Medicare Hospital Manual

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

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REFER TO CHANGE REQUEST 1762

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
460 (Cont.) - 460 (Cont.)	4-501 - 4-502 (2pp.)	4-501 - 4-502 (2pp.)
	4-507 - 4-522 (16pp.)	4-507 - 4-522 (16pp.)
	4-529 - 4-530 (2pp.)	4-529 - 4-530 (2pp.)
	4-535 - 4-536 (2pp.)	4-535 - 4-536 (2pp.)
	4-547 - 4-552 (6pp.)	4-547 - 4-552 (6pp.)
	4-552.3 - 4-552.8 (6pp.)	4-552.3 - 4-552.8 (6pp.)
	4-552.11 - 4-552.12 (2pp.)	4-552.11 - 4-552.12 (2pp.)
Addendum A (Cont.) - Addendum A (Cont.)	A-5 - A-6 (2pp.)	A-5 - A-6 (2pp.)
	A-17 - A-20 (4pp.)	A-17 - A-20 (4pp.)
	A-39 - A-42 (4pp.)	A-39 - A-42 (4pp.)
	A-51 - A-56 (6pp.)	A-51 - A-56 (6pp.)
Addendum B - Addendum B (Cont.)	B-1 - B- 2 (2pp.)	B-1 - B- 2 (2pp.)
	B-9 - B-12 (4pp.)	B-9 - B-12 (4pp.)
	B-17 - B-18 (2pp.)	B-17 - B-18 (2pp.)
	B-27 - B-28 (2pp.)	B-27 - B-28 (2pp.)
	B-31 - B-32 (2pp.)	B-31 - B-32 (2pp.)

MANUALIZATION--*EFFECTIVE DATE: Not Applicable*

This manual revision incorporates Change Request 1762, Medicare Intermediary Manual, Transmittal 1840, which was effective October 1, 2001 and the implementation was October 31, 2001.

Section 460, Completion of Form CMS-1450 for Inpatient and/or Outpatient Billing, is being update to include changes that have been made for the coding of the following: Form Locator (FL) 4 (Bill Type), FL 22 (Patient Status Code), FLs 24-30 (Condition Code), FLs 32-35 (Occurrence Codes), FL 36 (Occurrence Span Codes), FLs 39-41 (Value Codes), and FL 42 (Revenue Codes). FL 52, (Release of Information) and FL 76 (Admitting Diagnosis/Patient's Reason for Visit) have been updated. Revenue Code 0024 is effective January 1, 2002. All other codes are already being used.

Addendum A-Provider Electronic Billing File and Record Formats, adds version 6.0 of the UB-92 flat file format. Record Types (RT) 01 (Processor Data), RT50 (IP Accommodation Data), RT60 (IP Ancillary Services Data), RT61 (Outpatient Procedures), RT90 (Claims Control Screen), RT91 (Remarks), RT95 (Provider Batch Control), RT99 (File Control), and Coordination Of Benefits RTs, RT51 (IP Accommodations Line Item Remarks Codes), RT52 (Inpatient Accommodation Reason Codes), RT62 (Ancillary or Outpatient Line Item Remarks Codes), and RT63 (Ancillary or Outpatient Reason Codes) are included in the update.

Addendum B-Alphabetic Listing of Data Elements, adds several data definitions that were previously omitted from this section.

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

These instructions should be implemented within your current operating budget.

Uniform Billing

460. COMPLETION OF FORM -1450 FOR INPATIENT AND/OR OUTPATIENT BILLING

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on Form HCFA-1450 are described, but detailed information is given only for items required for Medicare claims.

This section details only the data elements which are required for Medicare billing. When billing multiple third parties, complete all items required by each payer who is to receive a copy.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

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

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is your 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. This is one of four State use fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's control number may be shown if you assign one and need 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 a "frequency" code.

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

1st Digit-Type of Facility
1 - Hospital
4 - Religious Non-Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit-Bill Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).

4 - Other - Part B - (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to nonpatients, and referenced diagnostic services).
7 - Subacute Inpatient (Revenue Code 19X 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
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center
7 - 8 Reserved for National Assignment
9 - OTHER

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

3rd Digit-Frequency	Definition
A - Hospice Admission Notice	Use when the hospice is submitting Form HCFA-1450 as an Admission Notice.
B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/ Revocation Notice	Use when the UB-92 is used as a Termination/ Revocation of a hospice, Medicare Coordinated Care Demonstration, or Religious Non-medical Health Care Institution election.
C - Hospice Change of Provider Notice	Use when Form HCFA-1450 is used as a Notice of Change to the hospice provider.
D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel	Use when the UB-92 is used as a Notice of a Void/ Cancel of a hospice Medicare Coordinated Care Demonstration Entity, or Religious Non-medical Health Care Institution election.
E - Hospice Change of Ownership	Use when Form HCFA-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 intermediary use only.
G - CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For intermediary use only.
H - CMS Initiated Adjustment Claim	Used to identify adjustments initiated by CMS. For intermediary use only.
I - Intermediary Adjustment Claim (Other Than Pro or Provider)	Used to identify adjustments initiated by the intermediary. For intermediary use only.

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 his or her personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Inpatient: The patient was admitted 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 he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.
5	Transfer from a SNF	Inpatient: The patient was admitted to this facility as a transfer from a SNF where he or she was an inpatient (including swing-beds and distinct part SNF). Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she is an inpatient.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility 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 nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where he or she is an inpatient.

7	Emergency Room	Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's emergency room physician.
8	Court/Law Enforcement	Inpatient: The patient was admitted 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 hospital is not known. Outpatient: For Medicare outpatient bills, this is not a valid code.
A	Transfer from a Critical Access Hospital (CAH)	Inpatient: The patient was admitted to this facility as a transfer from a CAH where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were he or she is an inpatient.

FL 21. Discharge Hour
Not Required.

FL22. Patient Status
Required. Enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting discharges/transfers to a non-certified SNF, use Code 04-ICF.)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharge/transferred to home under care of a home IV drug therapy provider
*09	Admitted as an inpatient to this hospital
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (Hospice claims only)

Code	Structure
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)
50	Hospice - home
51	Hospice - medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care

*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. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

FLs 24, 25, 26, 27, 28, 29, 30. Condition Codes
Required. Enter the corresponding code to describe any of the following conditions that apply to this billing period.

