

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1254	Date: MAY 25, 2007
	Change Request 5593

Subject: National Uniform Billing Committee (NUBC) Update to Chapter 25

I. SUMMARY OF CHANGES: Chapter 25 is being updated to reflect approved NUBC changes. Changes include definition changes for value codes 48 and 49, deletion of UB-92 information, removal of periods from bill type numbers, correction of a typo in condition code 6, and replaced secondary qualifiers EI (Employer Identification Number) and SY (Social Security Number) with G2 (Provider Commercial Number).

New / Revised Material

Effective Date: June 11, 2007

Implementation Date: June 11, 2007

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
D	25/50/Uniform Bill (UB) -Form CMS-1450 (UB-92)
D	25/50.1/Uniform Billing with Form CMS 1450
D	25/50.2/Disposition of Copies of Completed Forms
D	25/60/General Instructions for Completion of Form CMS-1450 for Billing (UB-92)
D	25/60.1/Form Locators 1-20
D	25/60.2/Form Locators 21-30
D	25/60.3/Form Locators 31-41
D	25/60.4/Form Locator 42

D	25/60.5/Form Locators 43-86
R	25/75.1/Form Locators 1-15
R	25/75.2/Form Locators 16-30
R	25/75.3/Form Locators 31-41
R	25/75.5/Form Locators 43-81

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1254	Date: May 25, 2007	Change Request: 5593
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SUBJECT: National Uniform Billing Committee (NUBC) Update to Chapter 25

Effective Date: June 11, 2007

[Note: The effective date on or after the date of service for outpatient claims and on or after the date of discharge for inpatient claims.]

Implementation Date: June 11, 2007

I. GENERAL INFORMATION

A. Background: Chapter 25 is being updated to reflect changes approved by NUBC. CR 5072, dated November 3, 2006 announced that the UB-92 format would be discontinued after May 22, 2007. This CR removes the UB-92 information from Chapter 25 leaving only UB-04 information.

B. Policy: Section 42 CFR 424.5(a)(5) requires providers of services to submit a claim for payment prior to any Medicare reimbursement. The Form CMS-1450 Part A claim form (UB-04) is a vehicle used to collect claim information for payment.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I I E R	C A I E R	D M R C	R H I	Shared-System Maintainers				OTHER
						F I S	M C S	V M S	C W F			
5593.1	Contractors shall be aware of the Chapter 25 update removing UB-92 information (CR 5072, dated November 3, 2006 announced that the UB-92 format would be discontinued after May 22, 2007).	X		X			X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)
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		A / B M A C	D M M A C	F I I E R	C A R R I E R	D M R C	R E R I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
5593.2	None (CR 5072 already included provider education).			X			X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Matt Klischer (matthew.klischer@cms.hhs.gov)

Post-Implementation Contact(s): Matt Klischer (matthew.klischer@cms.hhs.gov)

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC):

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

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80 - Reserved

75.1 - Form Locators 1-15

(Rev.1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

Form Locator (FL) 1 - (Untitled) Provider Name, Address, and Telephone Number

Required. The minimum entry is the provider 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. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

FL 2 – Pay-to Name, address, and Secondary Identification Fields

Situational. Required when the pay-to name and address information is different than the Billing Provider information in FL1. If used, the minimum entry is the provider name, address, city, State, and ZIP code.

FL 3a - Patient Control Number

Required. The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.

FL 3b – Medical/Health Record Number

Situational. The number assigned to the patient's medical/health record by the provider (not FL3a).

FL 4 - Type of Bill

Required. This four-digit alphanumeric code gives three specific pieces of information after a leading zero. **CMS will ignore the leading zero. CMS will continue to process three specific pieces of information.** The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure

2nd Digit-Type of Facility (CMS will process this as the 1st digit)

- 1 Hospital
- 2 Skilled Nursing
- 3 Home Health (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)
- 4 Religious Nonmedical (Hospital)
- 5 Reserved for national assignment (discontinued effective 10/1/05).
- 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

3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)

1 Inpatient (Part A)

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

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

4 Other (Part B) - Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for “nonpatients,” and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim. **NOTE: 24X is discontinued effective 10/1/05.**

5 Intermediate Care - Level I

6 Intermediate Care - Level II

7 Reserved for national assignment (discontinued effective 10/1/05).

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

9 Reserved for National Assignment

3rd Digit-Classification (Clinics Only) (CMS will process this as the 2nd digit)

1 Rural Health Clinic (RHC)

2 Hospital Based or Independent Renal Dialysis Facility

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

4 Other Rehabilitation Facility (ORF)

5 Comprehensive Outpatient Rehabilitation Facility (CORF)

6. Community Mental Health Center (CMHC)

7-8 Reserved for National Assignment

9 OTHER

3rd Digit-Classification (Special Facilities Only) (CMS will process this as the 2nd digit)

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
- 6-8 Reserved for National Assignment
- 9 OTHER

4th Digit-Frequency – Definition (CMS will process this as the 3rd digit)

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

	Other	entities. For FI use only.
K	OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For FI use only.
M	MSP Initiated Adjustment Claim	Used to identify adjustments initiated by MSP. For FI use only. Note: MSP takes precedence over other adjustment sources.
P	QIO Adjustment Claim	Used to identify an adjustment initiated as a result of a QIO review. For FI use only.
0	Nonpayment/Zero Claims	Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The “Through” date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care.
1	Admit Through Discharge Claim	The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2	Interim-First Claim	Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment. For HHAs, used for the submission of original or replacement RAPs.
3	Interim-Continuing Claims (Not valid for PPS Bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4	Interim-Last Claim (Not valid for PPS Bills)	This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The “Through” date of this bill (FL 6) is the discharge for this treatment.
5	Late Charge Only	Used for outpatient claims only. Late charges are not accepted for Medicare inpatient, home health,

or Ambulatory Surgical Center (ASC) claims.

