition Exemption (Medicare Payer Only Code)	Code indicates an exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Code indicates patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole community hospitals only). Code indicates the patient was referred for a diagnostic laboratory test. Use to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.

Code	Title	Definition
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part-time employees; or, (2) the EGHP is a multi- or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance coverage from a LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and that the employer has fewer than 100 full and part-time employees; or, (2), the LGHP is a multi- or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time - Day)	Patient declares that he/she is enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that he/she enrolled in a cooperative/ work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that he/she is enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that he/she is enrolled as a part-time student.
ACCOMMODATIONS		
35		Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Code indicates the hospital temporarily placed the patient in a special care unit because no general care beds were available.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) Code indicates that the patient was assigned to ward

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

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

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Code indicates patient's assignment to a private room was for medical reasons.
40	Same Day Transfer	Code indicates patient was transferred from one participating provider to another before midnight on the day of admission.
41	Partial Hospitalization	Code indicates claim is for partial hospitalization services. For outpatients this includes a variety of psychiatric programs. (See §§3112.7C and D for a description of coverage.)
42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Postdischarge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the postdischarge window.
55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Code indicates the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
60	Operating Cost Day Outlier	(Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. Indicate the operating cost outlier portion paid in value code 17.
61	Operating Cost Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost

Code	Title	Definition
		outlier. Indicate the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Code indicates bill was paid under PIP. Record this from your system.
63	Payer Only Code	Code reserved for internal use only. HCFA assigns as needed. Providers do not report this code.
64	Other Than Clean Claim	(Not reported by providers.) Code indicates the claim is not "clean." Record this from your system.
65	Non-PPS Bill	(Not reported by providers.) Code indicates bill is not a PPS bill. Record this from your system for non-PPS hospital bills.
66	Provider Does Not Wish Cost Outlier Payment	Code indicates a hospital paid under PPS is not requesting additional payment as a cost outlier for this stay.
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary has elected to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/Payment Only Bill	Code indicates a hospital is requesting a supplemental payment consisting only of applicable IME for a Medicare managed care enrollee.
70	Self-Administered EPO	Code indicates the billing is for a dialysis patient who self-administers EPO.
71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care In Unit	Code indicates the billing is for a patient who managed his/her own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where the patient and his/her helper (if necessary) were learning to perform dialysis.
74	Home	Code indicates the billing is for a patient who received dialysis services at home.
75	Home 100 percent Payment	(Not to be used for services furnished 4/16/90 or later.) Code indicates the billing is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100 percent program.

Code	Title	Definition
76	Back-up In-facility Dialysis	Code indicates the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Code indicates the provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	Code indicates this bill is for a Medicare newly covered service for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off Site	Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

Special Program Indicator Codes

Code	Title	Definition
A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A3	Special Federal Funding	This code is designed for uniform use by State uniform billing committees.
A5	Disability	This code is designated for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumonia/ Influenza 100% Payment	This code identifies that pneumococcal/influenza vaccine (PPV) services given that are to be paid under a special Medicare program provision.
A7	Induced Abortion-Danger to Life	Code indicates an abortion was performed to avoid danger to woman's life.
A8	Induced Abortion- Victim of Rape/Incest	Self-explanatory.
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.
M0-M9	Payer Only Codes	
M0	All-Inclusive Rate for Outpatient	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

Code	Title	Definition
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Code indicates the influenza virus vaccine or Pneumococcal Pneumonia Vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.

PRO Approval Indicator Codes

C1	Approved as Billed	Code indicates claim has been reviewed by the PRO and is fully approved including any day or cost outlier.
C3	Partial Approval	Code indicates the bill has been reviewed by the PRO and some portion (days or services) has been denied. From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. Exclude grace days and any period at a noncovered level of care (code "77" in FL 36 or code "46" in FL 39-41.)
C4	Admission Denied	Code indicates patient's need for inpatient services was reviewed by the PRO and none of the stay was medically necessary.
C5	Postpayment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/ Preprocedure	Code indicates that the PRO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	Code indicates the PRO authorized these services for an extended length of time, but has not reviewed the services provided.

Claim Change Reasons

Code	Title	Definition
D0	Changes to Service Dates	Self-explanatory.
D1	Changes to Charges	Self-explanatory.
D2	Changes to Revenue Codes/HCPCs/HIPPS Rate Code	Self-explanatory.
D3	Second or Subsequent Interim PPS Bill	Self-explanatory.

Code	Title	Definition
D4	Change in GROUPER Input or Minimum Data Set	Use for inpatient acute care hospital and inpatient SNF.
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory.
D8	Change to Make Medicare the Primary Payer	Self-explanatory.
D9	Any Other Change	Self-explanatory.
E0	Change in Patient Status	Self-explanatory.
H0	Delayed Filing, Statement Of Intent Submitted	Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
M0	All-Inclusive Rate for Outpatient Services (Payer only code)	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

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

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

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

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

When FLs 36 A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

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

Code	Title	Definition
01	Auto accident	Code indicates the date of an auto accident. This code is used to report an auto accident that involves liability insurance. (See §§3419ff.)
02	No-Fault Insurance Involved - Including Auto Accident/Other	Code indicates the date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicates the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicates the date of accident relating to the patient's employment. (See §§3407-3416.)
05	Other Accident	Code indicates the date of an accident not described by the above codes. This code is used to report that the provider has developed for other casualty related payers and has determined there are none. (Additional development not needed.)
11	Onset of Symptoms/Illness	Code indicates the date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	(HHA Claims only) Code indicates the date the patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit.
17	Date Occupational Therapy Plan Established or Reviewed	Code indicates the date a plan was established or last reviewed for occupational therapy.
18	Date of Retirement Patient/Beneficiary	Code indicates the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code indicates the date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A claims only.) Code indicates date on which the provider began claiming payment under the guarantee of payment provision. (See §3714.)
21	UR Notice Received	(Part A SNF claims only.) Code indicates date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See §3421.1.)