Code	Title	Definition
02	Condition is Employment Related	Enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from his employment. (See §289ff. for WC and BL.)
04	Patient is HMO Enrollee	Enter this code to indicate the patient is a member of an HMO. (See §310.)
05	Lien Has Been Filed	Enter this if you have 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 18 Months of Entitlement Covered By Employer Group Health Insurance	Enter this code if Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during his first 18 month of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice Patient	Enter this code to indicate the patient has elected hospice care, but you are not treating the patient for the terminal condition and are, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide you with information concerning other insurance coverage.

Code	Title	Definition
09	Neither Patient Nor Spouse is Employed	Enter this code to indicate that in response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Enter this code to indicate that 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 LGHP	Enter this code to indicate that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance will not report them.
12-16	Payer Codes	Codes reserved for internal use only by third party payers.
20	Beneficiary Requested Billing	Enter this code to indicate the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Enter this code to indicate you realize services are at a noncovered level of care or excluded, but you are 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	Enter this code if a 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). Enter this code to indicate the patient was referred for a diagnostic laboratory test. Use to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Enter this code to indicate that, in response to development questions, the patient and/or spouse have 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.

Code	Title	Definition
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Enter this code to indicate that in response to development questions, the patient and/or family member(s) have indicated that one or more are employed and there is group health insurance coverage under 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 that the employer has fewer than 100 full and part-time employees; or, (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time - Day)	Patient declares that he/she is enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that he/she is enrolled in a cooperative/work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that he/she is enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that he/she is enrolled as a part-time student.

ACCOMMODATIONS

Code	Title	Definition
35		Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Enter this code to indicate you 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	Enter this code if the patient was assigned to ward accommodations at his/her own request.
38	Semi-private Room Not Available	Enter this code to indicate that either private or ward accommodations were assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Enter this code if the patient needed a private room for medical necessity.

Code	Title	Definition
40	Same Day Transfer	Enter this code if the patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization	Enter this code when claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol). (See §§230.5C and D for coverage guidelines.)
42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Postdischarge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the postdischarge window.
55	SNF Bed Not Available	Enter this code to indicate the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Enter this code to indicate 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	Enter this code to indicate the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Medicare+ Choice Organization Enrollee	Enter this code to indicate the patient is a terminated enrollee in a Medicare+Choice Organization plan whose 3-day inpatient hospital stay was waived.
60-65	Payer Codes	(For use by third party payers only.)
66	Hospital Does Not Wish Cost Outlier Payment	Enter this code to indicate you are not requesting additional payment for this stay as a cost outlier. (Used only by hospitals paid under PPS.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	Enter this code to indicate that the beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use LTR Days	Enter this code to indicate that the beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/Payment Only Bill	Code indicates a hospital is requesting a supplemental payment consisting only of applicable IME for a Medicare managed care enrollee.

Code	Title	Definition
70	Self-Administered Epoetin (EPO)	Enter this code to indicate the billing is for a home dialysis patient who self-administers EPO.
7l	Full Care In Unit	Enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care In Unit	Enter this code to indicate the billing is for a patient who managed his/her own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Enter this code to indicate billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.
74	Home	Enter this code to indicate the billing is for a patient who received dialysis services at home.
75	Home 100-percent Payment	(Note to be used for services furnished 4/16/90, or later.) Enter this code to indicate the billing 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	Enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Enter this code to indicate you have accepted or are 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	Enter this code to indicate billing 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	Enter this code to indicate that physical therapy, occupational therapy, or speech pathology services were provided off-site.

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 has been designed for uniform use by State uniform billing committees.

Code	Title	Definition
A5	Disability	This code has been designed for uniform use by State uniform billing committees.
A6	Medicare Pneumococcal Pneumonia Vaccine (PPV); Influenza Virus Vaccine	This code identifies the services given that are to be paid under special Medicare program provisions.
A7	Induced Abortion-- Danger to Life	Abortion was performed to avoid danger to woman's life.
A8	Induced Abortion-- Victim Rape/Incest	Self-explanatory.
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
B0	Medicare Coordinated Care Demonstration Program	Patient is a participant in a Medicare Coordinated Care Demonstration.
M0-M9	Payer Only Codes	
M0	All-Inclusive Rate for Outpatient	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or PPV	Enter this code to indicate the influenza virus vaccine or PPV is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.
PRO Approval Indicator Codes		
C1	Approved as Billed	Enter this code to indicate claim has been reviewed by the PRO and has been fully approved including any day or cost outlier.
C3	Partial Approval	Enter this code to indicate the bill has been reviewed by the PRO and some portion (days or services) has been denied. From/Through dates of the approved portion of the stay are shown as code "MO" in FL 36. Exclude grace days and any period at a noncovered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	Enter this code to indicate patient's need for inpatient services was reviewed and the PRO found that none of the stay was medically necessary.
C5	Postpayment Review Applicable	Enter this code to indicate that 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.

Code	Title	Definition
C6	Preadmission/ Preprocedure	Enter this code to indicate that the PRO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The PRO 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	Self-explanatory.
D3	Second or Subsequent Interim PPS Bill	Self-explanatory.
D4	Change in GROUPER Input	Self-explanatory.
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.
H0	Delayed Filing, Statement Of Intent Submitted	Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
M0	All Inclusive Rate for Outpatient Services (Payer Only Code)	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

FL 31. (Untitled)
Not Required. This is one of three national use fields which has not been assigned. Use of the field, if any, is assigned by the NUBC.

FL 32, 33, 34, and 35. Occurrence Codes and Dates
Required. Enter 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 you enter occurrence codes 01-04 and 24, make sure the entry includes the appropriate value code in FLs 39-41.

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.