- | | | |
|---|---|--|
| 7 | Replacement of Prior Claim | This is used to correct a previously submitted bill. The provider applies this code to the corrected or “new” bill. |
| 8 | Void/Cancel of a Prior Claim | The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code “7” (Replacement of Prior Claim) is being submitted showing corrected information. |
| 9 | Final Claim for a Home Health PPS Episode | This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment. |

Bill Type Codes

The following table lists “Type of Bill,” FL4, codes by Provider Number Range(s). For a definition of each facility type, see the Medicare State Operations Manual.

Bill Type Code

- 011X Hospital Inpatient (Part A)
- 012X Hospital Inpatient Part B
- 013X Hospital Outpatient
- 014X Hospital Other Part B
- 018X Hospital Swing Bed
- 021X SNF Inpatient
- 022X SNF Inpatient Part B
- 023X SNF Outpatient
- 028X SNF Swing Bed
- 032X Home Health
- 033X Home Health
- 034X Home Health (Part B Only)
- 041X Religious Nonmedical Health Care

Institutions

- 071X Clinical Rural Health
- 072X Clinic ESRD
- 073X Federally Qualified Health Centers
- 074X Clinic OPT
- 075X Clinic CORF
- 076X Community Mental Health Centers
- 081X Nonhospital based hospice
- 082X Hospital based hospice
- 083X Hospital Outpatient (ASC)
- 085X Critical Access Hospital

FL 5 - Federal Tax Number

Required. The format is NN-NNNNNNNN.

FL 6 - Statement Covers Period (From-Through)

Required. The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY). Days before the patient's entitlement are not shown. With the exception of home health PPS claims, the period may not span two accounting years. The FI uses the "From" date to determine timely filing.

FL 7

Not Used.

FL 8 - Patient's Name

Required. The provider enters the patient's last name, first name, and, if any, middle initial, along with patient ID (if different than the subscriber/insured's ID).

FL 9 - Patient's Address

Required. The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.

FL 10 - Patient's Birth Date

Required. The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.

FL 11 - Patient's Sex

Required. The provider enters an “M” (male) or an “F” (female). The patient’s sex is recorded at admission, outpatient service, or start of care.

FL 12 - Admission Date

Required For Inpatient and Home Health. The hospital enters the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.

FL 13 - Admission Hour

Not Required. If submitted, the data will be ignored.

FL 14 - Type of Admission/Visit

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, suitable accommodation.
- 3 Elective - The patient’s condition permitted adequate time to schedule the availability of a suitable accommodation.
- 4 Newborn - Use of this code necessitates the use of a Special Source of Admission codes.
- 5 Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.
- 6-8 Reserved for National Assignment
- 9 *Information Not Available*

FL 15 – Source of Admission

Required. The provider enters the code indicating the source of the referral for this admission or visit.

Code Structure:

- 1 Physician Referral
Inpatient: The patient was admitted to this facility upon the recommendation of their personal physician.
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral).

- 2 Clinic Referral
Inpatient: The patient was admitted to this facility 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 Managed Care Plan Referral
Inpatient: The patient was admitted to this facility upon the recommendation of a Managed Care Plan physician.
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a Managed Care Plan physician.
- 4 Transfer from a Hospital
(different facility *)
Inpatient: The patient was admitted to this facility as a transfer from a different acute care facility where they were an inpatient
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility.
* For transfers from hospital inpatient in the same facility, see code D.
- 5 Transfer from a SNF
Inpatient: The patient was admitted to this facility 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 was an inpatient.
- 6 Transfer from Another Health Care Facility
Inpatient: The patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a non-skilled 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 they are an inpatient.
- 7 Emergency Room
Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency

		room physician.
		Outpatient: The patient received services in this facility's emergency department.
8	Court/Law Enforcement	Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency 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 to this facility is not known. Outpatient: For Medicare outpatient bills, this is not a valid code.
A	Transfer from a Critical Access Hospital (CAH)	Inpatient: The patient was admitted to this facility as a transfer from a CAH 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 CAH where the patient was 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	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer	The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
E-Z		Reserved for national assignment.

75.2 - Form Locators 16-30

(Rev.1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

FL 16 – Discharge Hour

Not Required.