Code	Title	Definition
22	Date Active Care Ended	Code indicates date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period	For Intermediary Use Only. Providers Do Not Report. Code is not required if code "21" is used.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	Code indicates the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is not longer available to the patient.
26	Date SNF Bed Available	Code indicates the date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date CORF Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for CORF care. (See §3350.)
29	Date OPT Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for OPT. (See §3350.)
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for outpatient speech pathology. (See §3350.)
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or reasonable or Treatments)	Code indicates the date of the notice provided by the hospital stating that requested care (diagnostic procedures or treatments) is not considered necessary by Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	Code indicates the first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.

Code	Title	Definition
34	Date of Election of Extended Care Services	Code indicates the date the guest elected to receive extended care services (used by Religious Non-medical Health Care Institution only)
35	Date Treatment Started For Physical Therapy	Code indicates the date the billing provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge For Transplant Procedure	Code indicates the date of discharge for the inpatient hospital stay during which the patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
37	Date of Inpatient Hospital Discharge Non-covered Transplant Patient	Code indicates the date of discharge for inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test, was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the tests (s).
42	Date of Discharge	(Hospice claims only.) Code indicates date on which the beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (See §3648, FLS 32-35, code 42.) The frequency digit (3rd digit, FL 4, Type of Bill) should be 1 or 4.
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 this	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 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. HCFA 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.

Code	Title	Definition
A3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer A.
B1	Birthdate- Insured B	Code indicates the birth date of the individual in whose name the insurance is carried.
B2	Effective Date- Insured B Policy	Code indicates the first date the insurance is in force.
B3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate- Insured C	Code indicates the birth date of the individual in whose name the insurance is carried.
C2	Effective Date- Insured C policy	Code indicates the first date the insurance is in force.
C3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer C.
C4-C9		Reserved for national assignment.
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-W9		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 HCFA-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 HCFA 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
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.
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.)

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

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

							5	7

A reading of 100 percent is shown as:

						1	0	0

60	HHA Branch MSA	Code indicates MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's - Report the MSA number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.)
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
62-65	Payer Codes	THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
66		Reserved for national assignment
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 Period	Code indicates the number of units of EPO administered and/or supplied relating to the billing period and is reported in whole units to the left of the dollar/cents delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

				3	1	0	6	0

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

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

					5	0	0	0

77-79	Payer Codes	Codes reserved for internal use only by third party payers. HCFA assigns as needed. Providers do not report payer codes.
A1	Deductible Payer A	The amount assumed by the provider to be applied to the patient’s deductible amount involving the indicated payer.
B1	Deductible Payer B	The amount assumed by the provider to be applied to the patient’s deductible amount involving the indicated payer.
C1	Deductible Payer C	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 toward the patient’s coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	The amount assumed by the provider to be applied toward the patient’s coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	The amount assumed by the provider to be applied toward the patient’s coinsurance amount involving the indicated payer.

Code	Title	Definition
A3	Estimated Responsibility Payer A	The amount estimated by the provider to be paid by the indicated payer.
B3	Estimated Responsibility Payer B	The amount estimated by the provider to be paid by the indicated payer.
C3	Estimated Responsibility Payer C	The amount estimated by the provider to be paid by the indicated payer.
D3	Estimated Responsibility Patient	The amount estimated by the provider to be paid by the indicated patient.
A4	Covered Self-Administrable Drugs - Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charge for an ordinarily non-covered, self-administered drug is for insulin administered to a patient in a diabetic coma. For use with Revenue Code 637.)

FL 42. Revenue Code
Required. For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered on the adjacent line in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry in FL 47 is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48 are summed.

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

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

290s - rental/purchase of DME
304 - rental and dialysis/laboratory
330s - radiology therapeutic
367 - kidney transplant
420s - therapies
520s - type of clinic visit (RHC or other)
550s-590s - home health services
624 - Investigational Device Exemption (IDE)
636 - hemophilia blood clotting factors
800s-850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

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

001 Total Charge

01X Reserved for Internal Payer Use

02X 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 (effective 10/1/00)
4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (effective 01/1/02)
5 - Reserved	
6 - Reserved	
7 - Reserved	
8 - Reserved	
9 - Reserved	

03X to 06X Reserved for National Assignment

07X to 09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X 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

11X Room & Board - Private (Medical or General)

Routine service charges for single bed rooms.

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

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT

5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
8 - Rehabilitation	REHAB/PVT
9 - Other	OTHER/PVT

12X Room & Board - Semi-private Two Bed (Medical or General)

Routine service charges incurred for accommodations with two beds.

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

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

13X Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

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

14X Private (Deluxe)

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

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 - OB	OB/DLX
3 - Pediatric	PEDS/DLX
4 - Psychiatric	PSYCH/DLX
5 - Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX

7 - Oncology	ONCOLOGY/DLX
8 - Rehabilitation	REHAB/DLX
9 - Other	OTHER/DLX

15X Room & Board Ward
(Medical or General)

Routine service charge for accommodations with five or more beds.

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

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

16X Other Room & Board

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

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

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

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

17X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

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

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

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

Level III - Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).

Level IV - Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).

