CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 311 | **Date: OCTOBER 8, 2004**

CHANGE REQUEST 3417

NOTE: This Transmittal replaces Transmittal 303, dated September 24, 2004. We are adding condition code 59 that was omitted in error. All other information remains the same.

SUBJECT: Instructions for Completion of Form CMS-1450

I. SUMMARY OF CHANGES: Chapter 25 is being revised to remove sections 20 and 30. The information in these sections was moved to Chapter 24 as part of CR 3443. Section 60 is being revised to clarify Form Locators (FL) 8 Non-covered days, FL 22 Patient Status Code, and FL 42 Revenue Codes. FL 24-30 Condition Codes and FL 39-41 Value Codes are being updated to include one new condition code and two new value codes approved by the National Uniform Billing Committee.

NEW/REVISED MATERIAL: EFFECTIVE DATE: January 3, 2005
IMPLEMENTATION DATE: January 5, 2005

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

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
D	25/20/Health Insurance Portability and Accountability Act (HIPAA) Health Care and Coordination of Benefits
D	25/30/Coordination of Benefits
R	25/60/General Instructions for Completion of Form CMS-1450 for Billing

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements

	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 311	Date: October 8, 2004	Change Request 3417

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SUBJECT: Instructions for Completion of Form CMS-1450

I. GENERAL INFORMATION

A. Background: The National Uniform Billing Committee (NUBC) has approved the use of new value codes with the effective date of January 1, 2005.

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 is the vehicle used to collect claims' information for payment.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3417.1	The intermediary shall notify its providers of the UB-92 changes.	X	X							

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3417.2	The intermediary shall accept the following value codes (FL 39-41) • A8 Weight • A9 Height	X				X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 3, 2005 **Implementation Date:** January 5, 2005 **Pre-Implementation Contact(s):** Jean Harris, Jharris2@cms.hhs.gov, 410-786-6168 **Post-Implementation Contact(s):** Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

60 - General Instructions for Completion of Form CMS-1450 for Billing

(Rev. 311, Issued: 10-08-04, Effective: 01-03-05, Implementation: 01-05-05)

This section contains Medicare requirements for use of codes maintained by the National Uniform Billing Committee that are needed in completion of the Form CMS-1450 and compliant X12N 837 version 4010A1 institutional claims.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. If required data is omitted, the FI obtains it from the provider or other sources and maintains it on its history record. The FI need not search paper files to annotate missing data unless it does not have an electronic history record. It need not obtain data that is not needed to process the claim.

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

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the hard copy UB-92 or Form CMS-1450, this simply means that the FI accepts claims of up to 9 pages. For the electronic format (the UB-92 Flat File), the new requirements are described on the CMS Web page at http://cms.hhs.gov/providers/edi/ub92v6.rtf.

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

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

Required. The minimum entry is the provider 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 - (Untitled)

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

FL 3 - 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 4 - Type of Bill

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

Code Structure

1st Digit-Type of Facility

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

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

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.
5. Intermediate Care - Level I
6. Intermediate Care - Level II
7. Sub acute Inpatient (Revenue Code 019X required)
8. Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9. Reserved for National Assignment

2nd Digit-Classification (Clinics Only)

1. Rural Health Clinic (RHC)

2. Hospital Based or Independent Renal Dialysis Facility
3. Free Standing Provider-Based Federally Qualified Health 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

2nd Digit-Classification (Special Facilities Only)

1. Hospice (Nonhospital Based)
2. Hospice (Hospital Based)
3. Ambulatory Surgical Center Services to Hospital Outpatients
4. Free Standing Birthing Center
5. Critical Access Hospital
6-8. Reserved for National Assignment
9. OTHER

3rd Digit-Frequency - Definition

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-Other	Used to identify adjustments initiated by other entities. For FI use only.

K	OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For FI use only.
M	MSP Initiated Adjustment Claim	Used to identify adjustments initiated by MSP. For FI use only. Note: MSP takes precedence over other adjustment sources.
P	QIO Adjustment Claim	Used to identify an adjustment initiated as a result of a QIO review. For FI use only.
0	Nonpayment/Zero Claims	Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care.
1	Admit Through Discharge Claim	The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2	Interim-First Claim	Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. For HHAs, used for the submission of original or replacement RAPs.
3	Interim-Continuing Claims (Not valid for PPS Bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4	Interim-Last Claim (Not valid for PPS Bills)	This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL 6) is the discharge for this treatment.
5	Late Charge Only	Used for outpatient claims only. Late charges are not accepted for Medicare inpatient, home health, or Ambulatory Surgical Center (ASC) claims.
7	Replacement of Prior Claim	This is used to correct a previously submitted bill. The provider applies this code to the corrected or "new" bill.
8	Void/Cancel of a Prior Claim	The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.

9	Final Claim for a Home Health PPS Episode	This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

Bill Type Codes and Allowable Provider Numbers

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		Provider Number Range(s)
11X	Hospital Inpatient (Part A)	0001-0879, 1225-1299, *1300-1399*, 2000-2499, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999
12X	Hospital Inpatient Part B	Same as 11X
13X	Hospital Outpatient	Same as 11X
14X	Hospital Other Part B	Same as 11X
18X	Hospital Swing Bed	U001-U999, W001-W999, Y001-Y999, Z001-Z999
21X	SNF Inpatient	5000-6499
22X	SNF Inpatient Part B	5000-6499
23X	SNF Outpatient	5000-6499
28X	SNF Swing Bed	5000-6499
32X	Home Health	7000-7999, 8000-8499, 9000-9499
33X	Home Health	7000-7999, 8000-8499, 9000-9499
34X	Home Health (Part B Only)	7000-7999, 8000-8499, 9000-9499
41X	Religious Nonmedical Health Care Institutions	1990-1999
71X	Clinical Rural Health	3400-3499, 3800-3999, 8500-8999
72X	Clinic ESRD	2300-2399, 3500-3799
73X	Federally Qualified Health Centers	1800-1989
74X	Clinic OPT	6500-6989
75X	Clinic CORF	3200-3299, 4500-4599, 4800-4899
76X	Community Mental Health Centers	1400-1499, 4600-4799, 4900-4999
81X	Nonhospital based hospice	1500-1799
82X	Hospital based hospice	1500-1799
83X	Hospital Outpatient (ASC)	Same as 11X
85X	Critical Access Hospital	1300-1399

FL 5 - Federal Tax Number

Not Required.

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 - Covered Days

Required for inpatient. The provider enters the total number of covered days during the billing period applicable to the cost report, including lifetime reserve days elected for which it requested Medicare payment. This should be the total of accommodation units reported in FL 46. It excludes any days classified as non-covered as defined in FL 8, leave of absence days, and the day of discharge or death.

If the FI makes an adverse coverage decision, it enters the number of covered days through the last date for which program payment can be made. If "Limitation on Liability" provisions apply, see Chapter 30.