FL 17 – Patient Status

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

Code	Structure
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01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care.
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05). Usage Note: Cancer hospitals excluded from Medicare PPS and children’s hospitals are examples of such other types of institutions.
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).
07	Left against medical advice or discontinued care
08	Reserved for National Assignment
*09	Admitted as an inpatient to this hospital
10-19	Reserved for National Assignment
20	Expired (or did not recover - Religious Non Medical Health Care Patient)
21-29	Reserved for National Assignment
30	Still patient or expected to return for outpatient services
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)

Code	Structure
43	Discharged/transferred to a federal health care facility. (effective 10/1/03) <u>Usage note:</u> Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration (VA) hospital or VA hospital or a VA nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
44-49	Reserved for national assignment
50	Discharged/transferred to Hospice - home
51	Discharged/transferred to Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)
67-99	Reserved for national assignment

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

FLs 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28 - Condition Codes

Situational. The provider enters the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period.

Code	Title	Definition
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Code	Title	Definition
02	Condition is Employment Related	Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment.
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed	The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance	Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 30 months of end stage renal disease entitlement.
07	Treatment of Non-terminal Condition for Hospice Patient	The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	The beneficiary would not provide information concerning other insurance coverage. The FI develops to determine proper payment.
09	Neither Patient Nor Spouse is Employed	In response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that

Code	Title	Definition
		covers the patient.
11	Disabled Beneficiary But no Large Group Health Plan (LGHP)	In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. The CMS will assign as needed for FI use. Providers will not report.
15	Clean Claim Delayed in CMS's Processing System (Medicare Payer Only Code)	The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to CPE/CPT standards.
16	SNF Transition Exemption (Medicare Payer Only Code)	An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
17	Patient is Homeless	The patient is homeless.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits that does not have his/her father's last name.
20	Beneficiary Requested Billing	Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)
21	Billing for Denial Notice	The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility	Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole	(Sole Community Hospitals only). The

Code	Title	Definition
	Community Hospital for a Diagnostic Laboratory Test	patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part time employees; or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time - Day)	Patient declares that they are enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that they are enrolled in a cooperative/work study program.

Code	Title	Definition
33	Patient is a Student (Full-Time - Night)	Patient declares that they are enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that they are enrolled as a part-time student.
Accommodations		
35	Reserved for National Assignment	Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available. Accommodation charges for this period are at the prevalent semi-private rate.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) The patient was assigned to ward accommodations at their own request.
38	Semi-private Room Not Available	(Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private accommodations were not available.
NOTE: If revenue charge codes indicate a ward accommodation was assigned and neither code 37 nor code 38 applies, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, Medicare pays semi-private costs.		
39	Private Room Medically Necessary	(Not used by hospitals under PPS.) The patient needed a private room for medical reasons.
40	Same Day Transfer	The patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization	The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).
42	Continuing Care Not Related	Continuing care plan is not related to the

Code	Title	Definition
	to Inpatient Admission	condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Post Discharge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. (Note: For Medicare, the change in patient status from inpatient to outpatient is made prior to discharge or release <u>while the patient is still a patient of the hospital</u>).
45		Reserved for national assignment
46	Non-Availability Statement on File	A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.
47		Reserved for TRICARE
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a “TRICARE – authorized” psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49	Product replacement within product lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product replacement for known recall of a product	Manufacturer or FDA has identified the product for recall and therefore replacement.
51-54		Reserved for national assignment

Code	Title	Definition
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	The patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Managed Care Organization Enrollee	Code indicates that patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
59	Non-primary ESRD Facility	Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. Effective 10/01/04
60	Operating Cost Day Outlier	Day Outlier obsolete after FY 1997. (Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. The FI indicates the cost outlier portion paid value code 17.
61	Operating Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI indicates the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Bill was paid under PIP. The FI records this from its system.
63	Payer Only Code	Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b)

Code	Title	Definition
		for payment
64	Other Than Clean Claim	(Not reported by providers.) The claim is not "clean." The FI records this from its system.
65	Non-PPS Bill	(Not reported by providers.) Bill is not a PPS bill. The FI records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Cost Outlier Payment	The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	The beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	The beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/DGME/N&A Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health.
70	Self-Administered Anemia Management Drug	Code indicates the billing is for a home dialysis patient who self administers an anemia management drug such as erythropoetin alpha (EPO) or darbepoetin alpha.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis

Code	Title	Definition
		services at home.
75	Home 100-percent	Not used for Medicare.
76	Back-up In-Facility Dialysis	The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by Managed Care Plan	The bill is for a newly covered service under Medicare for which a managed care plan does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off-Site	Physical therapy, occupational therapy, or speech pathology services were provided off-site.
80	Home Dialysis-Nursing Facility	Home dialysis furnished in a SNF or Nursing Facility.
81-99		Reserved for National assignment.

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

A0	TRICARE External Partnership Program	Not used for Medicare.
A3	Special Federal Funding	This code is for uniform use by State uniform billing committees.
A5	Disability	This code is for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment	Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services.