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

Code	Title	Definition
01	Auto Accident	Enter the date of an auto accident. Use this code to report an auto accident that involves liability insurance. (See §§262-262.4ff.)
02	No-Fault Insurance Involved - Including Auto Accident/Other	Enter the date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt). Use this code to report a non-automobile accident. Auto accidents are covered by codes 01 and 02 above. (See §§262-262.4ff.)
03	Accident/Tort Liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability. Use this code to report a nonautomobile accident. Auto accidents are covered by codes 01 and 02 above. (See §§262-262.4ff.)
04	Accident/Employment Related	Enter the date of an accident which relates to the patient's employment. (See §§289ff.)
05	Other Accident	Enter the date of an accident that is not described by any preceding occurrence codes. Use this code to report that you have developed for other casualty-related payers and have determined that there are none.

Code	Title	Definition
11	Onset of Symptoms/Illness	(Outpatient claims only.) Enter the date that the patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual (CDI)	(HHA Claims Only.) Enter the date that the patient/ beneficiary becomes a CDI. This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.
17	Date Outpatient Occupational Therapy Plan Established or Reviewed	Enter the date that occupational therapy plan was established or last reviewed.
18	Date of Retirement Patient/Beneficiary	Enter the date of retirement for the patient/ beneficiary.
19	Date of Retirement Spouse	Enter the date of retirement for the patient's spouse.
20	Guarantee of Payment Began	Enter the date on which you begin claiming payment under the guarantee of payment provision. (See §286.)
21	UR Notice Received	(Part A SNF claims only.) Enter code to indicate the date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary.
22	Date Active Care Ended	Enter code to indicate the date on which a covered/active level of care ended in a SNF, general, psychiatric or tuberculosis hospital or date on which patient was released on a trail basis from a residential facility. Code is not required if code A21" is used.
24	Date Insurance Denied	Enter the date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	Enter 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	Enter 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	Enter the date of certification or recertification 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	Enter the date a plan of treatment was established or last reviewed for CORF care.

Code	Title	Definition
29	Date OPT Plan Established or Last Reviewed	Enter the date a plan was established or last reviewed for OPT.
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Enter the date a plan was established or last reviewed for outpatient speech pathology.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	Enter the date you notified the beneficiary that he/she does not (or no longer) require a covered level of inpatient care.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	Enter the date you provided notice to a patient stating that requested care (diagnostic procedures or treatments) is not considered reasonable or necessary by Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	Enter 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	Enter the date the guest elected to receive extended to receive extended care services (used by Christian Science Sanatoria only).
35	Date Treatment Started for Physical Therapy	Enter the date you initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)	Enter the date of discharge for the inpatient for a hospital stay in which the patient received a covered transplant procedure when you are billing for immunosuppressive drugs.
37	Date of Inpatient Hospital Discharge Patient Received Non-covered Transplant	Enter this code to indicate the date of discharge for an inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
41	Date of First Test for Pre-admission Testing	Enter the date on which the first outpatient diagnostic test was performed as part of a PAT program. This Code may only be used if a date of admission was Scheduled prior to the administration of the test (s).
42	Date of Discharge	(Hospice claims only.) Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill.
43	Scheduled Date of Canceled Surgery	Enter the date for which ambulatory surgery was scheduled.

Code	Title	Definition
44	Date Treatment Started for Occupational Therapy	Enter the date you initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	Enter the date you initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	Enter the date you initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	Enter code is the first day the cost outlier threshold is reached. For Medicare, a beneficiary must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments.
48-49	Payer Codes	(For use by third party payers only.)
A1	Birthdate-Insured A	Enter the birthdate of the insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy	Enter the first date the insurance is in force.
A3	Benefits Exhausted	Enter the last date for which benefits are available and after which no payment can be made to payer A.
B1	Birthdate-Insured B	Enter the birthdate of the individual in whose name the insurance is carried.
B2	Effective Date-Insured B Policy	Enter the first date the insurance is in force.
B3	Benefits Exhausted	Enter the last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate-Insured C	Enter the birthdate of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	Enter the first date the insurance is in force.
C3	Benefits Exhausted	Enter the last date for which benefits are available and after which no payment can be made to payer C.
C4-C9		Reserved for National Assignment.
D0-D9		Reserved for National Assignment.

FL 36. Occurrence Span Code and Dates

Required. Enter codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits and dates are shown numerically as MMDDYY.

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

70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) Enter the From/Through dates for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Nonutilization Dates (For Payer Use on Hospital Bills Only)	Enter 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.) Enter the From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	Enter the actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.
74	Noncovered Level of Care	Enter the code that indicates the From/Through dates for a period at a noncovered level of care in an otherwise covered stay excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most noncovered care used for leave of absence. These codes are also used for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. This code is also used for HHA or hospice services billed under Part A.
75	SNF Level of Care	Enter the From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since PROs no longer routinely review inpatient hospital bills for hospitals under PPS the code is needed only in length of stay outlier cases (code "60" in FLS 24-30). It is not applicable to swing bed hospitals which transfer the patient from the hospital to a SNF level of care.

76	Patient Liability	Enter the From/Through dates for a period of noncovered care for which the hospital is permitted to charge the beneficiary. Codes should be used only where you or the PRO have 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	Enter the From/Through dates of a period of care for which you are 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. You may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) Enter the From/Through dates given by the patient of any SNF stay that ended within 60 days of this hospital admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care, does not continue a spell of illness and, therefore, is not shown in FL 36.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
M0	PRO/UR Stay Dates	If a code "C3" is in FL 24-30, enter the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Enter the From/Through dates of a period of noncovered care due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. You may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	Enter the From/Through dates of a period of inpatient respite care for hospice patients.

FL 37. Internal Control Number (ICN)/Document Control Number (DCN) Required. Enter the control number assigned to the original bill here. Utilize on adjustment requests (Bill Type, FL 4 = XX7). When requesting an adjustment to a previously processed claim, insert 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. Space is provided for you to use a window envelope if you use the patient's copy of the bill. For claims which involve payers of higher priority than Medicare, as defined in the second paragraph of FL 58, enter 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 amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed accept in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." Use FLs 39a through 41a before 39b through 41b (i.e., use the first line before the second).

(Only codes used to bill Medicare are shown.)