Subcategory	Standard Abbreviation
0 - General Classification	NURSERY
1 - Newborn - Level I	NURSERY/LEVEL I
2 - Newborn - Level II	NURSERY/LEVELII
3 - Newborn - Level III	NURSERY/LEVELIII
4 - Newborn - Level IV	NURSERY/LEVELIV
9 - Other	NURSERY/OTHER

18X Leave of Absence

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

NOTE: Charges are billable for codes 2 - 5

0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - Reserved	
2 - Patient Convenience - charges billable	LOA/PT CONV CHGS BILLABLE
3 - Therapeutic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

19X Subacute Care

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

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

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

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

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

Subcategory	Standard Abbreviation
0 - General Classification	SUBACUTE
1 - Subacute Care - Level I	SUBACUTE/LEVEL I

2 - Subacute Care - Level II	SUBACUTE/LEVEL II
3 - Subacute Care - Level III	SUBACUTE/LEVEL III
4 - Subacute Care - Level IV	SUBACUTE/LEVEL IV
9 - Other Subacute Care	SUBACUTE/OTHER

20X Intensive Care

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

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

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

21X Coronary Care

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

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

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

ANCILLARY REVENUE CODES (22X - 99X)

22X Special Charges

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

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

Subcategory	Standard Abbreviation
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG
3 - U.R. Service Charge	UR CHARGE

4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

23X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU (includes transitional care)	NUR INCR/ICU
4 - CCU (includes transitional care)	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER

24X All Inclusive Ancillary

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

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

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

25X Pharmacy

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

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

Subcategory	Standard Abbreviation
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Nongeneric Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD

6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Nonprescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

26X IV Therapy

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

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

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

27X Medical/Surgical Supplies. (Also see 62X, an extension of 27X.)

Code indicates the charges for supply items required for patient care.

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

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

28X Oncology

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

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

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

60X Oxygen (Home Health)

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

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

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

Subcategory	Standard Abbreviation
0 - General Classification	02/HOME HEALTH
1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
3 - Oxygen - Stat/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	02/STAT EQUIP/PORT ADD-ON

61X Magnetic Resonance Technology (MRT)

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

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

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

62X Medical/Surgical Supplies - Extension of 27X

Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that do not bill supplies used under radiology revenue codes as part of the radiology procedure charges. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

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

63X Pharmacy-Extension of 25X

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

Subcategory	Standard Abbreviation
0 - RESERVED (Effective 1/1/98)	
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythroepoetin (EPO) less than 10,000 units	DRUG/EPO/≤10,000 units
5 - Erythroepoetin (EPO) 10,000 or more units	DRUG/EPO/≥10,000 units
6 - Drugs Requiring Detailed Coding*	DRUGS/DETAIL CODE
7 - Self-administrable Drugs	DRUGS/SELFADMIN

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

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

64X Home IV Therapy Services

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

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY SVC
1 - Nonroutine Nursing, Central Line	NON RT NURSING/CENTRAL
2 - IV Site Care, Central Line	IV SITE CARE/CENTRAL
3 - IV Start/Change Peripheral Line	IV STRT/CHNG/PERIPHAL
4 - Nonroutine Nursing, Peripheral Line	NONRT NURSING/PERIPHRL
5 - Training Patient/Caregiver, Central Line	TRNG/PT/CARGVR/CENTRAL

6 - Training, Disabled Patient, Central Line	TRNG DSBLPT/CENTRAL
7 - Training Patient/Caregiver, Peripheral Line	TRNG/PT/CARGVR/PERIPHRL
8 - Training, Disabled Patient, Peripheral Line	TRNG/DSBLPAT/PERIPHRL
9 - Other IV Therapy Services	OTHER IV THERAPY SVC

NOTE: Units need to be reported in 1 hour increments. Revenue code 642 relates to the HCPCS code.

65X Hospice Services

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

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

Subcategory	Standard Abbreviation
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care - 2	HOSPICE/CTNS HOME
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Respite Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (nonrespite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYSICIAN
9 - Other Hospice	HOSPICE/OTHER

66X Respite Care (HHA only)

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

Subcategory	Standard Abbreviation
0 - General Classification	RESPITE CARE
1 - Hourly Charge/Skilled Nursing	RESPITE/SKILLED NURSE
2 - Hourly Charge/Home Health Aide/ Homemaker	RESPITE/HMEAID/HMEMKE
9 - Other Respite Care	RESPITE/CARE

67X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

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

68X Not Assigned

69X Not Assigned

70X Cast Room

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

Rationale: Permits identification of this service, if necessary.

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

71X Recovery Room

Rationale: Permits identification of particular services, if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	RECOVERY ROOM
9 - Other Recovery Room	OTHER RECOV RM

72X Labor Room/Delivery

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

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

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

73X 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

90X Psychiatric/Psychological Treatments

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY TREATMENT
1 - Electroshock Treatment	ELECTRO SHOCK
2 - Milieu Therapy	MILIEU THERAPY
3 - Play Therapy	PLAY THERAPY
4 - Activity Therapy	ACTIVITY THERAPY
9 - Other	OTHER PSYCH RX

91X Psychiatric/Psychological Services

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.

Rationale: This breakdown provides additional identification of services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PSYCH/SERVICES
1 - Rehabilitation	PSYCH/REHAB
2 - Partial Hospitalization* - Less Intensive	PSYCH/PARTIAL HOSP
3 - Partial Hospitalization - Intensive	PSYCH/PARTIAL INTENSIVE
4 - Individual Therapy	PSYCH/INDIV RX
5 - Group Therapy	PSYCH/GROUP RX
6 - Family Therapy	PSYCH/FAMILY RX
7 - Bio Feedback	PSYCH/BIOFEED
8 - Testing	PSYCH/TESTING
9 - Other	PSYCH/OTHER

NOTE: Medicare does not recognize codes 912 and 913 services under its partial hospitalization program.

92X 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

93X 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

94X Other Therapeutic Services (Also see 95X an extension of 94X)

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

95X Other Therapeutic Services-Extension of 94X

Charges for other therapeutic services not otherwise categorized.

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

96X 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

97X Professional Fees-Extension of 96X

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

98X Professional Fees-Extension of 96X & 97X

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

99X 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

1XXX to 8999 Reserved for National Assignment

9000 to 9044 Reserved for Medicare Skilled Nursing Facility Demonstration Project

9045 to 9099 Reserved for National Assignment

FL 43. Revenue Description

Not Required. A narrative description or standard abbreviation for each revenue code in FL 42 is shown on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates

Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here.

On inpatient hospital or SNF bills, the accommodation rate or HIPPS code is shown here.