Code	Title	Definition
A7-A8		Reserved for national assignment
A9	Second Opinion Surgery	Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
AA	Abortion Performed due to Rape	Self-explanatory – Effective 10/1/02
AB	Abortion Performed due to Incest	Self-explanatory – Effective 10/1/02
AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Self-explanatory – Effective 10/1/02
AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself	Self-explanatory – Effective 10/1/02
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory – Effective 10/1/02
AF	Abortion Performed due to Emotional/psychological Health of the Mother	Self-explanatory – Effective 10/1/02
AG	Abortion Performed due to Social Economic Reasons	Self-explanatory – Effective 10/1/02
AH	Elective Abortion	Self-explanatory – Effective 10/1/02
AI	Sterilization	Self-explanatory – Effective 10/1/02
AJ	Payer Responsible for Copayment	Self-explanatory – Effective 4/1/03
AK	Air Ambulance Required	For ambulance claims. Air ambulance required – time needed to transport poses a threat – Effective 10/16/03
AL	Specialized Treatment/bed	For ambulance claims. Specialized treatment/bed unavailable. Transported to

Code	Title	Definition
	Unavailable	alternate facility. – Effective 10/16/03
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective 10/16/03
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening. Effective 1/1/04
AO-AZ		Reserved for national assignment
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.
B1	Beneficiary is Ineligible for Demonstration Program	Full definition pending
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the Ambulance Fee Schedule
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable Law. – Effective 10/16/03
B4	Admission Unrelated to Discharge	Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004. Effective January 1, 2005
B5-BZ		Reserved for national assignment

QIO Approval Indicator Codes

C1	Approved as Billed	Claim has been reviewed by the QIO and has been fully approved including any outlier.
C3	Partial Approval	The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as code “M0” in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code “77” in FL 36 or code “46” in FL 39-41).

Code	Title	Definition
C4	Admission Denied	The patient's need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.
C5	Post-payment Review Applicable	Any medical review will be completed after the claim is paid.
C6	Preadmission/Pre-procedure	The QIO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
C8-CZ		Reserved for national assignment
Claim Change Reasons		
D0	Changes to Service Dates	Self-explanatory
D1	Changes to Charges	Self-explanatory
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Changes In ICD-9-CM Diagnosis and/or Procedure Code	Use for inpatient acute care hospital, long-term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF).
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a 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	Self-explanatory

Code	Title	Definition
	Secondary Payer	
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory
DA – DQ		Reserved for national assignment
DR	Disaster related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
DS – DZ		Reserved for national assignment
E0	Change in Patient Status	Self-explanatory
E1 – FZ		Reserved for national assignment
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.
G1 – GZ		Reserved for national assignment
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.
H1-LZ		Reserved for national assignment

Code	Title	Definition
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.
M1-MZ		Reserved for national assignment
N0-OZ		Reserved for national assignment
P0-PZ		Reserved for national assignment. FOR PUBLIC HEALTH DATA REPORTING ONLY
Q0-VZ		Reserved for national assignment.
W0	United Mine Workers of America (UMWA) Demonstration Indicator	United Mine Workers of America (UMWA) Demonstration Indicator ONLY
W1-ZZ		Reserved for national assignment.

FL 29 – Accident State

Not used. Data entered will be ignored.

FL 30 - (Untitled)

Not used. Data entered will be ignored.

75.3 - Form Locators 31-41

(Rev.1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

FLs 31, 32, 33, and 34 - Occurrence Codes and Dates

Situational. Required when there is a condition code that applies to this claim.

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

Due to the varied nature of Occurrence and Occurrence Span Codes, provisions have been made to allow the use of both type codes within each. The Occurrence Span Code can contain an occurrence code where the “Through” date would not contain an entry. This allows as many as 10 Occurrence Codes to be utilized. With respect to Occurrence Codes, complete field 31a - 34a (line level) before the “b” fields. Occurrence and Occurrence Span codes are mutually exclusive. An example of Occurrence Code use: A Medicare beneficiary was confined in hospital from January 1, 2005 to January 10, 2005, however, his Medicare Part A benefits were exhausted as of January 8, 2005, and he was

not entitled to Part B benefits. Therefore, Form Locator 31 should contain code A3 and the date 010805.

The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved. Occurrence and occurrence span codes are mutually exclusive. When FLs 36 A and B are fully used with occurrence span codes, FLs 34a and 34b and 35a and 35b may be used to contain the “From” and “Through” dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span “From” dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span “Through” date is in the date field. Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

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

Code	Title	Definition
01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
02	No-Fault Insurance Involved - Including Auto Accident/Other	Date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Date of an accident resulting from a third party’s action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Date of an accident that relates to the patient’s employment.
05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08		Reserved for national assignment.

Code	Title	Definition
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.
11	Onset of Symptoms/Illness	(Outpatient claims only.) Date that the patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual (CDI)	(HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.
13-15		Reserved for national assignment
16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).
17	Date Outpatient Occupational Therapy Plan Established or Reviewed	The date the occupational therapy plan was established or last reviewed.
18	Date of Retirement Patient/Beneficiary	Date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision.
21	UR Notice Received	(Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary.
22	Date Active Care Ended	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

Code	Title	Definition
		tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period. For FI Use Only. Providers Do Not Report.	Code is not required if code "21" is used.
24	Date Insurance Denied	Date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available	The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	The date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date CORF Plan Established or Last Reviewed	The date a plan of treatment was established or last reviewed for CORF care.
29	Date OPT Plan Established or Last Reviewed	The date a plan was established or last reviewed for OPT.
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	The date a plan was established or last reviewed for outpatient speech pathology.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date the hospital notified the beneficiary that the beneficiary does not (or no longer) requires inpatient care and that coverage has ended.
32	Date Beneficiary Notified of Intent to Bill (Procedures or	The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be

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

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

Code	Title	Definition
		payer A.
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as "Split Bill Date"). Effective 10/1/03.
A5-AZ		Reserved for national assignment
B1	Birth Date-Insured B	The birth-date of the individual in whose name the insurance is carried.
B2	Effective Date-Insured B Policy	The first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer B.
B4-BZ		Reserved for national assignment
C1	Birth Date-Insured C	The birth-date of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	The first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer C.
C4-CZ		Reserved for National Assignment.
D0-DQ		Reserved for National Assignment.
DR		Reserved for Disaster Related Code
DS-DZ		Reserved for National Assignment
E0		Reserved for National Assignment
E1	Birth Date-Insured D	Discontinued 3/1/07.
E2	Effective Date-Insured D Policy	Discontinued 3/1/07.