The provider may not deduct any days for payment made under Workers Compensation (WC), automobile medical, no-fault, liability insurance, an EGHP for an ESRD beneficiary, employed beneficiaries and spouses age 65 or over or a LGHP for disabled beneficiaries. The FI calculates utilization based upon the amount Medicare will pay and makes the necessary utilization adjustment. (See Chapter 28.)
See Chapter 3 for the special situations requiring that no program payment bills show an entry of covered days in FL 7.

See Chapter 3 if the hospital is being paid under PPS.

The FI enters the number of days shown in this FL in the cost report days field on the UB-92 CWF record. However, when the other insurer has paid in full, the FI enters zero days in the utilization days on the UB-92 CWF record. For MSP cases only, it calculates utilization based upon the amount Medicare pays and enters the utilization days chargeable to the beneficiary in the utilization days field on the UB-92 CWF record. For a discussion of how to determine whether part of a day is covered, see Chapter 3.

FL 8 – Non-covered Days

Required for inpatient. The provider enters the total number of non-covered days in the billing period that it **cannot** claim as Medicare patient days on the cost report; and that Medicare will not charge to the beneficiary as utilization of Part A services.
Non-covered days include:

- Days for which no Part A payment can be made because the services rendered were furnished without cost or will be paid for by the VA. (See Chapter 28.)
- Days for which no Part A payment can be made because payment will be made under a National Institutes of Health grant;
- *Days after the date covered services ended, such as non-covered level of care, or emergency services after the emergency has ended in non-participating institutions;*
- Days for which no Part A payment can be made because the patient was on a leave of absence and was not in the hospital.
- Days for which no Part A payment can be made because a hospital whose provider agreement has terminated, expired, or been cancelled may be paid only for covered inpatient services during the limited period following such termination, expiration, or cancellation. All days after the expiration of the

period are non-covered. See Chapter 3 for determining the effective date of the limited period and for billing for Part B services; and

- Days after the time limit when utilization is not chargeable because the beneficiary is at fault. (See Chapter 28.)

The hospital must give a brief explanation of any non-covered days not described in the occurrence codes in FL 84. It must show the number of days for **each** category of non-covered days (e.g., "5 leave days").

NOTE: Day of discharge or death is not counted as a non-covered day.

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

The hospital must always bill laboratory tests (revenue codes 0300-0319) net for outpatient or inpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The FI will inform the hospital whether to bill net or gross for each revenue center other than lab.

The hospital must bill the physician component in all cases to the carrier to obtain payment for physician's services.

FL 9 - Coinsurance Days

Required for inpatient. The provider enters the total number of covered inpatient hospital days occurring after the 60th day and before the 91st day or the number of covered inpatient SNF days occurring after the 20th day and before the 101st day of the benefit period as shown for this billing period.

FL 10 - Lifetime Reserve Days

Required. Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The hospital must notify the patient of the patient's right to elect not to use lifetime reserve days before billing the program for inpatient hospital services furnished after the 90th day in the spell of illness.

See Chapter 3 for special considerations in election of lifetime reserve days when paid under PPS.

FL11 - (Untitled)

Not Required. This is one of 7 fields that have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 12 - Patient's Name

Required. The provider enters the patient's last name, first name, and, if any, middle initial.

FL 13 - 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 14 - Patient's Birth Date

Required. The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If it does not obtain the date of birth after reasonable efforts, it zero fills the field.

FL 15 - Patient's Sex

Required. The provider enters an "M" for male or an "F" for female. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16 - Patient's Marital Status

Not Required for for Medicare claims but must accept all valid values under HIPAA.

Valid Values are :
S=Single
M=Married
P=Life Partner
X=Legally Separated
D=Divorced
W=Widowed
U=Unknown

FL 17 - 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 (MM-DD-YY).

FL 18 - Admission Hour

Not Required.

FL 19 - 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 – Visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.

FL 20 – Source of Admission

Required For Inpatient Hospital. The provider enters the code indicating the source of this admission or outpatient registration.

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

1	Physician Referral	**Inpatient**: The patient was admitted 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	HMO Referral	**Inpatient**: The patient was admitted to this facility upon the recommendation of a HMO physician. **Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a HMO physician.
4	Transfer from a Hospital	**Inpatient**: The patient was admitted to this facility as a transfer from an 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 another acute care facility.
5	Transfer from a SNF	**Inpatient**: The patient was admitted to this facility as a transfer from a SNF where they were an inpatient.

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

FL 21 – Discharge Hour

Not Required.

FL22 – Patient Status

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

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital *for inpatient care.*
03	Discharged/transferred to SNF-see Code 61 below
04	Discharged/transferred to an ICF
05	Discharged/transferred to a *non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care.* *Usage Note: A Medicare distinct part unit/facility must meet certain Medicare requirements and is exempt from the inpatient Prospective Payment System; children's hospitals and cancer hospitals are two examples. Other distinct part units/facilities types have specific patient status codes:* • *Skilled Nursing Facilities (various codes* • *Inpatient rehabilitation facilities (IRF) including rehabilitation distinct part units of a hospital (code 62)* • *Medicare certified long term care hospitals (LTCH) (code 63)* • *Psychiatric hospitals or psychiatric distinct part units of a hospital (code 65)*
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
*09	Admitted as an inpatient to this hospital
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)
43	Discharged/transferred to a Federal hospital (effective for discharges after October 1, 2003) *Usage Note: Applies to discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides 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

Code	Structure
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.
66-70	Reserved for national assignment
71	Discharged/transferred to another institution for outpatient services (discontinued effective October 1, 2003)
72	Discharged/transferred to this institution for outpatient services (discontinued effective October 1, 2003)
73-99	Reserved for national assignment

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

FL 23 - Medical Record Number

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

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

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

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

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

Code	Title	Definition
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits that does not have its father's last name.
20	Beneficiary Requested Billing	Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)
21	Billing for Denial Notice	The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility	Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
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

Code	Title	Definition
		and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time - Day)	Patient declares that they are enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that they are enrolled in a cooperative/work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that they are enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that they are enrolled as a part-time student.
Accommodations		
35	Reserved for National Assignment	Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available. Accommodation charges for this period are at the prevalent semi-private rate.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) The patient was assigned to ward accommodations at their own request. This must be supported by a written request in the provider's files. (See the Benefit Policy Manual, Chapter 1.)
38	Semi-private Room Not Available	(Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private accommodations were not available.

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

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) The patient needed a private room for medical reasons.
40	Same Day Transfer	The patient was transferred to another participating Medicare provider before midnight on the day of admission.