Code	Title	Definition
04	Inpatient Professional Component Charges Which Are Combined Billed	Enter this code to indicate the amount shown is the sum of the inpatient professional component charges which are combined billed. Medicare uses this information in internal processes and also in the HCFA notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all-inclusive rate hospitals.)
05	Professional Component Included in Charges and Also Billed Separately to Carrier	(Applies to Part B bills only.) Enter this code to indicate 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 bill for physician's services is processed by the carrier. These charges are also deducted when computing interim payment. Use this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.
06	Medicare Blood Deductible	Enter this code to indicate the amount shown is the product of the number of unreplaced 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 unreplaced pint furnished. If all deductible pints have been replaced, this code is not to be used. When you give a discount for unreplaced deductible blood, show charges after the discount is applied.
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	Enter this code to indicate the amount shown is 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.

Code	Title	Definition
A2	Coinsurance Payer A	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	Enter the amount estimated to be paid by the indicated payer.
B3	Estimated Responsibility Payer B	Enter the amount estimated to be paid by the indicated payer.
C3	Estimated Responsibility Payer C	Enter the amount estimated to be paid by the indicated payer.
D3	Estimated Responsibility Patient	Enter the amount estimated to be paid by the indicated patient.
A4	Covered Self-Administrable Drugs--Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. **(The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. See §230.4.)**

FL42. Revenue Code
Required. Enter the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. 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. 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 noncovered charges, in FL 48, if any, are summed.

To assist in bill review, list revenue codes in ascending numeric sequence and do not repeat on the same bill to the extent possible. To limit the number of line items on each bill, sum revenue codes at the "zero" level to the extent possible.

Provide detail level coding for the following revenue code series:

290s - rental/purchase of DME
304 - renal dialysis/laboratory
330s - radiology therapeutic
367 - kidney transplant
420s - therapies
520s - type or clinic visit (RHC or other)
550s - 590s - home health services
636 - hemophilia blood clotting factors

800s - 850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

Zero level billing is encouraged for all other services; however, your intermediary may require detailed breakouts of other revenue code series.

00l Total Charge

01X

02X Health Insurance Prospective Payment System (HIPPS)

Subcategory	Standard Abbreviation
0 - Reserved	
1 - Reserved	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HH PPS (effective 10/1/00)
4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (effective 1/1/02)
5 - Reserved	
6 - Reserved	
7 - Reserved	
8 - Reserved	
9 - Reserved	

03X
to
06X Reserved for National Assignment

07X
to
09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X All Inclusive Rate

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

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

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

Routine service charges for single bed rooms.

ANCILLARY REVENUE CODES (22X - 99X)

22X Special Charges

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

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

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

23X Incremental Nursing Charge Rate

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

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

24X All Inclusive Ancillary

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

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

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

25X Pharmacy

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

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

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

26X IV Therapy

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

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

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

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

Code indicates charges for supply items required for patient care.

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

Subcategory	Standard Abbreviation
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

59X 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 Abbreviation
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

60X Oxygen (Home Health)

Code indicates charges by a home health agency for oxygen equipment supplies or contents, excluding purchased equipment.

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

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

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

61X Magnetic Resonance Technology (MRT)

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 Abbreviation
0 - General Classification	MRI
1 - Brain (including Brainstem)	MRI - BRAIN
2 - Spinal Cord (including Spine)	MRI - SPINE
3 - Reserved	
4 - MRI - Other	

Subcategory	Standard Abbreviation
5 - MRA - Head and Neck	MRA - HEAD AND NECK
6 - MRA - Lower Extremities	MRA - LOWER EXT
7 - Reserved	
8 - MRA - Other	MRA - OTHER
9 - Other MRI	MRI - OTHER

62X Medical/Surgical Supplies - Extension of 27X

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

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

63X Pharmacy-Extension of 25X

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

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

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

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

64X Home IV Therapy Services

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

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

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

65X Hospice Services

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

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

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

66X Respite Care (HHA only)

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

Subcategory	Standard Abbreviation
0 - General Classification	RESPITE CARE

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

67X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

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

68X Not Assigned

69X Not Assigned

70X Cast Room

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

Rationale: Permits identification of this service, if necessary.

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

71X Recovery Room

Rationale: Permits identification of particular services, if necessary.

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

72X Labor Room/Delivery

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

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

Subcategory	Standard Abbreviation
0 - General Classification	DELIVROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM

Subcategory	Standard Abbreviation
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

73X 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 Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

74X 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 Abbreviation
0 - General Classification	EEG
9 - Other EEG	OTHER EEG

75X Gastro-Intestinal Services

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

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

76X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 762 should be used for observation services.

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

Subcategory	Standard Abbreviation
0 - General Classification	TREATMENT/OBSERVATION RM
1 - Treatment Room	TREATMENT RM

Subcategory	Standard Abbreviation
2 - Observation Room	OBSERVATION RM
9 - Other Treatment Room	OTHER TREATMENT RM

77X Preventative Care Services

Charges for the administration of vaccines.

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

78X Telemedicine

Future use to be announced - Medicare Demonstration Project.

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

79X Lithotripsy

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategory	Standard Abbreviation
0 - General Classification	LITHOTRIPSY
9 - Other Lithotripsy	LITHOTRIPSY/OTHER

80X Inpatient Renal Dialysis

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

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

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

89X Reserved for National Assignment

90X Psychiatric/Psychological Treatments

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

91X Psychiatric/Psychological Services

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

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

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

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

92X Other Diagnostic Services

Code indicates charges for other diagnostic services not otherwise categorized.

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

93X Medical Rehabilitation Day Program

Medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy and speech therapy. The subcategories of 93X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported for in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable therapy revenue codes as normal.

Subcategory	Standard Abbreviation
1 - Half Day	HALF DAY
2 - Full Day	FULL DAY

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

Code indicates charges for other therapeutic services not otherwise categorized.

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

95X Other Therapeutic Services-Extension of 94X

Charges for other therapeutic services not otherwise categorized.

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

96X Professional Fees

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

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSYCH
2 - Ophthalmology	PRO FEE/EYE

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

97X Professional Fees - Extension of 96X

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

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

Subcategory	Standard 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

99X 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 Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

1XXX to 8999 Reserved for National Assignment

9000 to 9044 Reserved for Medicare Skilled Nursing Facility Demonstration Project

9045 to 9099 Reserved for National Assignment

FL 43. Revenue Description
Not Required. Enter 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 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

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

FL 44. HCPCS/Rates
Required. When coding HCPCS for outpatient services, enter the HCPCS code describing the procedure here.