Code	Title	Definition
E3	Benefits Exhausted	Discontinued 3/1/07.
E4-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Birth Date-Insured E	Discontinued 3/1/07.
F2	Effective Date-Insured E Policy	Discontinued 3/1/07.
F3	Benefits Exhausted	Discontinued 3/1/07.
F4-FZ		Reserved for national assignment
G0		Reserved for national assignment
G1	Birth Date-Insured F	Discontinued 3/1/07.
G2	Effective Date-Insured F Policy	Discontinued 3/1/07.
G3	Benefits Exhausted	Discontinued 3/1/07.
G4-LZ		Reserved for national assignment
M0-MQ		See instructions in FLs 35 and 36 – Occurrence Span Codes and Dates
MR		Reserved for Disaster Related Code
MS-ZZ		Reserved for national assignment

FLs 35 and 36 - Occurrence Span Code and Dates

Required For Inpatient.

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

Code Structure

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for

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

Code	Title	Definition
		patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability- Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay

Code	Title	Definition
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5-ZZ		Reserved for National Assignment

FL 37 - (Untitled)

Not used. Data entered will be ignored.

FL 38 - Responsible Party Name and Address

Not Required. For claims that involve payers of higher priority than Medicare.

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

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

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line “a” through line “d.” The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second). **Note that codes 80-83 are only available for use on the UB-04.**

Code	Title	Definition
01	Most Common Semi-Private Rate	To provide for the recording of hospital’s most common semi-private rate.
02	Hospital Has No Semi-Private Rooms	Entering this code requires \$0.00 amount.
03		Reserved for national assignment
04	Inpatient Professional Component Charges Which Are Combined Billed	The sum of the inpatient professional component charges that are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all-inclusive rate hospitals.)

Code	Title	Definition
05	Professional Component Included in Charges and Also Billed Separately to Carrier	<p>(Applies to Part B bills only.) Indicates that the charges shown are included in billed charges FL 47, but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the carrier processes the bill for physician's services. These charges are also deducted when computing interim payment.</p> <p>The hospital uses this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.</p>
06	Medicare Part A and Part B Blood Deductible	<p>The product of the number of un-replaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each un-replaced pint furnished.</p> <p>If all deductible pints have been replaced, this code is not to be used.</p> <p>When the hospital gives a discount for un-replaced deductible blood, it shows charges after the discount is applied.</p>
07		Reserved for National Assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	<p>The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. The provider may not use this code on Part B bills.</p> <p>For Part B coinsurance use value codes A2, B2 and C2.</p>

Code	Title	Definition
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. The provider uses this code only on bills spanning 2 calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. The provider uses this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. It may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other

Code	Title	Definition
		insurer has denied coverage or there has been a substantial delay in its payment. If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
15	Worker's Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
16	PHS, Other Federal Agency	That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. NOTE: A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).
17	Operating Outlier Amount	(Not reported by providers.) The FI reports the amount of operating outlier payment made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.
18	Operating Disproportionate Share Amount	(Not reported by providers.) The FI reports the operating disproportionate share amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital DSH adjustment in this entry.
19	Operating Indirect Medical Education Amount	(Not reported by providers.) The FI reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It

Code	Title	Definition
		does not include any PPS capital IME adjustment in this entry.
20	Payer Code	(For internal use by third party payers only.)
21	Catastrophic	Medicaid-eligibility requirements to be determined at State level.
22	Surplus	Medicaid-eligibility requirements to be determined at State level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at State level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at State level.
25	Offset to the Patient-Payment Amount – Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount – Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount – Vision and Eye Services	Vision and eye services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount – Dental Services	Dental services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount – Chiropractic Services	Chiropractic Services paid for out of a long term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
31	Patient Liability Amount	The FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients

Code	Title	Definition
		transported.
33	Offset to the Patient-Payment Amount – Podiatric Services	Podiatric services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount – Other Medical Services	Other medical services paid for out of a long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount – Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident/patient’s funds in the billing period submitted (Statement Covers Period).
36		Reserved for national assignment.
37	Pints of Blood Furnished	The total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.
38	Blood Deductible Pints	The number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of Blood Replaced	The total number of pints of blood that were donated on the patient’s behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a “replacement deposit fee” for un-replaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by Managed Care Plan	(For inpatient service only.) Inpatient charges covered by the Managed Care Plan. (The hospital uses this code when the bill includes inpatient

Code	Title	Definition
		charges for newly covered services that are not paid by the Managed Care Plan. It must also report condition codes 04 and 78.)
41	Black Lung (BL)	That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
42	Veterans Affairs (VA)	That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill.
43	Disabled Beneficiary Under Age 65 With LGHP	That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
44	Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received	That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due.
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, indicating that the QIO has denied all or a portion of this

Code	Title	Definition
		billing period, the provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient's post discharge. The field contains one numeric digit.
47	Any Liability Insurance	That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer's payment.
48	Hemoglobin Reading	<i>The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.</i>
49	Hematocrit Reading	<i>The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.</i>
50	Physical Therapy Visits	The number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	The number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	The number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.