FL 45. Service Date

Required. Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service wherever a HCPCS code is required. This includes claims where the from and through dates are equal.

FL 46. Service Units

Required. Generally, the entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable, for the following:

Accommodations - 100s - 150s, 200s, 210s (days)
Blood - 380s (pints)
DME - 290s (rental months)
Emergency room - 450, 452, and 459 (HCPCS code definition for visit or procedure)
Clinic - 510s and 520s (HCPCS code definition for visit or procedure)
Dialysis treatments - 800s (sessions or days)
Orthotic/prosthetic devices - 274 (items)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (Units are equal to the number of times the procedure/service being reported was performed.)
Outpatient clinical diagnostic laboratory tests - 30X - 31X (tests)
Radiology - 32x, 34x, 35x, 40x, 61x, and 333 (HCPCS code definition of tests or services)
Oxygen - 600s (rental months, feet or pounds)
Hemophilia blood clotting factors - 636

Up to seven numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.

FL 47. Total Charges

Required. The total charges for the billing period are summed by revenue code (FL 42) or in the case of revenue codes requiring HCPCS by procedure code and entered on the adjacent line in FL 47. The last revenue code entered in FL 42 is "0001" which represents the grand total of all covered and non-covered charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional component is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

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

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

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

FLS 50A, B, C. Payer Identification
Required. If Medicare is the primary payer, "Medicare" is entered on line A. If Medicare is entered, the provider has developed for other insurance and has determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on lines B or C, as appropriate. (See §§3407-3415, §§3419, and §§3489-3492 to determine when Medicare is not the primary payer.)

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

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

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

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

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

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

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

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

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

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across that line (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider is requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, another payer denied the claim, or the provider is requesting a conditional payment as described in "3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

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

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

Code	Title	Definition
01	Patient is Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured has Financial Responsibility	Self-explanatory
04	Natural Child/Insured does not have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.

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

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

FLs 68-75. Other Diagnoses Codes
Inpatient--Required. The provider reports the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

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

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

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

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

FL 77. E-Code
Not Required.

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

FL 79. Procedure Coding Method
Not Required.

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

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

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

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

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

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

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

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

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

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

ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

NOTE: ALL DATE FORMATS SHOULD BE (CCYYMMDD).

Data Element	Definition	Record	Field
Accommodations Days	A numeric count of accommodations days in accordance with payer instructions. Includes UB-92 revenue codes 10X through 21X.	50	6 Three additional iterations in related locations for RT 50, fields 11-13.
Accommodations Non-Covered Charges	Accommodations charges pertaining to the related UB-92 accommodations revenue code that are not covered by the primary payer as determined by the provider.	50	8 Three additional iterations in related locations for RT 50, fields 11-13.
Accommodations Noncovered Charges for the Batch	Sum of charges recorded in related field in RT 90, field 14.	95	9
Accommodations Noncovered Charges for the File	Sum of charges recorded in related field in RT 95, field 9.	99	7
Accommodations Rate	Per diem rate for related UB-92 accommodations revenue codes.	50	5 Three additional iterations in related locations for RT 50, fields 11-13.
Accommodations Revenue Code	UB-92 revenue center code for the accommodation provided. Includes codes 10X through 21X.	50	4 Three additional iterations in related locations for RT 50, fields 11-13.
Accommodations Total Charges	Total charges for the related revenue code.	50	7 Three additional iterations in related locations for RT 50, fields 11-13.
Accommodations Total Charges for the Batch	Sum of charges recorded in related field in RT 90, field 13.	95	8

	Data Element	Definition	Record	Field
	Accommodations Total Charges for the File	Sum of charges recorded in related field in RT 95, field 8.	99	6
	Activities Permitted	Codes describing the activities permitted by the physician or for which physician's orders are present. "Other" is described in RT 73. 1 = Complete Bedrest 2 = Bedrest BRP 3 = Up as Tolerated 4 = Transfer Bed/Chair 5 = Exercises Prescribed 6 = Partial Weight Bearing 7 = Independent at Home 8 = Crutches 9 = Cane A = Wheelchair B = Walker C = No Restrictions D = Other A minimum of one must be present for the abbreviated POC.	71	16
	Admission Date/Start of Care Date	The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits. For RT 71, from most recent patient stay.	20 71 74 77-A	17 29 17 24
*	Admission Hour	The hour during which the patient was admitted for inpatient care. Use hour in military time (00 to 23). If hour not known, use 99. Default to spaces if not applicable (e.g., outpatient).	20	18
	Admitting Diagnosis/ Patient's Reason For Visit	The ICD-9-CM diagnosis code describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration.	70	25
	Air Ambulance Justification	Reason air ambulance was chosen instead of land transport. A01 = Life Threatening A02 = Instability of Roads A03 = Time Required for Land Transportation A04 = Local Ground Ambulance Lacks Staff or Equipment to Meet Patient Needs	75-02	6

* Not required for Medicare

	Data Element	Definition	Record	Field
	Date of Receipt	The date the file was received from the submitter. This is to be entered by the receiver of the file.	01	19
	Date of Service	The line item date the service was performed.	61	13
	Destination Address	Address of the institution or home where patient transported by ambulance.	75-01	21-25
		Name	75-01	21
		Place	75-01	22
		City	75-01	23
		State	75-01	24
		Zip Code	75-01	25
	Discharge Date	Date that the patient was discharged from most recent inpatient care.	71	30
*	Discharge Hour	Hour that the patient was discharged from inpatient care. Use hour in military time (00 to 23). If hour not known, use 99. Default to spaces if not applicable (e.g., outpatient).	20	22
	Discipline	Code indicating discipline(s) ordered by physician: SN = Skilled Nursing PT = Physical Therapy ST = Speech language Pathology OT = Occupational Therapy MS = Medical Social Worker AI = Home Health Aide CR = Cardiac Rehabilitation RT = Respiratory (Inhalation) Therapy PS = Psychiatric Services For RT 77, AI (Home Health Aide) is not a valid code.	72 77	4 5
	Drugs Administered (Narrative)	Identifies medications administered as part of a psychiatric services plan of treatment.	77-R	23
	Drug Units	Number of standard units from the National Drug Code (NDC) administered to the patient. For example, if the standard dosage for the drug is 10 mg and 40 mg was administered, enter 0004 as the value in this field.	76-M Two additional iterations in related locations on RT 76, format type M, fields 10-11.	6