On inpatient hospital bills the accommodation rate is shown here.

FL 45. Service Date
Required. Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam and Saipan), report line item dates of service wherever a HCPCS code is required. This includes claims where the from and through dates are equal.

FL 46. Units of Service
Required. Enter the number of digits or units of service on the line adjacent to revenue code and description where appropriate, e.g., number of covered days in a particular type of accommodation, pints of blood. When HCPCS codes are required for hospital outpatient services, the units are equal to the number of times the procedure/service being reported was performed. Provide the number of covered days, visits, treatments, tests, etc., as applicable for the following:

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

Enter up to seven numeric digits. Show charges for noncovered services as noncovered.

FL 47. Total Charges
Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of revenue codes requiring HCPCS procedure codes, enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

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

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional 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, adjust your provider statistical and reimbursement (PS&R) reports that you derive from the bill.

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

FL 48. Non-Covered Charges
Required. The total 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 which has 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, enter "Medicare" on line A. Entering Medicare indicates that you have developed for other insurance and have 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, identify the primary payer on line A and enter Medicare information on line B or C as appropriate. (See §§262, 263, 264, and 289 to determine when Medicare is not the primary payer.)

FL 51A, B, and C. Provider Number
Required. Enter 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 you have on file a signed statement permitting you to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

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

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

FLs 54A, B, and C. Prior Payments
Required. Enter for all services other than inpatient 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 noncovered by Medicare. Thus, for example, if total inpatient hospital charges were $350.00 including $50.00 for a deductible pint of blood, 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.

FL 55A, B, and C. Estimated Amount Due From Patient
Not Required.

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

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

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on his/her 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 which follow explain when to complete these items.

Enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and you are requesting payment because:

- Another payer paid some of the charges and Medicare is secondarily liable for the remainder;
- Another payer denied the claim; or
- You are requesting conditional payment as described in §§469G, 470G, 47lG, or 472G.

If that person is the patient, enter "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and spouses age 65 or over (See §263);
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period of up to l2 months (See §264);
- LGHPs for disabled beneficiaries;
- An auto-medical, no-fault, or liability insurer (See §262); or
- WC including BL (See §289).

FL 59A, B, and C. Patient's Relationship to Insured
Required. If you are claiming payment under any of the circumstances described under FLs 58 A, B, or C, enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Code	Title	Definition
01	Patient is Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured Financial Responsibility	Self-explanatory
04	Natural Child/Insured Does Not Have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.

FLs 68-75. Other Diagnoses Codes
Inpatient--Required. Enter 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.

Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

Outpatient--Required. Enter 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 PRO 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 not required by Medicare but may be used by providers for non scheduled visits for outpatient bills.

FL 77. E-Code
Not Required.

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

FL 79. Procedure Coding Method Used
Not Required.

FL 80. Principal Procedure Code and Date
Required for Inpatient Only. Enter the full ICD-9-CM, Volume 3, procedure code, including all four digits where applicable, for the 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 above).

For this purpose, surgery includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation.

Show the date of the principal procedure numerically as MMDDYY in the "date" portion.

FL 81. Other Procedure Codes and Dates
Required for Inpatient Only. Enter 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). Show the date of each procedure numerically as MMDDYY in the "date" portion of FL 81, as applicable. Do not repeat procedures unless you do them more than once. The paper Form HCFA-1450 accommodates only two other procedures. An additional three other procedures may be reported in Remarks. Your intermediary's data entry screens will be capable of accepting the principle procedures and five other procedures. EMC formats include principle and five other procedures.

FL 82. Attending/Requesting Physician I.D.
Required. Enter 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.--Enter 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 hospital episode. For SNF services, i.e., swing bed, the attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Outpatient and Other Part B.--Enter 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), enter SLF000 in the first six positions, and do 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. 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), enter 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, enter 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. Enter the UPIN and name of the physician who performed the principal procedure. If no principal procedure is performed, enter the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, leave 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 PRO furnishes that require approval. Enter the UPIN and name of the operating physician using the format for inpatient reporting.

Record Name	Record Type Code
Physician Data	80
Reserved for National Assignment	81-84
Local Use	85-89
Claim Control Screen	90
Remarks (Overflow from RT 90)	91
*Claim Control Totals	92
Reserved for National Assignment	93-94
Provider Batch Control	95
Local Use	96-97
*Provider Chain Control	98
File Control	99

5. Record Layouts

RECORD TYPE 01 - PROCESSOR DATA

- Must be first record on file.
- Must be followed by RT 10.

NOTE: Files will be formatted so that this is a data record, not a conventional label. From a system standpoint, this will be a "labelless" file.

The processor data record will be the first record on each reel.

This record indicates, in fields 5 thru 7, the class and identification of the organization designated to receive this file or transmission. If the code in field 5 is a "Z", the file contains records for multiple primary payers. In this case, the employer identification number (EIN), also known as the tax identification number (TIN), identifies the organization designated to receive this tape or transmission. Otherwise, the code in field 5 designates the types of primary payer. Field 6 contains the receiver/primary payer identification (NAIC number for commercials, Blue Cross number for PLANS, as indicated by each State agency for Medicaid, as assigned by CHAMPUS where applicable, etc.). For commercial insurers, Field 7 contains the specific office within the insurance carrier designated to receive this tape or transmission. For Blue Cross Plans, this field will be used as designated by the Plan receiving the file.

It is recommended that you and other billers establish a protocol limiting a file to a single reel of tape, single disk, cartridge, or cassette. In the event a file exceeds that limit, the reel, cartridge, or disk must end in a batch control (record type (RT) 95).

*COB specific records.