Code	Title	Definition
54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law.
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse – Home Visit Hours (HHA only)	The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.)
57	Home Health Aide – Home Visit Hours (HHA only)	The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (The number is rounded to the nearest whole hour.)

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

						1	3		
--	--	--	--	--	--	---	---	--	--

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

58	Arterial Blood Gas (PO2/PA2)	Indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. The provider reports right justified in the cents area. (See note following code 59 for an example.)
59	Oxygen Saturation (O2 Sat/Oximetry)	Indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the

fourth month's bill. The hospital reports right justified in the cents area. (See note following this code for an example.)

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

								5	7
--	--	--	--	--	--	--	--	---	---

A reading of 100 percent is shown as:

								1	0	0
--	--	--	--	--	--	--	--	---	---	---

Code	Title	Definition
60	HHA Branch MSA	The MSA in which HHA branch is located. (The HHA reports the MSA when its branch location is different than the HHA's main location – It reports the MSA number in dollar portion of the form locator, right justified to the left of the dollar/cents delimiter.)
61	Location Where Service is Furnished (HHA and Hospice)	MSA number or Core Based Statistical Area (CBSA) number (or rural State code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter. For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.
62	HH Visits – Part A (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by <u>§1812(a)(3)</u> of the Social Security Act.
63	HH Visits – Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to

Code	Title	Definition
	(Internal Payer Use Only)	reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
64	HH Reimbursement – Part A (Internal Payer Use Only)	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
65	HH Reimbursement – Part B (Internal Payer Use Only)	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
66	Medicare Spend-down Amount	The dollar amount that was used to meet the recipient’s spend-down liability for this claim.
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. The provider counts only the hours spent in the home, excluding travel time. It reports in whole hours, right justifying to the left of the dollar/cent delimiter. (Rounded to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Indicates the number of units of EPO administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0		
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Code Title Definition

69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of ESRD Networks	(For third party payer use only.) The FI reports the amount the Medicare payment was reduced to help fund ESRD networks.
72	Flat Rate Surgery Charge	(For third party payer use only.) The standard charge for outpatient surgery where the provider has such a charging structure.
73-75	Payer Codes	(For use by third party payers only.)
76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0
--	--	--	--	--	---	---	---	---

Code	Title	Definition
77	Medicare New Technology Add-On Payment	Code indicates the amount of Medicare additional payment for new technology.
78-79	Payer Codes	Codes reserved for internal use only by third party payers. The CMS assigns as needed. Providers do not report payer codes.

Code	Title	Definition
80	Covered days	The number of days covered by the primary payer as qualified by the payer.
81	Non-Covered Days	Days of care not covered by the primary payer.
82	Co-insurance Days	The inpatient Medicare days occurring after the 60 th day and before the 91 st day or inpatient SNF/Swing Bed days occurring after the 20 th and before the 101 st day in a single spell of illness.
83	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.
84-99		Reserved for national assignment.
A0	Special Zip Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.
A4	Covered Self-Administrable Drugs – Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin

Code	Title	Definition
		administered to a patient in a diabetic coma. For use with Revenue Code 0637. See The Medicare Benefit Policy Manual).
A5	Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05)
A9	Patient Height	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05)
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.

Code	Title	Definition
		Effective 10/16/2003
AC-B0		Reserved for national assignment.
B1	Deductible Payer B	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.
B3	Estimated Responsibility Payer B	Amount the provider estimates will be paid by the indicated payer.
B4-B6		Reserved for national assignment
B7	Co-payment Payer B	The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer.
B8-B9		Reserved for national assignment
BA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer B	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated
BC-C0		Reserved for national assignment
C1	Deductible Payer C	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
C2	Coinsurance Payer C	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use

Code	Title	Definition
		Value Codes 8-11.
C3	Estimated Responsibility Payer C	Amount the provider estimates will be paid by the indicated payer.
C4-C6		Reserved for national assignment
C7	Co-payment Payer C	The amount the provider assumes is applied to the patient's co-payment amount involving the indicated payer.
C8-C9		Reserved for national assignment
CA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer C	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
CC-CZ		Reserved for national assignment
D0-D2		Reserved for national assignment
D3	Patient Estimated Responsibility	The amount estimated by the provider to be paid by the indicated patient
D4-DQ		Reserved for national assignment
DR		Reserved for disaster related code
DS-DZ		Reserved for national assignment
E0-Y0		Reserved for national assignment
Y1	Part A Demonstration Payment	This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No

Code	Title	Definition
Y2	Part B Demonstration Payment	deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
Y3	Part B Coinsurance	This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ		Reserved for national assignment

75.5 - Form Locators 43-81

(Rev.1254, Issued: 05-25-07, Effective: 06-11-07, Implementation: 06-11-07)

FL 43 - Revenue Description

Not Required. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. “Other” code categories 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 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or non-routine 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 80, Remarks.)