Code	Title	Definition
41	Partial Hospitalization	The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol). (See the Benefit Policy Manual, Chapter 6 for a description of coverage.)
42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Post Discharge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. Effective April 1, 2004
45		Reserved for national assignment
46	Non-Availability Statement on File	A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.
47		Reserved for TRICARE
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49-54		Reserved for national assignment
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	The patient previously received Medicare covered SNF care within 30 days of the

Code	Title	Definition
		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) 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

Code	Title	Definition
		Education/Nursing and Allied Health.
70	Self-Administered Epoetin (EPO)	The billing is for a home dialysis patient who self-administers EPO.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis services at home.
75	Home 100-percent	(Not to be used for services Payment furnished 4/16/90, or later.) The bill is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100-percent program.
76	Back-up In-Facility Dialysis	The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by *the Primary Payer* as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	The bill is for a newly covered service under Medicare for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off-Site	Physical therapy, occupational therapy, or speech pathology services were provided off-site.
80-99		Reserved for state assignment. Discontinued Effective October 16, 2003.

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A3	Special Federal Funding	This code is for uniform use by State uniform

Code	Title	Definition
		billing committees.
A5	Disability	This code is for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment	Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services.
A7		*Reserved for national assignment (Discontinued 10/1/02)*
A8	Induced Abortion - Victim of Rape/Incest	Self-explanatory. Discontinued 10/01/02 *Reserved for national assignment*
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
AA	Abortion Performed due to Rape	Self-explanatory – Effective 10/1/02
AB	Abortion Performed due to Incest	Self-explanatory – Effective 10/1/02
AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Self-explanatory – Effective 10/1/02
AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself	Self-explanatory – Effective 10/1/02
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory – Effective 10/1/02
AF	Abortion Performed due to Emotional/psychological Health of the Mother	Self-explanatory – Effective 10/1/02
AG	Abortion Performed due to Social Economic Reasons	Self-explanatory – Effective 10/1/02
AH	Elective Abortion	Self-explanatory – Effective 10/1/02
AI	Sterilization	Self-explanatory – Effective 10/1/02
AJ	Payer Responsible for Copayment	Self-explanatory – Effective 4/1/03
AK	Air Ambulance Required	For ambulance claims. Air ambulance required – time needed to transport poses a threat – Effective 10/16/03
AL	Specialized Treatment/bed Unavailable	For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate facility. – Effective 10/16/03
AM	Non-emergency Medically Necessary Stretcher Transport	For ambulance claims. Non-emergency medically necessary stretcher transport

Code	Title	Definition
	Required	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*
M0-M9	Payer Only Codes	
M0	All-Inclusive Rate for Outpatient	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Code indicates the influenza virus vaccine or pneumococcal pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.
QIO Approval Indicator Codes		
C1	Approved as Billed	Claim has been reviewed by the QIO and has been fully approved including any outlier.
C3	Partial Approval	The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	The patient's need for inpatient services was reviewed and the QIO found that none of the

Code	Title	Definition
		stay was medically necessary.
C5	Post-payment Review Applicable	Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/Pre-procedure	The QIO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
Claim Change Reasons		
D0	Changes to Service Dates	Self explanatory
D1	Changes to Charges	Self explanatory
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Changes In *ICD-9-CM Diagnosis and/or Procedure Code*	Use for inpatient acute care hospital, *long-term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF).*
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory
E0	Change in Patient Status	Self-explanatory
E1 – E9		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

Code	Title	Definition
		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.
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.
X0-ZZ		Reserved for state assignment. Discontinued, Effective October 16, 2003.

FL 31 - (Untitled)

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

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

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

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

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

Occurrence span codes have values from 70 through 99 and M0 through Z9.

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

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

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

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

Code	Title	Definition
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. (See the Financial Management Manual, Chapter 3.)
21	UR Notice Received	(Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See Chapter 3.)
22	Date Active Care Ended	(SNF claims only.) Date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period. For	Code is not required if code "21" is used.

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

Code	Title	Definition
		which the hospital is billing for immunosuppressive drugs. **NOTE:** When the patient received a covered and a non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant	The date of discharge for an inpatient hospital stay during which the patient received a non-covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs.
38	Date treatment started for Home IV Therapy	Date the patient was first treated at home for IV therapy (Home IV providers - bill type 85X).
39	Date discharged on a continuous course of IV therapy	Date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers- bill type 85X).
40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test was performed as a part of a PAT program. This code may be used only if a date of admission was scheduled prior to the administration of the test(s).
42	Date of Discharge	(Hospice claims only.) The date on which a beneficiary terminated their election to receive hospice benefits from the facility rendering the bill. See Chapter 11. The frequency digit (3rd digit, FL 4, Type of Bill) should be 1 or 4.
43	Scheduled Date of Cancelled Surgery	The date for which ambulatory 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

Code	Title	Definition
		to allow coverage of additional daily charges for the purpose of making cost outlier payments.
48-49	Payer Codes	For use by third party payers only. The CMS assigns for FI use. Providers do not report these codes.
50-69		Reserved for State Assignment. Discontinued Effective October 16, 2003.
A1	Birth Date-Insured A	The birth-date of the insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy	The first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer A.
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-DZ		Reserved for National Assignment.
E0		Reserved for national assignment
E1	Birth date-Insured D	The birth date of the individual in whose name the insurance is carried.
E2	Effective Date-Insured D Policy	A code indicating the first date insurance is in force.
E3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer D.

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

FL 36 - Occurrence Span Code and Dates

Required For Inpatient.

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

Code Structure

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Non-utilization Dates (For Payer Use on Hospital Bills Only)	The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates	(Part A claims only.) The From/Through dates given by the patient of any hospital stay

Code	Title	Definition
		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 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

Code	Title	Definition
		hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36. (See Chapter 1)
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5-WZ		Reserved for National Assignment
X0-ZZ		Reserved for state assignment. Discontinued, effective October 16, 2003

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

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

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

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

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

Required. Code(s) and related dollar *or unit* amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.
If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Code	Title	Definition
01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital Has No Semi-Private Rooms	Entering this code requires $0.00 amount.
03		Reserved for national assignment
04	Inpatient Professional Component Charges Which Are Combined Billed	The sum of the inpatient professional component charges that are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. **(Used only by some all-inclusive rate hospitals.)**
05	Professional Component Included in Charges and Also Billed Separately to Carrier	(Applies to Part B bills only.) Indicates that the charges shown are included in billed charges FL 47, but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the carrier processes the bill for physician's services. These charges are also deducted when computing interim payment. The hospital uses this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.