RECORD TYPE 01 - PROCESSOR DATA

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '01'	XX	L	1	2
2	Submitter EIN	9(10)	R	3	12
3	Multiple Provider Billing File Indicator	9		13	13
4	Filler (National Use)	X(17)	L	14	30
5	Receiver Type Code	X		31	31
6	Receiver Identification	X(5)	L	32	36
7	Receiver Sub-Identification	X(4)	L	37	40
8	Filler (National Use)	X(6)		41	46
9	Submitter Name	X(21)	L	47	67
	Submitter Address (Fields 10-13)				
10	Address	X(18)	L	68	85
11	City	X(15)	L	86	100
12	State	XX	L	101	102
13	ZIP Code	X(9)	L	103	111
14	Submitter FAX Number	9(10)	R	112	121
15	Country Code	X(4)	L	122	125
16	Submitter Telephone Number	9(10)	R	126	135
17	File Sequence & Serial Number	X(7)	L	136	142
18	Test/Production Indicator	X(4)	L	143	146
19	Date of Receipt (CCYYMMDD) (intermediary use only)	9(8)	R	147	154
20	Processing Date (Date Bill Submitted on HCFA 1450) (CCYYMMDD)	9(8)	R	155	162
21	Filler (Local Use)	X(27)		163	189
*22	Version Code 060	X(3)	L	190	192

*VERSION 060

See footnote C-1 for benefit coordination

RECORD TYPE 41 - CLAIM DATA CONDITION-VALUE

- o May follow RT 40 or 41.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '41'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
	CONDITION CODE Repeats 10 times				
4	Condition Code - 1	X(2)	L	25	26
5	Condition Code - 2	X(2)	L	27	28
6	Condition Code - 3	X(2)	L	29	30
7	Condition Code - 4	X(2)	L	31	32
8	Condition Code - 5	X(2)	L	33	34
9	Condition Code - 6	X(2)	L	35	36
10	Condition Code - 7	X(2)	L	37	38
11	Condition Code - 8	X(2)	L	39	40
12	Condition Code - 9	X(2)	L	41	42
13	Condition Code - 10	X(2)	L	43	44
14	Form Locator 31 (upper)	X(5)	L	45	49
15	Form Locator 31 (lower)	X(6)	L	50	55
	VALUE CODE Repeats 12 times				
16	Value Code - 1	X(2)	L	56	57
17	Value Amount - 1	9(7)V99S	R	58	66
18	Value Code - 2	X(2)	L	67	68
19	Value Amount - 2	9(7)V99S	R	69	77
20	Value Code - 3	X(2)	L	78	79
21	Value Amount - 3	9(7)V99S	R	80	88
22	Value Code - 4	X(2)	L	89	90
23	Value Amount - 4	9(7)V99S	R	91	99
24	Value Code - 5	X(2)	L	100	101
25	Value Amount - 5	9(7)V99S	R	102	110
26	Value Code - 6	X(2)	L	111	112
27	Value Amount - 6	9(7)V99S	R	113	121
28	Value Code - 7	X(2)	L	122	123
29	Value Amount - 7	9(7)V99S	R	124	132
30	Value Code - 8	X(2)	L	133	134
31	Value Amount - 8	9(7)V99S	R	135	143
32	Value Code - 9	X(2)	L	144	145
33	Value Amount - 9	9(7)V99S	R	146	154
34	Value Code - 10	X(2)	L	155	156
35	Value Amount - 10	9(7)V99S	R	157	165
36	Value Code - 11	X(2)	L	166	167
37	Value Amount - 11	9(7)V99S	R	168	176
38	Value Code - 12	X(2)	L	177	178
39	Value Amount - 12	9(7)V99S	R	179	187
40	Filler (National Use)	X(5)		188	192

See footnote C-11 for benefit coordination.

RECORD TYPE 50 - IP ACCOMMODATIONS DATA

- o May be preceded by RT 40 - 4n or 50 - 5n.
- o May be followed by RT 50 - 5n, 51, 60, or 70.
- o Accommodations must be entered in numeric sequence.
- o The sequence number for record type 50 can go from 01 to 999, each such physical record containing four accommodations, thus making provision for reporting up to 3996 accommodations on a single claim.

ACCOMMODATION REVENUE CODES: 100 THRU 21X

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record type '50'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Patient Control Number	X(20)	L	6	25
4	Filler (National Use)	X(3)		26	28
	Accommodations (occurs 4 times)				
	Accommodations - 1	X(41)		29	69
5	Accommodations Revenue Code	9(4)	R	29	32
6	Accommodations Rate	9(7)V99	R	33	41
7	Accommodations Days	9(4)	R	42	45
8	Accommodations Total Charges	9(8)V99S	R	46	55
9	Accommodations Noncovered Charges	9(8)V99S	R	56	65
10	Form Locator 49	X(4)	L	66	69
11	Accommodations - 2	X(41)		70	110
12	Accommodations - 3	X(41)		111	151
13	Accommodations - 4	X(41)		152	192

See footnote C-12 for benefit coordination.

RECORD TYPE 60 - IP Ancillary Services Data

- o May be preceded by RT 40, 41, 50 - 5n, 60, or 63.
- o May be followed by RT 60, 62, 63, or 70.
- o The sequence number for record type 60 can go from 001 to 999, with each such physical record containing three inpatient ancillary service codes, thus making provisions for reporting up to 2997 inpatient ancillary services although only 450 items will be accepted on a single claim.
- o Write all sequences of RT 60.

PAYER AND RELATED INFORMATION REVENUE CODES: CODES 010 - 099.

THESE CODES MAY BE REPORTED IN RT 60, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RTS 90 AND 91.

INPATIENT ANCILLARY SERVICES REVENUE CODES: CODES 220 - 99X.

INPATIENT ANCILLARY CODES MUST BE IN CODE NUMBER SEQUENCE.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record type '60'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Patient Control Number	X(20)	L	6	25
4	Filler (National Use)	X(2)		26	27
	Inpatient Ancillaries (occurs 3 times)				
	Inpatient Ancillaries - 1	X(55)		28	82
5	Inpatient Ancillary Revenue Code If Revenue Code is 624, then also use RT 34. When Revenue Code is 002X then field 6 contains a HIPPS Rate Code	9(4)	R	28	31
6	HCPCS Procedure Code/HIPPS	X(5)	L	32	36
7	Modifier 1 (HCPCS & CPT-4)	X(2)	L	37	38
8	Modifier 2 (HCPCS & CPT-4)	X(2)	L	39	40
9	Inpatient Ancillary Units of Service	9(7)	R	41	47
10	Inpatient Ancillary Total Charges 9(8)V99S		R	48	57
11	Inpatient Ancillary Noncovered Charges	9(8)V99S	R	58	67
12	Form Locator 49	X(4)	L	68	71
* 13	Assessment Date (CCYYMMDD)	9(8)	L	72	79
14	Filler (National Use)	X(3)		80	82
15	Inpatient Ancillaries - 2	X(55)		83	137
16	Inpatient Ancillaries - 3	X(55)		138	192

*Field 13 must only be completed when Revenue Code 002X is used, otherwise leave blank.