* Not required for Medicare

Data Element	Definition	Record	Field
Employer Location	The specific location for the employer of the individual identified in RT 30.	21 21 31	5-8 12-15 10-13
Employer Name	Name of employer that may provide health care coverage for the individual identified in RT 30.	21 21 31	4 11 9
Employer Qualifier	Identifies the patient's relationship to the person not claiming insurance. See "Patient Relationship to Insured" and its codes listed in §3604.	21	9a, 16a
Employment Status Code	A code used to define the employment status of the individual identified by the name in RT 30. 1 = Employed full time 2 = Employed part time 3 = Not employed 4 = Self employed 5 = Retired 6 = On active military duty 7-8 = Reserved for national assignment 9 = Unknown	21 21 30	9 16 19
Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer.	20 30	24 26
Estimated Date of Completion of Outpatient Rehabilitation	An approximate date for discontinuance of outpatient rehabilitative services for a specific discipline due to goal achievement.	77-R	14
* Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payer or patient. Shown as value code A3, B3, C3, or D3.	41	16-39
* External Cause of Injury (E-code)	The ICD-9-CM code which describes the external cause of the injury, poisoning or adverse effect. Use of this data element is voluntary in States where E-coding is not required.	70	26
Extra Dialysis Sessions	Reports the date and justification for extra dialysis sessions during the billing period.	76-M	12-14
	Date (for each session) Justification: Code specifies the reason for each extra session. 1 = New method of dialysis 2 = New caretaker 3 = Fluid overload 4 = Abnormal lab values	76-M 76-M Two additional iterations in related positions in RT 76, format type M, fields 15 and 16.	12 14

* Not required for Medicare

	Data Element	Definition	Record	Field
	Federal Tax Number (EIN)	The number assigned to the provider by the Federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
*	Federal Tax Sub ID	Four position modifier to Federal Tax ID listed above.	10	5
	File Sequence and Serial Number	Sequence number from 01 to nn assigned to each file in this submission of records, followed by the inventory number of the file.	01	17
	Form Locator	The item number on the UB-92 hard copy form.	22	5-15
	Free Form Narrative	Text describing specific topics on the plan of treatment for outpatient rehabilitative services (e.g., initial assessment, progress report). Must have a narrative text indicator.	77-N	7
	Frequency and Duration	6 position code indicating the expected frequency and duration of an activity. For home health or outpatient rehabilitation, it is the expected frequency and duration of visits in the period covered by a plan of care/ treatment. It can also describe an expected number of activities, such as medication administration for ESRD patients. Position 1 is the number of visits/ activities. Positions 2-3 are an alpha expression of the period of time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. Position 1 codes = 1-9 Position 2-3 codes = DA, WK, MO, Q_, __ DA = day, WK = week, MO = month, Q_ = every n days where n = the number in positions 4-6, __ = PRN (whenever necessary) Position 4-6 is duration in days. Codes = 001-999 unless positions 2-3 are blank, then enter PRN. A value of 999 indicates 2 ½ years or more. Examples: 1 visit daily for 10 days = 1DA010 1 visit every 2 months = 1Q_060 4 visits whenever necessary = 4__PRN	72 76-M 77-R	7 9 13

* Not required for Medicare

Data Element	Definition	Record	Field
	3 medication administrations/week for 3 months = 3WK090 1 medication administration every other week = 1Q_014 A minimum of one group must be present for the abbreviated POC.		
Functional Limitation Code	Codes describing the patient's functional limitations as assessed by the physician. "Other" is described in RT 73. 1 = Amputation 2 = Bowel/Bladder (Incontinence) 3 = Contracture 4 = Hearing 5 = Paralysis 6 = Endurance 7 = Ambulation 8 = Speech 9 = Legally Blind A = Dyspnea with Minimal Exertion B = Other A minimum of one must be present on abbreviated POC.	71	15
HCPCS/ Procedure Code	Procedure code reported in record types identify services so that appropriate payment can be made. HCPCS code is required for many specific types of outpatient services and a few inpatient services. May include up to two modifiers.	60 61 Two additional iterations in related locations for RT 60 and 61, fields 14-15.	5-7 5-7
HICN	Health Insurance Claim Identification Number.	74	5
HIPPS	Health Insurance Prospective Payment System	60 61	5-7 5-7
IDE	Investigational Device Exemption #	34	5
Injectable Drugs	Charges for all drugs administered intravenously, intramuscularly, or subcutaneously while providing ambulance services.	75-01	16
Inpatient Ancillary Noncovered Charges	Charges pertaining to the related UB-92 inpatient ancillary revenue center code that the primary payer will not cover.	60 Two additional iterations in related locations for RT 60, fields 13-14.	10

	Data Element	Definition	Record	Field
	Inpatient Ancillary Revenue Code	UB-92 revenue center code for the inpatient ancillary services provided. Include codes 22X through 99X.	60 Two additional iterations in related locations for RT 60, fields 13-14.	4
	Inpatient Ancillary Total Charges	Total charges pertaining to the related UB-92 inpatient ancillary revenue center code.	60	9
	Inpatient Ancillary Units of Service	A quantitative measure of services furnished, by inpatient UB-92 revenue center category, to or for the patient that includes items such as number of miles, pints of blood, number of renal dialysis treatments, etc.	60 Two additional iterations in related locations for RT 60, fields 13-14.	8
	Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	10
	Insured Address	Insured's current mailing address. Address Line 1 Address Line 2 City State Zip	31 31 31 31 31 31	4-8 4 5 6 7 8
	Insured Group Name	Name of the group or plan that provides insurance to the insured.	30	11
	Insured's Name	Name of individual in whose name the insurance is carried. Last Name First Name Middle Initial	30 30 30 30	12-14 12 13 14
*	Insured's Sex	Code indicating the sex of the insured. M = Male F = Female U = Unknown	30	15
	Internal Control/ Document Control Number (ICN/DCN)	The control number assigned to the original bill by the payer or the payer's intermediary to identify a unique claim.	74	21