Code	Title	Definition
06	Medicare Part A and Part B Blood Deductible	The product of the number of un-replaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each un-replaced pint furnished. If all deductible pints have been replaced, this code is not to be used. When the hospital gives a discount for un-replaced deductible blood, it shows charges after the discount is applied.
07		Reserved for national assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission. (See Chapter .3)
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. (See Chapter 3.) The provider may not use this code on Part B bills. For Part B coinsurance use value codes A2, B2 and C2.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. The provider uses this code only on bills spanning 2 calendar years when lifetime reserve days were used in the

Code	Title	Definition
		year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. The provider uses this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. It may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. (See Chapter 28.) If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it

Code	Title	Definition
		enters the amount that would have been payable had it filed a proper claim
15	Worker's Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. (See Chapter 28.). Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
16	PHS, Other Federal Agency	That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. ***NOTE:*** A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).
17	Operating Outlier Amount	(Not reported by providers.) The FI reports the amount of operating outlier payment made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.
18	Operating Disproportionate Share Amount	(Not reported by providers.) The FI reports the operating disproportionate share amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital DSH adjustment in this entry.
19	Operating Indirect Medical Education Amount	(Not reported by providers.) The FI reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.
20	Payer Code	(For internal use by third party payers only.)
21	Catastrophic	Medicaid-eligibility requirements to be determined at state level.
22	Surplus	Medicaid-eligibility requirements to be determined at state level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be

Code	Title	Definition
		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 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

Code	Title	Definition
		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. (See Chapter 3.) Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by HMO	(For inpatient service only.) Inpatient charges covered by the HMO. (The hospital uses this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO. It must also report condition codes 04 and 78.)
41	Black Lung (BL)	That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See

Code	Title	Definition
		Chapter 28.)
42	Veterans Affairs (VA)	That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. (Any payment must conform to Chapter 28.)
43	Disabled Beneficiary Under Age 65 With LGHP	That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.)
44	Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received	That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due. (See Chapter 28.)
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.
46	Number of Grace Days	If a code “C3” or “C4” is in FL 24-30, indicating that the QIO has denied all or a portion of this billing period, the provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient’s post discharge. The field contains one numeric digit.
47	Any Liability Insurance	That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer’s payment. (See Chapter 28.)

Code	Title	Definition
48	Hemoglobin Reading	The latest hemoglobin reading taken during this billing cycle. The provider reports in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, it uses the position to the right of the delimiter for the third digit.
49	Hematocrit Reading	The latest hematocrit reading taken during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, the provider uses the position to the right of the delimiter for the third digit.
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.
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

Code	Title	Definition
		dollars/cents delimiter. (The number is rounded to the nearest whole hour.)

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

					1	3		

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

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

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

						5	7

A reading of 100 percent is shown as:

					1	0	0

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

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

Code	Title	Definition
68	Number of Units of EPO Provided During the Billing Period	Indicates the number of units of EPO administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0		

Code	Title	Definition
69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of ESRD Networks	(For third party payer use only.) The FI reports the amount the Medicare payment was reduced to help fund ESRD networks.
72	Flat Rate Surgery Charge	(For third party payer use only.) The standard charge for outpatient surgery where the provider has such a charging structure.
73-74	Payer Codes	(For use by third party payers only.)
75	Gramm/Rudman/Hollings	(For third party payer internal use only.) The contractor reports the amount of sequestration.
76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					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.
80-99		Reserved for state use. Discontinued, Effective October 16, 2003.
A0	Special Zip Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.

Code	Title	Definition
A4	Covered Self-Administrable Drugs - Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. For use with Revenue Code 0637. See The Medicare Benefit Policy Manual, Chapter 6.)
A5	Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's *co-payment* amount involving the indicated payer.
A8	*Patient Weight*	*Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05)*
A9	*Patient Height*	*Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05)*
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003

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

Code	Title	Definition
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
CC-CZ		Reserved for national assignment
D0-D2		Reserved for national assignment
D3	Estimated Responsibility Patient	Amount the provider estimates will be paid by the indicated patient.
D4-DZ		Reserved for national assignment
E0		Reserved for national assignment
E1	Deductible Payer D	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
E2	Coinsurance Payer D	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
E3	Estimated Responsibility Payer D	Amount the provider estimates will be paid by the indicated payer.
E4-E6		Reserved for national assignment
E7	Co-payment Payer D	The amount the provider assumes will be applied toward the patient's *co-payment* amount involving the indicated payer.
E8-E9		Reserved for national assignment
EA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer D	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
EB	Other Assessments or Allowances (e.g., Medical Education) Payer D	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
EC-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Deductible Payer E	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
F2	Coinsurance Payer E	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
F3	Estimated Responsibility Payer E	Amount the provider estimates will be paid by the indicated payer.
F4-F6		Reserved for national assignment
F7	Co-payment Payer E	The amount the provider assumes will be applied toward the patient's *co-payment* amount involving the indicated payer.

Code	Title	Definition
F8-F9		Reserved for national assignment
FA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer E	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
FB	Other Assessments or Allowances (e.g., Medical Education) Payer E	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
FC-FZ		Reserved for national assignment
G0		Reserved for national assignment
G1	Deductible Payer F	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
G2	Coinsurance Payer F	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.
G3	Estimated Responsibility Payer F	Amount the provider estimates will be paid by the indicated payer.
G4-G6		Reserved for national assignment
G7	Co-payment Payer F	The amount the provider assumes will be applied toward the patient's *co-payment* amount involving the indicated payer.
G8-G9		Reserved for national assignment
GA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer F	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
GB	Other Assessments or Allowances (e.g., Medical Education) Payer F	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
GC-GZ		Reserved for national assignment
H0-WZ		Reserved for national assignment
X0-ZZ		Reserved for national assignment

FL42 - Revenue Code

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

To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.
The biller must provide detail level coding for the following revenue code series:

0290s - Rental/purchase of DME
0304 - Renal dialysis/laboratory
0330s - Radiology therapeutic
0367 - Kidney transplant
0420s - Therapies
0520s - Type or clinic visit (RHC or other)
0550s - 590s - home health services
0624 - Investigational Device Exemption (IDE)
0636 - Hemophilia blood clotting factors
0800s - 0850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

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

NOTE: RHCs and FQHCs, in general, use revenue codes 052X and 091X with appropriate subcategories to complete the Form CMS-1450. The other codes provided are not generally used by RHCs and FQHCs and are provided for informational purposes. Those applicable are: 0025-0033, 0038-0044, 0047, 0055-0059, 0061, 0062, 0064-0069, 0073-0075, 0077, 0078, and 0092-0095.

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

0304 - rental and dialysis/laboratory,
0636 - hemophilia blood clotting factors,
0800s thru 0850s - ESRD services.
The remaining applicable codes are 0025, 0027, 0031-0032, 0038-0039, 0075, and 0082-0088.

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

The Hospice uses the following revenue codes to bill Medicare:

Code	Description	Standard Abbreviation
0651*	Routine Home Care	RTN Home

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

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

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

Revenue Code	Description
0001	Total Charge For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, FIs report the total charge in the appropriate data segment/field
001X	Reserved for Internal Payer Use
002X	Health Insurance Prospective Payment System (HIPPS)

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

003X to 006X	Reserved for National Assignment
007X to 009X	Reserved for State Use until October 16, 2003. Thereafter, Reserved for National Assignment

ACCOMMODATION REVENUE CODES (010X - 021X)

010X	All Inclusive Rate

Revenue Code	Description

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

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

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

Routine service charges for single bedrooms.