See footnote C-13 for benefit coordination.

RECORD TYPE 61 - OUTPATIENT PROCEDURES

- o May be preceded by RT 40, 41, 61, or 63.
- o May be followed by RT 61 - 6n, 62, 63, 70, or 80.
- o The sequence number for record type 61 can go from 001 to 999, each such physical record containing three procedure codes, thus making provision for reporting up to 2997 services although only 450 items will be accepted on a single claim.

PAYER AND RELATED INFORMATION REVENUE CODES: CODES 010 -099.

THESE CODES MAY BE REPORTED IN RT 61, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RTS 90 AND 91.

OUTPATIENT ANCILLARY CODES MUST BE IN CODE NUMBER SEQUENCE.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	THRU
1	Record type '61'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Patient Control Number	X(20)	L	6	25
4	Filler (National Use)	XX		26	27
	Revenue Center (occurs 3 times)				
	Revenue Code - 1	X(55)		28	82
5	Revenue Code If Revenue Code is 624, then also use RT 34. When Revenue Code is 002X then field 6 contains a HIPPS Rate Code	9(4)	R	28	31
6	HCPCS Procedure Code/HIPPS	X(5)	L	32	36
7	Modifier 1 (HCPCS & CPT-4)	X(2)	L	37	38
8	Modifier 2 (HCPCS & CPT-4)	X(2)	L	39	40
9	Units of Service	9(7)	R	41	47
10	Form Locator 49	X(6)	L	48	53
11	Outpatient Total Charges	9(8)V99S	R	54	63
12	Outpatient Noncovered Charges	9(8)V99S	R	64	73
13	Date of Service (CCYYMMDD)	9(8)	R	74	81
14	Filler (National Use)	X		82	82
* 15	Revenue Code - 2	X(55)		83	137
* 16	Revenue Code - 3	X(55)		138	192

*Revenue Codes 2 and 3 have the same format as fields 5-14 in Revenue Center 1.

See footnote C-14 for benefit coordination.

RECORD TYPE 90 - CLAIM CONTROL SCREEN

- o May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80 - 8N.
- o Must be followed by RT 20, 74, 91, or 95.
- o If more than 110 characters are required for Form Locator 84, use RT 91 to report the additional characters and code a "1" in field 12 of RT 90. A "0" indicates that no RT 91 follows.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '90'	XX	L	1	2
2	Filler (National Use)	XX	L	3	4
3	Patient Control Number	X(20)	L	5	24
4	Physical Record Count (Excluding RT 90 + 91)	9(4)	R	25	28
	Record Type nn Count (Fields 5-11)				
5	Record Type 2n Count	99	R	29	30
6	Record Type 3n Count	99	R	31	32
7	Record Type 4n Count	99	R	33	34
8	Record Type 5n Count	9(3)	R	35	37
9	Record Type 6n Count	9(3)	R	38	40
10	Record Type 7n Count	99	R	41	42
11	Record Type 8n Count	99	R	43	44
12	Record Type 91 Qualifier	9		45	45
13	Total Accommodation Charges Revenue Centers	9(8)V99S	R	46	55
14	Noncovered Accommodation Charges - Revenue Centers	9(8)V99S	R	56	65
15	Total Ancillary Charges Revenue Centers	9(8)V99S	R	66	75
16	Noncovered Ancillary Charges - Revenue Centers	9(8)V99S	R	76	85
17	Filler (National Use	X(2)		86	87
18	Remarks	X(110)	L	88	192

See footnote C-25 for benefit coordination.

RECORD TYPE 91 - REMARKS

- Must be preceded by RT 90.
- Must be followed by RT 20, 74, or 95.
- The first 110 characters from Form Locator 84, Remarks, that are required to provide additional information on the claim must be entered on RT 90. If more than 110 characters are required, use field 4 of RT 91 to report them.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '91'	XX	L	1	2
2	Filler (National Use)	XX		3	4
3	Patient Control Number	X(20)	L	5	24
4	Remarks (Additional)	X(87)	L	25	111
5	Filler (National Use)	X(81)		112	192

See footnote C-26 for benefit coordination.

RECORD TYPE 95 - PROVIDER BATCH CONTROL

- Must be preceded by RT 90 or 91.
- Must be followed by RT 10 or 99.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '95'	XX	L	1	2
2	Federal Tax Number (EIN)	9(10)	R	3	12
3	Receiver Identification	X(5)	L	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Type of Batch	XXX	L	22	24
6	Number of Claims	9(6)	R	25	30
7	Number of 3M Batch Attachment Records	9(6)	R	31	36
8	Accommodations Total Charges for the Batch	9(10)V99S	R	37	48
9	Accommodations Noncovered Charges for the Batch	9(10)V99S	R	49	60
10	Ancillary Total Charges for the Batch	9(10)V99S	R	61	72
11	Ancillary Noncovered Charges for the Batch	9(10)V99S	R	73	84
12	Total Charges for Batch (COB only)	9(10)V99S	R	85	96
13	Total Noncovered Charges for the Batch (COB only)	9(10)V99S	R	97	108
14	Reserve for Future Use	X(12)	L	109	120
15	Filler (National Use)	X(18)		121	138
16	Filler (Local Use)	X(54)		139	192

See footnote C-27 for benefit coordination.