* Not required for Medicare

Data Element	Definition	Record	Field
IV Solutions	Charges for supplies (e.g., needles, tubing, solutions) related to intravenous administration of solutions (e.g., saline), while providing ambulance services. Do not include charges for drugs administered intravenously. See "Injectable Drugs" on RT 75, sequence 01, field 16 for drug charges during ambulance services.	75-01	14
Justification for Extra Session	Specifies the reason for each extra dialysis session. 1 = New method of dialysis 2 = New caretaker 3 = Fluid overload 4 = Abnormal lab values	76-M	14
Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	30	23
* Medicaid Provider Number	The number assigned to the provider by Medicaid. Provider number also appears on RT 30 in field 24. RT 30 may be repeated for each payer, A, B, and C.	10 30	7 24
Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records.	20 74	25 6
Medical Surgical Supplies	Charges for non-reusable medical surgical supplies (e.g., bandages, topical solutions) used while providing ambulance services.	75-01	13
Medicare Covered	The following are applicable codes: Y= Covered N= Noncovered	71	24
Medicare Provider Number	The number assigned to the provider by Medicare. The provider number also appears in RT 30 in field 24. RT 30 may be repeated for each payer, A, B, and C.	10 30	6 24

* Not required for Medicare

Data Element	Definition	Record	Field
Medication Administration	Information related to the administration of medications used for end stage renal disease patients. See individual field definitions for information listed below for composite fields 10 and 11.	76-M	5-9 Two additional iterations with related locations RT76, format M, fields 10 and 11.
	National Drug Code	76-M	5
	Drugs Units	76-M	6
	Place of Administration	76-M	7
	Route of Administration	76-M	8
	Frequency and Duration	76-M	9
Mental Status Code	Codes describing the patient's mental condition. "Other" is described in RT 73. 1 = Oriented 2 = Comatose 3 = Forgetful 4 = Depressed 5 = Disoriented 6 = Lethargic 7 = Agitated 8 = Other A minimum of one must be present for the abbreviated POC.	71	17
Modifier	Two position codes serving as modifier to HCPCS procedure.	60 61	6-7 6-7
Multiple Provider Billing File Indicator	A code indicating whether bills for more than one provider are contained on this file submission according to the following coding scheme. 1 = Single Provider 2 = Multiple Providers	01	3
Narrative Type Indicator	Used to identify the type of narrative text for outpatient rehabilitative services. 01 = Medical History/ Prior Functional Level 02 = Initial Assessment 03 = Functional Goals 04 = Plan of Treatment 05 = Progress Report 06 = Continued Treatment 07 = Justification for Admission 08 = Symptoms/Present Behavior	77-N	6

Data Element	Definition	Record	Field
National Drug Code	Used to identify the drug/medication administered. Use the National Drug Code list maintained by the Food and Drug Administration (FDA).	76-M	5 Two additional iterations in related positions on RT 76-M, fields 10 and 11.
National Provider Identifier (NPI)	Refer to Medicare provider number.	10	6
Noncovered Accommodation Charges-Revenue Centers	Sum of accommodation charges not covered by primary payer for this bill as reflected in RT 50, field 8, and subsequent accommodation packets in RT type 50, fields 11-13.	90	14
Noncovered Ancillary Charges-Revenue Centers	Sum of "Ancillary Charges-Noncovered" for this bill as reflected in RT 60, field 10. If an outpatient batch, sum of "Noncovered Charges" for this bill as reflected in RT 61, fields 11, 14, or 15.	90	16
Noncovered Days	Days of care not covered by the primary payer.	30	21
Non-Routine and Separately Billable Laboratory Tests	Report the HCPCS code, results of previous test(s), date(s) of previous test(s), results of test(s) this billing period, and date(s) of test(s) this period for each separately billed test. Lab results are placed in the fields "lab value" which are seven position numeric fields with an implied decimal at five left of the decimal point. For example, the implied decimal is 99999.99	76-L	5-9 Three additional iterations in related locations are in RT 76, format type L, fields 12-14.
	HCPCS Code	76-L	5
	Previous Lab Value	76-L	6
	Date Previous Lab	76-L	7
	Current Lab Value	76-L	8
	Date Current Lab	76-L	9
Number of Batches Billed this File	A count of the number of batches billed on this file or transmission.	99	5

Data Element	Definition	Record	Field
Number of 3M Batch Attachment Records	A count of the number of RT 71, 75-seq1, 76-seq1, and 77-A entries for this provider batch. (RT 10 to RT 95.)	95	7
Number of Claims	A count of the number of RT 20 entries for this provider batch. (RT 10 to RT 95.)	95	6
Number of Claims for the File	A count of the number of RT 20 entries for this file (RT 01 through RT 99). Required only for benefit coordination (COB).	99	12
Number of Grace Days	The number of days determined by the the PRO to be necessary to arrange for the patient's post discharge care. Shown as value code 46.	41	16-39
Number of Miles (Ambulance)	Exact number of miles from point of pick-up to destination and return, if applicable.	75-01	11
Number of Trips (Ambulance)	Number of trips that pertain to this record. S1-9 = Single trips reported in RT 75, seq. 01, field 8 (code 1 - pick-up code) R1-9 = Round trips reported in RT 75, seq. 01, field 8 (code 2 - destination code)	75-01	7
Number of Records for the File	Total number of records from 01 through 99 in a file transmission. Required only for COB.	99	13
Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. Occurrence code and and occurrence date repeat for a total of 10 iterations.	40	8-26
Occurrence Date	Date associated with the occurrence span code in the preceding field. Both occurrence code and occurrence date repeat for a total of 10 iterations.	40	9-27
Occurrence Span Code	A code that identifies an event that relates to payment of the claim. The occurrence span code and both of the associated dates are repeated for a total of 2 iterations.	40	22 & 25