FL 44 - HCPCS/Rates/HIPPS Rate Codes

Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.

Health Insurance Prospective Payment System (HIPPS) Rate Codes

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the “Grouper” software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a casemix group and assigns the correct RUG code. The AIs were developed by CMS.

The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HCPCS Modifiers (Level I and Level II)

The UB-04 accommodates up to four modifiers, two characters each. See AMA publication CPT 200x (x= to current year) Current Procedural Terminology Appendix A - HCPCS Modifiers Section: “Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use”. Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

Claims for home health (HH), inpatient skilled nursing facility (SNF), swing bed providers and inpatient rehabilitation facilities (IRF) enter the HIPPS code here where applicable. RHC/FQHC encounters billed on TOBs 071x or 073x do not require HCPCS coding. The complete list of HIPPS codes for use on SNF, swing bed, IRF and HH claims can be accessed at the following Web site:
http://new.cms.hhs.gov/PropMedicareFeeSvcPmtGen/02_HIPPSCodes.asp.

FL 45 - Service Date

Required Outpatient. 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 on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the “from” and “through” dates are equal. This change is due to a HIPAA requirement.

Inpatient claims for skilled nursing facilities and swing bed providers enter the assessment reference date (ARD) here where applicable.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date. Assessment Date – used for billing SNF PPS (Bill Type 021X).

FL 46 - Units of Service

Required. Generally, the entries in this column quantify services by revenue code 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 - 0100s - 0150s, 0200s, 0210s (days)
- Blood pints - 0380s (pints)
- DME - 0290s (rental months)
- Emergency room - 0450, 0452, and 0459 (HCPCS code definition for visit or procedure)
- Clinic - 0510s and 0520s (HCPCS code definition for visit or procedure)
- Dialysis treatments - 0800s (sessions or days)
- Orthotic/prosthetic devices - 0274 (items)
- Outpatient therapy visits - 0410, 0420, 0430, 0440, 0480, 0910, and 0943 (Units are equal to the number of times the procedure/service being reported was performed.)

- Outpatient clinical diagnostic laboratory tests - 030X-031X (tests)
- Radiology - 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS code definition of tests or services)
- Oxygen - 0600s (rental months, feet, or pounds)
- Drugs and Biologicals- 0636 (including hemophilia clotting factors)

The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.

For RHCs or FQHCs, a “visit” is defined as a face-to-face encounter between a clinic/center patient, and one of the certified RHC or FQHC health professionals. Encounters with more than one health professional, and encounters with the same health professional which take place on the same day and at a single location constitute a single “visit,” except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

EXAMPLE 1

A known diabetic visits the provider on the morning on May 1 and sees the physician assistant. The physician assistant believes an adjustment in current medication is required, but wishes to have the clinic’s physician, who will be present in the afternoon, check the determination. The patient returns in the afternoon and sees the physician, who revises the prescribed medication. The physician recommends that the patient return the following week, on May 8, for a fasting blood sugar analysis to check the response to the change in medication. In this situation, the provider bills the Medicare program for one visit. Also, it includes a line item charge for laboratory services for May 1.

EXAMPLE 2

A patient visits the provider on July 1 complaining of a sore throat, and sees the physician assistant. The physician assistant examines the patient, takes a throat culture and requests that the patient return on July 8 for a follow-up visit to the physician assistant. In this situation, the provider bills the Medicare program for two visits. Also, it includes an entry for laboratory.

FL 47 - Total Charges - Not Applicable for Electronic Billers

Required. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is “0001” which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The 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 components 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, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The FI determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where “gross” billing is used, the FI adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the carrier to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.

FL 48 - Noncovered Charges

Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49 - (Untitled)

Not used. Data entered will be ignored.

Note: the “PAGE ____ OF ____” and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A, B, and C - Payer Identification

Required. If Medicare is the primary payer, the provider must enter “Medicare” on line A. Entering Medicare indicates that the provider has developed for other insurance and 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 line B or C as appropriate. Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on a Home Health Agency Request for Anticipated Payment (RAP). A = Primary Payer, B = Secondary Payer, and C = Tertiary Payer. For example: If “Medicare” is entered in Form Locator 50A, this indicates that the provider has determined based on the responses from the patient or the patient’s representative or from the insurance enrollment card information that Medicare is the primary payer. In the UB-04, there are a number of value codes to indicate various reasons and amounts associated with insurance or other payers that are primary to Medicare (e.g., Form Locators 39-41, Codes 12, 13, 14, 15, 16, 41, 42, and 43). These value codes are analogous to “Payer Codes” (A, B, D, E, F, H, I, and G respectively). When applicable, use these value codes so they are consistent with the associated payer codes (both are required).

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID

Report the national health plan identifier when one is established;

otherwise report the “number” Medicare has assigned.

FLs 52A, B, and C - Release of Information Certification Indicator

Required. A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

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

FL 53A, B, and C - Assignment of Benefits Certification Indicator

Not used. Data entered will be ignored.