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

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

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

Routine service charges incurred for accommodations with two beds.

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

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

013X Semi-private - three and Four Beds (Medical or General)

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

Subcategory	Standard Abbreviations
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED

Revenue Code	Description	
	2 - OB	OB/3&4 BED
	3 - Pediatric	PEDS/3&4 BED
	4 - Psychiatric	PSYCH/3&4 BED
	5 - Hospice	HOSPICE/3&4 BED
	6 - Detoxification	DETOX/3&4 BED
	7 - Oncology	ONCOLOGY/3&4 BED
	8 - Rehabilitation	REHAB/3&4 BED
	9 - Other	OTHER/3&4 BED
014X	Private - (Deluxe) (Medical or General)	
	Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ROOM-BOARD/ PVT/DLX
	1 - Medical/Surgical/Gyn	MED-SUR-GY/ PVT/DLX
	2 - OB	OB/ PVT/DLX
	3 - Pediatric	PEDS/ PVT/DLX
	4 - Psychiatric	PSYCH/ PVT/DLX
	5 - Hospice	HOSPICE/ PVT/DLX
	6 - Detoxification	DETOX/ PVT/DLX
	7 - Oncology	ONCOLOGY/ PVT/DLX
	8 - Rehabilitation	REHAB/ PVT/DLX
	9 - Other	OTHER/ PVT/DLX
015X	Room & Board - Ward (Medical or General)	
	Routine service charges incurred for accommodations with five or more beds. Rationale: Most third party payers require ward accommodations to be identified.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	ROOM-BOARD/WARD
	1 - Medical/Surgical/Gyn	MED-SUR-GY/ WARD
	2 - OB	OB/ WARD
	3 - Pediatric	PEDS/ WARD
	4 - Psychiatric	PSYCH/ WARD
	5 - Hospice	HOSPICE/ WARD
	6 - Detoxification	DETOX/ WARD
	7 - Oncology	ONCOLOGY/ WARD
	8 - Rehabilitation	REHAB/ WARD
	9 - Other	OTHER/ WARD
016X	Other Room & Board (Medical or General)	
	Any routine service charges incurred for accommodations that cannot be included in the more specific revenue center codes	

Revenue Code **Description**

Rationale: Provides the ability to identify services as required by payers or individual institutions.
Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

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

017X Nursery

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

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

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

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

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

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

018X Leave of Absence

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

NOTE: Charges are billable for codes 2 - 5.

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

Revenue Code	Description	
	5 - Hospitalization	LOA/HOSPITALIZATION Effective 4/1/04
	9 - Other Leave of Absence	LOA/OTHER

019X Sub-acute Care

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

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

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

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

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

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

020X Intensive Care

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

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

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

Revenue Code	Description

021X Coronary Care

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

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

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

Code Description

ANCILLARY REVENUE CODES (022X - 099X)

022X Special Charges

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

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

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

023X Incremental Nursing Care Charges

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

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

024X All Inclusive Ancillary

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

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

Revenue Code	Description

charges.

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

025X Pharmacy

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

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

Subcategory	Standard Abbreviations
0 – General Classification	PHARMACY
1 – Generic Drugs	DRUGS/GENERIC
2 - Non-generic Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Nonprescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other DRUGS/OTHER	DRUGS/OTHER

026X IV Therapy

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

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

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

Revenue Code	Description	
	4 - IV Therapy/Supplies	IV THER/SUPPLIES
	9 - Other IV Therapy	IV THERAPY/OTHER
027X	Medical/Surgical Supplies (Also see 062X, an extension of 027X)	
	Code indicates charges for supply items required for patient care.	
	Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.	
	Subcategory	**Standard Abbreviations**
	0 – General Classification	MED-SUR SUPPLIES
	1 – Non--sterile Supply	NONSTER SUPPLY
	2 - Sterile Supply	STERILE SUPPLY
	3 - Take Home Supplies	TAKEHOME SUPPLY
	4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
	5 - Pace maker	PACE MAKER
	6 - Intraocular Lens	INTR OC LENS
	7 – Oxygen - Take Home	02/TAKEHOME
	8 - Other Implants	SUPPLY/IMPLANTS
	9 - Other Supplies/Devices	SUPPLY/OTHER
028X	Oncology	
	Code indicates charges for the treatment of tumors and related diseases.	
	Subcategory	**Standard Abbreviations**
	0 – General Classification	ONCOLOGY
	9 - Other Oncology	ONCOLOGY/OTHER
029X	Durable Medical Equipment (DME) (Other Than Rental)	
	Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).	
	Rationale: Medicare requires a separate revenue center for billing.	
	Subcategory	**Standard Abbreviations**
	0 – General Classification	MED EQUIP/DURAB
	1 – Rental	MED EQUIP/RENT
	2 - Purchase of new DME	MED EQUIP/NEW
	3 - Purchase of used DME	MED EQUIP/USED
	4 - Supplies/Drugs for DME Effectiveness (HHA's Only)	MED EQUIP/SUPPLIES/DRUGS
	9 - Other Equipment	MED EQUIP/OTHER
030X	Laboratory	
	Charges for the performance of diagnostic and routine clinical laboratory tests.	
	Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.	
	Subcategory	**Standard Abbreviations**
	0 – General Classification	LABORATORY or (LAB)
	1 - Chemistry	LAB/CHEMISTRY
	2 - Immunology	LAB/IMMUNOLOGY
	3 - Renal Patient (Home)	LAB/RENAL HOME
	4 – Non-routine Dialysis	LAB/NR DIALYSIS

Revenue Code	Description	
	5 - Hematology	LAB/HEMATOLOGY
	6 - Bacteriology & Microbiology	LAB/BACT-MICRO
	7 – Urology	LAB/UROLOGY
	9 - Other Laboratory	LAB/OTHER
031X	Laboratory Pathological	

Charges for diagnostic and routine laboratory tests on tissues and culture.
Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

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

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting radiographs and fluorographs.
Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify.

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

033X Radiology - Therapeutic

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

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

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

034X Nuclear Medicine

Revenue Code	Description

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.
Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify.