Data Element	Definition	Record	Field
Occurrence Span Dates	The from and through dates related to the occurrence pan code shown in the Preceding field.	40	23 & 26 24 & 27
Operating Physician Name	Name used by provider to identify the operating physician in provider records.	80	10
Operating Physician Identifier	Number used by provider to identify the operating physician in provider records.	80	6
Other Ancillary Charges (Ambulance)	Charge for ancillary services not listed in RT 75, sequence 01, fields 13-16.	75-01	7
Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.	70seq1 70seq2 74	5-11 4 13-16
* Other Insurer Provider Number	The number assigned to the provider by an insurer other than Medicare, Medicaid, or CHAMPUS.	10	9-10
Other Physician ID Name/Identifier	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	80	7, 8 11, 12
Other Procedure Code	The code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.	70seq1	15-23
Other Procedure Date	Date that the procedure indicated by the related code (preceding field) was performed.	70seq1	16-24

*Not required by Medicare

Data Element	Definition	Record	Field
Other Services	Report for each test/service for each separately billed item on and ESRD claim.	76-M Two additional iterations in related locations in RT 76, format M, fields 22-23.	17-20
	HCPCS/CPT Code Date of Previous Test/Service (CCYYMMDD) Date of Current Test/Service (CCYYMMDD)	76-M 76-M 76-M	17 18 20
Outpatient Date of Service	The date the associated service as identified by the outpatient UB-92 revenue center code was delivered.	61 Two additional iterations in related locations for RT 61, fields 14-15.	9
Outpatient Noncovered Charges	Charges pertaining to the related outpatient UB-92 revenue center code that the primary payer will not cover.	61 Two additional iterations in related locations for RT 61, fields 14-15.	11
Outpatient Revenue Center Code	UB-92 revenue center code for outpatient ancillary services provided.	61 61	4 14-15
Outpatient Total Charges	Total charges for this bill (revenue code 0001).	61	10
Outpatient Units of Service	A quantitative measure of services furnished by outpatient UB-92 revenue center category to or for the patient that includes items such as number of miles, pints of blood, number of renal dialysis treatments, etc.	61	8
Oxygen/Oxygen Supplies	Charges for oxygen contents and supplies required during the administration of oxygen while providing ambulance services.	75-01	15
Patient Address	The address of the patient as qualified by the payer organization. Address Line 1 Address Line 2 City State (P.O. Code) Zip	20	12-16 12 13 14 15 16
Patient Birthdate	The date of birth of the patient. Includes 4 pos. year. (CCYYMMDD).	20 74	8 10

Data Element	Definition	Record	Field
Patient Control Number	Patient's unique alpha-numeric identification number assigned by the provider to facilitate retrieval of individual case records and posting of payment. Use to link multiple records for a single claim.	20-90-91	3
* Patient Marital Status	The marital status of the patient at date of admission, outpatient service, or start of care. S = Single M = Married X = Legally Separated D = Divorced W = Widowed U = Unknown	20	9
Patient Name	Last name, first name, and middle initial of the patient.	20 74	4-6 7-9
	Last name	20 74	4 7
	First name	20 74	5 8
	Middle initial	20 74	6 9
Patient Receiving Care in 1861 (j)(1) Facility	Y = Yes N = No D = Do not know	71	27
Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured. See §3604 for coding list.	30	18
Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care. M = Male F = Female U = Unknown	20 74	7 11
Patient Status	A code indicating patient's status as of the statement covers thru date.	20	21

*Not required for Medicare

Data Element	Definition	Record	Field
*Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	11
PRO Approval Indicator	An indicator describing the determination arrived at by the PRO. Shown as condition codes C1-C7.	41	4-13
PRO Approved Stay Dates	The first and last days that were approved when not all of the stay is approved by the PRO. Shown as occurrence span code M0.	40	28,31
Reason for Ambulance Transportation	Code indicating reason patient had to be transported by ambulance. R01 = Unconsciousness or shock R02 = Severe hemorrhage R03 = Seizure R04 = Spinal injury R05 = DOA R06 = Acute respiratory distress R07 = Restraining psychiatric patient R08 = Vehicle accident R09 = Cardiac incident R10 = Trauma other than vehicle R11 = Overdose/poisoning R12 = Bedbound R13 = Altered level of consciousness R14 = Burns R15 = Acute metabolic or endocrine disorders R16 = Acute surgical emergency non-trauma R17 = Hemodynamic instability R18 = Acute infectious process R19 = Neurological/neurovascular incident R20 = Organ procurement R21 = Accident, possible injury	75-01 Two additional iterations are located in RT 75 sequence 01, fields 5 and 6.	4
Reason for Bypass of Nearest Facility	Reason the nearest facility was bypassed for another one. B01 = Lack of appropriate facilities/ specialists B02 = Trauma center B03 = Burn center B04 = Other special care unit	75-02	5