FLs 54A, B, and C - Prior Payments

Situational. For all services other than inpatient hospital or SNF the provider must enter the sum of any amounts collected from the patient toward deductibles (cash and blood) and/or coinsurance on the patient (fourth/last line) of this column. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as non-covered by Medicare. Thus, for example, if total inpatient hospital charges were \$350.00 including \$50.00 for a deductible pint of blood, the hospital would apportion \$300.00 to the Part A deductible and \$50.00 to the blood deductible. Blood is treated the same way in both Part A and Part B. Part A home health DME cost sharing amounts collected from the patient are reported in this item.

FL 55A, B, and C - Estimated Amount Due From Patient

Not required.

FL 56 – National Provider ID (NPI)

Required, effective May 23, 2007.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)

Situational. Use this field to report other provider identifiers as assigned by a health plan (as indicated in FL50 lines 1-3) prior to May 23, 2007.

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 must enter the patient’s name as shown on the HI card or other Medicare notice. All additional entries across line A (FLs 59-66) pertain to the person named in Item 58A. The instructions that follow explain when to complete these items.

The provider must enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and it 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 conditional payment. If that person is the patient, the provider enters “Patient.” Payers of higher priority than Medicare include:
- EGHPs for employed beneficiaries and spouses age 65 or over;
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period of up to 12 months;
- LGHPs for disabled beneficiaries;
- An auto-medical, no-fault, or liability insurer; or
- WC including BL.

FL 59A, B, and C - Patient’s Relationship to Insured

Required. If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Effective October 16, 2003

Code	Title
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

FLs 60A, B, and C – Insured’s Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN))

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 HICN, i.e., if Medicare is the primary payer, it enters this information in FL 60A. It shows the number as it appears on the patient’s HI Card, Certificate of Award, Medicare Summary Notice, or as reported by the Social Security Office.

If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP for the patient or the patient's spouse or during the first year of ESRD entitlement), it shows the involved claim number for that coverage on the appropriate line.

FL 61A, B, and C - Insurance Group Name

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C - Insurance Group Number

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63 - Treatment Authorization Code

Situational. Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever QIO review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

FL 64 – Document Control Number (DCN)

Situational. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 - Employer Name

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

FL 66 – Diagnosis and Procedure code Qualifier (ICD Version Indicator)

Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision. **Medicare does not accept ICD-10 codes. Medicare only processes ICD-9 codes.**

FL 67 - Principal Diagnosis Code

Required. The hospital enters the ICD code for the principal diagnosis. The code **must** be the full ICD diagnosis code, including all five digits where applicable. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of "V" codes. Where the proper code has fewer than five digits, the hospital may not fill with zeros. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital

enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a DRG and cause the hospital to be incorrectly paid under PPS. The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported (7862). If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis (4660). When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:

- Routine general medical examination (V700);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V709); and
- Examination of ears and hearing (V721).

NOTE: Diagnosis codes are not required on nonpatient claims for laboratory services where the hospital functions as an independent laboratory.

FLs 67A-67Q - Other Diagnosis Codes

Inpatient Required. The hospital enters the full ICD 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. It may **not** duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. If the principal diagnosis is duplicated, the FI will remove the duplicate diagnosis before the record is processed by GROUPER for IPPS claims. The MCE identifies situations where the principal diagnosis is duplicated for IPPS claims.

Outpatient - Required. The hospital enters the full ICD codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

NOTE: Medicare will ignore data submitted in 67I – 67Q.

FL 68

Not used. Data entered will be ignored.

FL 69 - Admitting Diagnosis

Required. For inpatient hospital claims subject to QIO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. This definition is not the same as that for SNF admissions.

FL70A – 70C - Patient's Reason for Visit

Situational. Patient's Reason for Visit is required for all un-scheduled outpatient visits for outpatient bills.

FL71 – Prospective Payment System (PPS) Code

Not used. Data entered will be ignored.

FL72 - External Cause of Injury (ECI) Codes

Not used. Data entered will be ignored.

FL 73

Not used. Data entered will be ignored.

FL 74 - Principal Procedure Code and Date

Situational. Required on inpatient claims when a procedure was performed. Not used on outpatient claims.

FL 74A – 74E - Other Procedure Codes and Dates

Situational. Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.

FL 75

Not used. Data entered will be ignored.

FL 76 - Attending Provider Name and Identifiers (including NPI)

Situational. Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient’s medical care and treatment reported in this claim/ encounter.

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FL 77 - Operating Provider Name and Identifiers (including NPI)

Situational. Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FLs 78 and 79 - Other Provider Name and Identifiers (including NPI)

Situational. The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

Provider Type Qualifier Codes/Definition/Situational Usage Notes:

DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.

ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send.

82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FL 80 - Remarks

Situational. For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's FI may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)

FL 81 - Code-Code Field

Situational. To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

Code List Qualifiers:

01-A0 Reserved for National Assignment

A1 National Uniform Billing Committee Condition Codes – not used for Medicare

A2 National Uniform Billing Committee Occurrence Codes – not used for Medicare

A3 National Uniform Billing Committee Occurrence Span Codes – not used for Medicare

A4 National Uniform Billing Committee Value Codes – not used for Medicare

A5 - B0 Reserved for National Assignment

B3 Health Care Provider Taxonomy Code

Code Source: ASC X12 External Code Source 682 (National Uniform Claim Committee)

B4-ZZ Reserved for National Assignment