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

035X Computed Tomographic (CT) Scan

Charges for CT scans of the head and other parts of the body.
Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

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

036X Operating Room Services

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

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

037X Anesthesia

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

Revenue Code	Description
	diagnostic service as part of the charge for the diagnostic service.
	Subcategory — **Standard Abbreviations**
	0 - General Classification — ANESTHESIA
	1 - Anesthesia Incident to RAD — ANESTHE/INCIDENT RAD
	2 - Anesthesia Incident to Other Diagnostic Services — ANESTHE/INCIDENT ODX
	4 - Acupuncture — ANESTHE/ACUPUNC
	9 - Other Anesthesia — ANESTHE/OTHER
038X	Blood
	Rationale: Charges for blood must be separately identified for private payer purposes.
	Subcategory — **Standard Abbreviations**
	0 - General Classification — BLOOD
	1 - Packed Red Cells — BLOOD/PKD RED
	2 - Whole Blood — BLOOD/WHOLE
	3 – Plasma — BLOOD/PLASMA
	4 – Platelets — BLOOD/PLATELETS
	5 - Leucocytes — BLOOD/LEUCOCYTES
	6 - Other Components — BLOOD/COMPONENTS
	7 - Other Derivatives Cryopricipitates) — BLOOD/DERIVATIVES
	9 - Other Blood — BLOOD/OTHER
039X	Blood Storage and Processing
	Charges for the storage and processing of whole blood
	Subcategory — **Standard Abbreviations**
	0 - General Classification — BLOOD/STOR-PROC
	1 - Blood Administration (e.g., Transfusions — BLOOD/ADMIN
	9 - Other Processing and Storage — BLOOD/OTHER STOR
040X	Other Imaging Services
	Subcategory — **Standard Abbreviations**
	0 - General Classification — IMAGE SERVICE
	1 - Diagnostic Mammography — MAMMOGRAPHY
	2 - Ultrasound — ULTRASOUND
	3 - Screening Mammography — SCR MAMMOGRAPHY/GEN MAMMO
	4 - Positron Emission Tomography — PET SCAN
	9 - Other Imaging Services — OTHER IMAG SVS

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

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

041X Respiratory Services

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

Rationale: Permits identification of particular services.

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

042X Physical Therapy

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

Rationale: Permits identification of particular services.

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

043X Occupational Therapy

Revenue Code	Description

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

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

044X Speech-Language Pathology

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

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

045X Emergency Room

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

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

Subcategory	Standard Abbreviations
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical screening services	ER/EMTALA
2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA

Revenue Code **Description**

6 - Urgent Care URGENT CARE
9 - Other Emergency Room OTHER EMER ROOM

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

Usage Notes

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

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

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

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

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

046X Pulmonary Function

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

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

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

047X Audiology

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

Rationale: Permits identification of particular services.

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

048X Cardiology

Revenue Code	Description

Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.
Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

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

049X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by any other category.

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

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

050X Outpatient Services

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

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

051X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.
Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

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

052X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party

Revenue Code	Description

payers may require.

Subcategory	Standard Abbreviations
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice	FR/STD FAMILY CLINIC
6 - Urgent Care Clinic	FR/STD URGENT CLINIC
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

053X Osteopathic Services

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

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

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

054X Ambulance

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

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

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

055X Skilled Nursing

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

Subcategory	Standard Abbreviations
0 - General Classification	SKILLED NURSING

Revenue Code	Description	
	1 - Visit Charge	SKILLED NURS/VISIT
	2 - Hourly Charge	SKILLED NURS/HOUR
	9 - Other Skilled Nursing	SKILLED NURS/OTHER
056X	Medical Social Services	
	Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.	
	Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	MED SOCIAL SVS
	1 - Visit Charge	MED SOC SERV/VISIT
	2 - Hourly Charge	MED SOC SERV/HOUR
	9 - Other Med. Soc. Services	MED SOC SERV/OTHER
057X	Home Health Aide (Home Health)	
	Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.	
	Rationale: Necessary for Medicare home health billing requirements.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	AIDE/HOME HEALTH
	1 - Visit Charge	AIDE/HOME HLTH/VISIT
	2 - Hourly Charge	AIDE/HOME HLTH/HOUR
	9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER
058X	Other Visits (Home Health)	
	Code indicates charges by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.	
	Rationale: This breakdown is necessary for Medicare home health billing requirements.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	VISIT/HOME HEALTH
	1 - Visit Charge	VISIT/HOME HLTH/VISIT
	2 - Hourly Charge	VISIT/HOME HLTH/HOUR
	3 - Assessment	VISIT/HOME HLTH/ASSES
	9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER
059X	Units of Service (Home Health)	
	This revenue code is used by an HHA that bills on the basis of units of service.	
	Rationale: This breakdown is necessary for Medicare home health billing requirements.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	UNIT/HOME HEALTH
	9 - Home Health Other Units	UNIT/HOME HLTH/OTHER
060X	Oxygen (Home Health)	
	Code indicates charges by a home health agency for oxygen equipment supplies or contents, excluding purchased equipment.	

Revenue Code	Description

If a beneficiary had purchased a stationary oxygen system, oxygen concentrator or portable equipment, current revenue codes 0292 or 0293 apply. DME (other than oxygen systems) is billed under current revenue codes 0291, 0292, or 0293.
Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

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

061X Magnetic Resonance *Technology* (*MRT)*
Code indicates charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body.
Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

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

062X Medical/Surgical Supplies - Extension of 027X
Code indicates charges for supply items required for patient care. The category is an extension of 027X for reporting additional breakdown where needed. Subcode 1 is for hospitals that do not bill supplies used for radiology revenue codes as part of the radiology procedure charges. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

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

063X Pharmacy - Extension of 025X

Revenue Code	Description

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

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

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

064X Home IV Therapy Services

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

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

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

Revenue Code	Description

HCPCS code.

065X Hospice Services

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

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

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

066X Respite Care (HHA Only)

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

Subcategory	Standard Abbreviations
0 - General Classification	RESPITE CARE
1 – Hourly Charge/ Nursing	RESPITE/ NURSE
2 - Hourly Charge/ Aide/Homemaker/Companion	RESPITE/AID/HMEMKE/COMP
3 – Daily Respite Charge	RESPITE DAILY
9 - Other Respite Care	RESPITE/CARE

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

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

068X Trauma Response

Charges for a trauma team activation.

Subcategory	Standard Abbreviations
0 - Not Used	
1 - Level I	TRAUMA LEVEL I

Revenue Code	Description	
	2 - Level II	TRAUMA LEVEL II
	3 - Level III	TRAUMA LEVEL III
	4 - Level IV	TRAUMA LEVEL IV
	9 - Other Trauma Response	TRAUMA OTHER
	Usage Notes:	
	1. To be used by trauma center/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.	
	2. Revenue Category 068X is used for patients for whom a trauma activation occurred. A trauma team activation/response is a "Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival."	
	3. Revenue Category 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X revenue code reported.	
	4. Revenue Category 068X is not limited to admitted patients.	
	5. Revenue Category 068X must be used in conjunction with FL 19 Type of Admission/Visit code 05 ("Trauma Center"), however FL 19 Code 05 can be used alone.	
	Only patients for who there has been **pre-hospital** notification, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are "drive-by" or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.	
	6. Levels I, II, III or IV refer to designations by the state or local government authority or as verified by the American College of Surgeons.	
	7. Subcategory 9 is for sate or local authorities with levels beyond IV.	
069X	Not Assigned	
070X	Cast Room	
	Charges for services related to the application, maintenance and removal of casts.	
	Rationale: Permits identification of this service, if necessary.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	CAST ROOM
	9 - Other Cast Room	OTHER CAST ROOM
071X	Recovery Room	
	Rationale: Permits identification of particular services, if necessary.	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	RECOVERY ROOM
	9 - Other Recovery Room	OTHER RECOV RM
072X	Labor Room/Delivery	

Revenue Code	Description

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.
Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because not all third party payers cover it.