*Not required for Medicare

Data Element	Definition	Record	Field
Reason for Transfer	Reason patient was transferred from one facility to another. T01 = Lack of appropriate facilities/ specialists T02 = Other	75-02	4
Receiver Identification	Number identifying to the provider the organization designated to receive this file.	01 95 99	6 3 3
*Receiver Sub-Identification	The identification of the specific location within the receiver organization designated to receive the tape or transmission.	01 95 99	7 4 4
Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission. A = Self Pay B = Workers Compensation C = Medicare D = Medicaid E = Other Federal Programs F = Insurance company G = Blue Cross H = CHAMPUS I = Other - local coding table applies Z = Multiple sources of payment	01	5
Record Format Type	Indicates specific record layout for a record type series with multiple formats under one record type designation. A = Administrative Data L = Laboratory Services M = Medication Data N = Narrative Text R = Treatment Data	76 77	4 4
Record Type nn Count	A count of RTs 20-2n through 80 fields 5 through 11 of this record. These fields must cross foot to the total in field 4 of this record.	90	5-11
Record Type 91 Qualifier	Indicates if RT 91 is present. Code "0" if not written or "1" if written.	90	12

*Not required for Medicare

Data Element	Definition	Record	Field
Rehabilitation Professional Identifier	Identifier assigned to the rehabilitation professional (e.g., therapist, nurse, psychologist) establishing the plan of treatment and/or recommending continued need (or discontinuance) of care. Currently unavailable to all providers.	77-A	11
Rehabilitation Professional Name	Last name, first name, and middle initial of the rehabilitation professional (e.g., therapist, nurse, psychologist) establishing the plan of treatment and/or recommending continued need (or discontinuance) of care.		12-14
	Last name	77-A	12
	First name	77-A	13
	Middle initial	77-A	14
Rehabilitation Professional Signature Date on Plan of Treatment (CCYYMMDD)	Date the rehabilitation professional verified and signed the plan of treatment for outpatient rehabilitative services.	77-A	16
Release of Information Certification Indicator	A code indicating that the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim.	30	16
* Remarks	Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Also used for overflow data for any element for which there is not enough space.	90 91	17 4
Revenue Code	Code that identifies a specific accommodation, ancillary service or billing calculation.	60 61	28, 111, 139 28, 111, 139

*Not required for Medicare

Data Element	Definition	Record	Field
Route of Administration	Used to report the method of medication administration. 1 = I.V. 2 = I.M. 3 = S.Q. 4 = Oral 5 = Topical 6-8= Reserved for national use 9 = Other	76-M	8
Route of Administration - IM	Identifies if any medications ordered are being administered intramuscularly.	77-R	20
Route of Administration - IV	Identifies if any medications ordered are being administered intravenously.	77-R	21
Route of Administration - PO	Identifies if any medications ordered are being administered by mouth.	77-R	22
Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Rts 21-2n do not have a sequence number greater than 01. Rts 01, 10, 90, 91, 95, and 99 do not have sequence numbers. The sequence number for RTs 30, 31, 34, and 80, are used as matching criteria to determine which type 30, type 31, type 34, and/or type 80 records are associated. Like sequence numbers indicate the records are associated. The sequence numbers for RT 77 indicate the sequence order of RT 77, not the format type (e.g., format A) of RT 77.	21-2n 30-3n 40-41 50-5n 60-6n 70-7n 80-8n	2 2 2 2 2 2 2

*Not required for Medicare

Data Element	Definition	Record	Field
Total Non-Covered Charges for the File	Sum of charges entered in RT 99, fields 7 (Accommodation Noncovered Charges for the File) and 9 (Ancillary Noncovered Charges for the File). Required only for COB.	99	11
Total Visits Projected This Cert.	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits. Required for abbreviated POC.	72	44
Total Visits From Start of Care (SOC)	The cumulative total visits (sessions) since the SOC through the last visit of of the current billing period.	77-A	26
Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill is authorized by the PRO or by the payer. Three iterations, one each for payers A, B, and/or C.	40	5-7
Treatment Codes	Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30 = Skilled Nursing B01-B15 = Physical Therapy C01-C09 = Speech Therapy D01-D11 = Occupational Therapy E01-E06 = Medical School Services F01-F15 = Home Health Aide One or more codes must be present for each discipline (e.g., SN,PT, etc.). Required for abbreviated POC.	72	18-43
Treatment Diagnosis Code (ICD-9)	The ICD-9-CM code which describes the treatment diagnosis (e.g., 781.2 - abnormality of gait) for which 50% or more of the rehabilitative services are rendered for a specific discipline.	77-A	29
Treatment Diagnosis (Narrative)	Treatment diagnosis for which 50% or more of the rehabilitative services are rendered for a specific discipline.	77-A	30
Type of Admission	A code indicating the priority of this admission.	20	10
Type of Batch	A code indicating the types of bills that occur in this batch; i.e., between a provider record (RT 10), and a provider batch control (RT 95).	10 95	2 5

Data Element	Definition	Record	Field
Type of Bill	A code indicating the specific type of bill (hospital inpatient, SNF outpatient, adjustments, voids, etc.).	40	4
Type Of Facility	Coding indicating type of facility from which the patient was most recently discharged. A = Acute S = SNF I = ICF R = Rehabilitation Facility O = Other	71	31
Value Amount	Amount of money related to the associated value code.	41	17-39
Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as required by the payer organization.	41	16-38
Verbal Start of Care Date (CCYYMMDD)	The date the agency received the verbal orders from the physician, if this is prior to the date care started.	71	19
Version Code	A code that indicates the version of the National Specifications submitted on this file, disk, etc. 001 = UB-82 data set as finally approved 08/17/82. 003 = UB-82 data set as revised to handle $1,000,000 charges, bigger fields for units and UPINs. Effective 01/01/92 and 04/01/92. 004 = UB-92 data set as approved by NUBC 2/92. Effective 10/01/93. 041 = UB-92 data set as approved by the NUBC 2/96. Effective 10/01/96. 050 = UB-92 data set as approved by the NUBC 11/97. Effective 10/01/98. 060 = UB-92 data set as approved by the NUBC 11/99. Effective 4/01/00.	01	20
Visits (This Bill) Rel. to Prior Certification	Total visits on this bill rendered prior to recertification "to" date. If applicable, required for abbreviated POC.	72	5
Weight in Kg	Last recorded weight of the patient.	76-M	24