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

073X Electrocardiogram (EKG/ECG)

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

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

074X Electroencephalogram (EEG)

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

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

075X Gastro-Intestinal Services

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

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

076X Treatment or Observation Room

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

Revenue Code	Description

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

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

077X Preventative Care Services

Charges for the administration of vaccines.

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

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

.

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

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

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

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

080X Inpatient Renal Dialysis

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

Rationale: Specific identification required for billing purposes.

Subcategory	**Standard Abbreviations**
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT

Revenue Code	Description	
	2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
	3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
	4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
	9 – Other Inpatient Dialysis	DIALY/INPT/OTHER

081X Organ Acquisition

The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.
Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation.
Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

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

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

082X Hemodialysis - Outpatient or Home Dialysis

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.
Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

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

Revenue Code	Description

083X Peritoneal Dialysis - Outpatient or Home

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

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

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

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

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

085X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient

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

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

086X Reserved for Dialysis (National Assignment)

087X Reserved for Dialysis (*National* Assignment)

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

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

Revenue Code	Description	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	DIALY/MISC
	1 – Ultra-filtration	DIALY/ULTRAFILT
	2 - Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
	9 - Other Miscellaneous Dialysis	DIALY/MISC/OTHER
089X	Reserved for National Assignment	
090X	Behavior Health Treatments/Services (Also see 091X, an extension of 090X)	
	Subcategory	**Standard Abbreviations**
	0 - General Classification	BH
	1 - Electroshock Treatment	BH/ELECTRO SHOCK
	2 - Milieu Therapy	BH/MILIEU THERAPY
	3 - Play Therapy	BH/PLAY THERAPY
	4 - Activity Therapy	BH/ACTIVITY THERAPY
	5 – Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
	6 – Intensive Outpatient Services-Chemical Dependency	BH/INTENS OP/CHEM DEP
	7 – Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY
	8 – Reserved for National Use	
	9 – Reserved for National Use	
091X	Behavioral Health Treatment/Services-Extension of 090X	
	Code indicates charges for providing nursing care and professional services for emotionally disturbed patients. This includes patients admitted for diagnosis and those admitted for treatment.	
	Subcategories 0912 and 0913 are designed as zero-billed revenue codes (no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract.	
	Subcategory	**Standard Abbreviations**
	0 – Reserved for National Assignment	
	1 - Rehabilitation	BH/REHAB
	2 - Partial Hospitalization* - Less Intensive	BH/PARTIAL HOSP
	3 - Partial Hospitalization* - Intensive	BH/PARTIAL INTENSIVE
	4 - Individual Therapy	BH/INDIV RX
	5 - Group Therapy	BH/GROUP RX
	6 - Family Therapy	BH/FAMILY RX
	7 - Bio Feedback	BH/BIOFEED
	8 - Testing	BH/TESTING
	9 – Other Behavior Health Treatments/Services	BH/OTHER

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

Revenue Code	Description
092X	Other Diagnostic Services Code indicates charges for other diagnostic services not otherwise categorized.

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

093X Medical Rehabilitation Day Program

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

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

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

Code indicates charges for other therapeutic services not otherwise categorized.

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

095X Other Therapeutic Services-Extension of 094X

Charges for other therapeutic services not otherwise categorized

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

096X Professional Fees

Revenue Code	Description

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

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSYCH
2 - Ophthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fees	OTHER PRO FEE

097X Professional Fees - Extension of 096X

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

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

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

099X Patient Convenience Items

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

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviations
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 – Non-patient Room Rentals	NONPT ROOM RENT

Revenue Code	Description	
	6 - Late Discharge Charge	LATE DISCHARGE
	7 - Admission Kits	ADMIT KITS
	8 - Beauty Shop/Barber	BARBER/BEAUTY
	9 - Other Patient Convenience Items	PT CONVENCE/OTH

100X Behavioral Health Accommodations

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

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

101X TO 209X Reserved for National Assignment

210X Alternative Therapy Services

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

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

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

211X to 300X Reserved for National Assignment

310X Adult Care - Effective April 1, 2003

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

Subcategory	**Standard Abbreviations**
0 - Note Used	
1 - Adult Day Care, Medical and Social - Hourly	ADULT MED/SOC HR
2 - Adult Day Care, Social - Hourly	ADULT SOC HR
3 - Adult Day Care, Medical and Social - Day	ADULT MED/SOC DAY
4 - Adult Day Care, Social - Daily	ADULT SOC DAY
5 - Adult Foster Care - Daily	ADULT FOSTER CARE
9 – Other Adult Care	Other Adult

311X to 899X Reserved for National Assignment

9000 to 9044 Reserved for Medicare Skilled Nursing Facility Demonstration Project

9045 - 9099 Reserved for National Assignment

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 84, Remarks.)

FL 44 - HCPCS/Rates

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

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 71x or 73x 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: www.cms.hhs.gov/providers/hippscodes/.

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

FL 46 - Units of Service

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 l 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 l 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). **NOTE: Electronic Billers do not submit a revenue center code 0001.**

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 Required. This is one of three national fields that have not been assigned. Use of the field, if any, is assigned by the NUBC.

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. (See Chapter 28.) Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on a Home Health Agency Request for Anticipated Payment (RAP).

FL 51A, B, and C - Provider Number

Required. The provider enters the six position alpha-numeric "number" assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 52A, B, and C - Release of Information 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. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file. **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 Required.

FLs 54A, B, and C - Prior Payments

Required. 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 - (Untitled)

Previously reserved for State Use. Discontinued Effective October 16, 2003.

FL 57 - (Untitled)

Previously reserved for State Use. Discontinued Effective October 16, 2003.

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 as described in Chapter 28. 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 l2 months;
- LGHPs for disabled beneficiaries;
- An auto-medical, no-fault, or liability insurer; or
- WC including BL.

For more information, see Chapter 28.

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.

1. Effective Until October 16, 2003

Code	Title	Definition	Map to List II
01	Patient is Insured	Self-explanatory	18
02	Spouse	Self-explanatory	01
03	Natural Child/Insured Has Financial Responsibility	Self-explanatory	19
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory	43
05	Step Child	Self-explanatory	17
06	Foster Child	Self-explanatory	10
07	Ward of the Court	Patient is ward of the insured as a result of a court order.	15
08	Employee	Patient is employed by the insured.	20
09	Unknown	Patient's relationship to the insured is unknown.	None
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage	22
11	Organ donor	The bill is submitted for care given to an organ donor where such care is paid by the receiving patient's insurance coverage.	39
12	Cadaver donor	The bill is submitted for procedures performed on a cadaver donor where such procedures are paid by the receiving patient's insurance coverage.	40
13	Grandchild	Self-explanatory	05
14	Niece/Nephew	Self-explanatory	07
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.	41
16	Sponsored Dependent	Individual not normally covered by insurance coverage but	23

Code	Title	Definition	Map to List II
		coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer	
17	Minor Dependent of a Minor Dependent	Patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured	24
18	Parent	Self-explanatory	None
19	Grandparent	Self-explanatory	04
20	Life Partner	Patient is covered under insurance policy of his/her life partner (or similar designation, e.g., domestic partner, significant other)	29*, 53*
21-99		Reserved for national assignment	None

2. Effective October 16, 2003

Code	Title	Definition	Map to List I
01	Spouse	Self-explanatory	01
04	Grandfather or Grandmother		19
05	Grandson or Granddaughter		13
07	Nephew or Niece		14
10	Foster Child		06
15	Ward	Ward of the Court. The patient is a ward of the insured as a result of a court order.	07
17	Stepson or Stepdaughter		05
18	Self		01
19	Child		03
20	Employee		08
21	Unknown		09
22	Handicapped Dependent		10
23	Sponsored Dependent		16
24	Dependent of Minor Dependent		17
29	Significant Other		None*
32	Mother		None
33	Father		None

Code	Title	Definition	Map to List I
36	Emancipated Minor		None
39	Organ Donor		11
40	Cadaver Donor		12
41	Injured Plaintiff		15
43	Child Where Insured Has No Financial Responsibility		04
53	Life Partner		None*
G8	Other Relationship		None

* No 1:1 map for Significant Other and Life Partner.

FLs 60A, B, and C - 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

Required. 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

Required. 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

Required. 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 - Employment Status Code

Required. Where claiming payment under the circumstances described in FLs 58A, B, or C, the provider enters the appropriate code.

Code	Title	Definition
1	Employed Full Time	Individual claimed full-time employment.
2	Employed Part Time	Individual claimed part-time employment.
3	Not Employed	Individual states that they are not employed full time or part time
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for National Assignment
9	Unknown	Individual's Employment Status is Unknown

FL 65 - Employer Name

Required. 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 - Employer Location

Required. 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 specific location of the employer of the individual identified on the same line in FL 58. A specific location is the city, plant, etc., in which the employer is located.

FL 67 - Principal Diagnosis Code

Required for Bill Types 11X, 12X, and 13X.

Inpatient - Required. The hospital enters the ICD-9-CM code for the principal diagnosis. The code **must** be the full ICD-9-CM diagnosis code, including all five digits where applicable. 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.

Outpatient-Required. The hospital reports the full ICD-9-CM 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 (786.2). 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 (466.0).

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-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:

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

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

FLs 68-75 - Other Diagnosis Codes

Inpatient - Required. The hospital enters the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

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-9-CM codes in FLs 68-75 for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

FL 76 - Admitting Diagnosis/Patient's Reason for Visit

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.

FL 76 is a dual use field. Patient's Reason for Visit is required by Medicare for all un-scheduled outpatient visits for outpatient bills.

FL 77 - E-Code

Not Required.

FL 78 - (Untitled)

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

FL 79 - Procedure Coding Method Used

Not Required.

FL 80 - Principal Procedure Code and Date

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

For this item, surgery includes incision, excision, amputation, introduction, repair, destruction, endoscopy, suture, and manipulation. FIs review this item against FLs 42-47. Such review may alert them to non covered services or omissions.

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

The hospital shows the date of the principal procedure numerically as MMDDYY in the "date" portion.

The FI transmits to CMS the original codes reported by the provider, unless in the course of the claims development it restores contradictory correct codes.

FL 81 - Other Procedure Codes and Dates

Required for Inpatient Only. The hospital enters the full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable, for up to five significant procedures other than the principle procedure (shown in FL 80). It shows the date of each procedure numerically as MMDDYY in the "date" portion of FL 81, as applicable. It does not repeat procedures unless it does them more than once. The paper Form CMS-1450 accommodates only two other procedures. An additional three other procedures may be reported in Remarks. The FI's data entry screens will be capable of accepting the principle procedures and five other procedures. EMC formats include principle and five other procedures.

The FI transmits to CMS the original codes reported by the provider, unless in the course of the claims development it restores contradictory correct codes.

FL 82 - Attending/Requesting Physician ID

Required. The hospital enters the UPIN and name of the attending physician on inpatient bills or the physician that requested outpatient services. This requirement applies to inpatient bills (hospital and SNF Part A) with a "Through" date of January 1, 1992, or later, and to outpatient and other Part B bills with a "From" date of January 1, 1992, or later.

Inpatient Part A - The provider enters the UPIN and name of the attending physician. For hospital services the Uniform Hospital Discharge Data Set definition for attending physician is used. This is the clinician primarily responsible for the care of the patient from the beginning of the inpatient episode. For SNF services, i.e., swing bed, the attending physician is the practitioner who certifies the SNF plan of care. The provider enters the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Outpatient and Other Part B - The provider enters the UPIN and name of the physician that requested the surgery, therapy, diagnostic tests or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), the provider enters SLF000 in the first six positions, and does not enter a name.

Claim Where Physician Not Assigned a UPIN. - Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. The provider must use the following UPINs to report these physicians:

INT000	for each intern
RES000	for each resident
PHS000	for Public Health Service physicians, includes Indian Health Services
VAD000	for Department of Veterans Affairs physicians
RET000	for retired physicians
SLF000	for providers to report that the patient is self-referred
OTH000	for all other unspecified entities not included above.

SLF will be accepted except where the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 ID may be audited.

If referrals originate from physician-directed facilities (e.g., rural health clinics), the hospital enters the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.
If more than one referring physician is indicated, the provider enters the UPIN of the physician requesting the service with the highest charge.

FL 83 - Other Physician ID

Inpatient Part A Hospital

Required if a procedure is performed. The hospital enters the UPIN and name of the physician who performed the principal procedure. If no principal procedure is performed, the hospital enters the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, the hospital leaves this item blank. See FL 82 (inpatient) for specifications.

Outpatient Hospital

Required where the HCPCS code reported is subject to the Ambulatory Surgical Center (ASC) payment limitation or where a reported HCPCS code is on the list of codes the QIO furnishes that require approval. The hospital enters the UPIN and name of the operating physician using the format for inpatient reporting.

Other Bills

Not Required.

FL 84 - Remarks

Required. 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. (See Chapter 28 for appropriate 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 85 - Provider Representative Signature

Required on Hardcopy. A provider representative makes sure that the required physician's certification and recertifications are in the records before signing the form. A stamped signature is acceptable.

FL 86 - Date

Not Required. This is the date of the provider representative's signature.