RECORD TYPE 99 - FILE CONTROL

- Must be preceded by RT 95.
- Must be last valid record on file.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '99'	XX	L	1	2
2	Submitter EIN	9(10)	R	3	12
3	Receiver Identification	X(5)	L	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Number of Batches Billed this File	9999	R	22	25
6	Accommodations Total Charges for the File	9(11)V99S	R	26	38
7	Accommodations Noncovered Charges for the File	9(11)V99S	R	39	51
8	Ancillary Total Charges for the File	9(11)V99S	R	52	64
9	Ancillary Noncovered Charges for the File	9(11)V99S	R	65	77
10	Total Charges for the File (COB only)	9(11)V99S	R	78	90
11	Total Noncovered Charges for the File (COB only)	9(11)V99S	R	91	103
12	Number of Claims for the File (COB only)	9(8)	R	104	111
13	Number of Records for the File (COB only)	9(8)	R	112	119
14	Filler (National Use)	X(16)		120	135
15	Filler (Local Use)	X(57)		136	192

See footnote C-28 for benefit coordination.

CLAIM CHANGE REASON CODE (Cont.)

RECORD TYPE 42

******* OPTIONAL RECORD *******

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	THRU
24	MIA/MOA Remark Code - 1	X(5)	L	131	135
25	MIA/MOA Remark Code - 2	X(5)	L	136	140
26	MIA/MOA Remark Code - 3	X(5)	L	141	145
27	MIA/MOA Remark Code - 4	X(5)	L	146	150
28	MIA/MOA Remark Code - 5	X(5)	L	151	155
29	Filler - (National Use)	X(37)		156	192

Comment: This is a payer generated Record Type and is not created by the provider.

NOTE: Mandatory for Medicare if ASC X12N 835 Remittance Reason Codes used in claims processing. Reason code values and amounts should be the same as those applied to the ANSI ASC X12N 835 Remittance.

IP ACCOMMODATIONS LINE ITEM REMARKS CODES

RECORD TYPE 51

*******MANDATORY IF LINE LEVEL REMARKS CODES ARE PRESENT*******

- May follow RT 50, RT 51, or RT 52.
- May be followed by RT 50, RT 51, RT 52, RT 60, or RT 70.
- RT 51 should directly correspond to the previous RT 50.
- The sequence number for RT 51 can go from 001 to 999.
- The payer sequence >01' would represent the Primary Payer, payer sequence >02' would represent the Secondary Payer, and payer sequence >03' would represent the Tertiary Payer.
- The revenue code sequence shows which of the four occurrences of revenue code on RT 50 is being referenced. Valid values are 1 through 4.
- The COB record type sequence references the order of this record where there are multiple occurrences (one claim line can generate multiple RT 51's). Valid values are 1 through 4.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '51'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Accommodation Revenue Code	9(4)	R	28	31
6	Remarks Code 1	X(4)	L	32	35
7	Remarks Code 2	X(4)	L	36	39
8	Remarks Code 3	X(4)	L	40	43
9	Remarks Code 4	X(4)	L	44	47
10	Remarks Code 5	X(4)	L	48	51
11	Remarks Code 6	X(4)	L	52	55
12	Remarks Code 7	X(4)	L	56	59
13	Remarks Code 8	X(4)	L	60	63
14	Remarks Code 9	X(4)	L	64	67
15	Remarks Code 10	X(4)	L	68	71
16	Revenue Code Sequence	9	R	72	72
17	COB Record Type Sequence	9	R	73	73
18	Filler (National Use)	X(119)		74	192

NOTE: All RT 51 records for the Primary Payer should be followed by all RT 51 for the Secondary Payer, followed by all RT 51 for the Tertiary Payer. All RT 51 for each payer should be in numerical sequence.

INPATIENT ACCOMMODATION REASON CODES

RECORD TYPE 52

****** MANDATORY IF LINE LEVEL REASON CODES ARE PRESENT*******

- o May follow RT 50, RT 51, or RT 52.
- o May be followed by RT 50, RT 52, RT 60, or RT 70.
- o Use RT 52 for IP accommodations.
- o RT 52 should directly corresponds to the previous RT 50.
- o The sequence number for RT 52 can go from 001 to 999.
- o The payer sequence >01' would represent the Primary Payer, payer sequence >02' would represent the Secondary Payer, and payer sequence >03' would represent the Tertiary Payer.
- o The revenue code sequence shows which of the four occurrences of the revenue code on RT 50 is being referenced. Valid values are 1 through 4.
- o COB record type sequence references the order of this record where there are multiple occurrences (one claim line can generate multiple RT 52's). Valid values are 1 through 4.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type 52	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Revenue Code	9(4)	L	28	31
6	Group Code	X(2)	L	32	33
7	Reason Code 1	X(3)	L	34	36
8	Adjustment Amount 1	9(7)V99S	R	37	45
9	Adjustment Quantity 1	9(5)S	R	46	50
10	Reason Code 2	X(3)	L	51	53
11	Adjustment Amount 2	9(7)V99S	R	54	62
12	Adjustment Quantity 2	9(5)S	R	63	67
13	Reason Code 3	X(3)	L	68	70
14	Adjustment Amount 3	9(7)V99S	R	71	79
15	Adjustment Quantity 3	9(5)S	R	80	84
16	Reason Code 4	X(3)	L	85	87
17	Adjustment Amount 4	9(7)V99S	R	88	96
18	Adjustment Quantity 4	9(5)S	R	97	101
19	Reason Code 5	X(3)	L	102	104
20	Adjustment Amount 5	9(7)V99S	R	105	113
21	Adjustment Quantity 5	9(5)S	R	114	118
22	Reason Code 6	X(3)	L	119	121
23	Adjustment Amount 6	9(7)V99S	R	122	130
24	Adjustment Quantity 6	9(5)S	R	131	135
25	Revenue Code Sequence	9	R	136	136
26	COB Record Type Sequence	9	R	137	137
27	Filler (National Use)	X(55)		138	192

ANCILLARY OR OP LINE ITEM REMARKS CODES

RECORD TYPE 62

*****MANDATORY IF LINE LEVEL REMARKS CODES ARE PRESENT*****

- o May follow RT 60, RT 61, RT 62 or RT 63.
- o May be followed by RT 60, RT 61, RT 62, RT 63, or RT 70.
- o RT 62 should directly correspond to the previous RT 60 or RT 61.
- o The sequence number for RT 62 can go from 001 to 999.
- o The payer sequence >01' would represent the Primary payer, payer sequence >02' would represent the Secondary payer, and payer sequence >03' would represent the Tertiary Payer.
- o The revenue code sequence shows which of the three occurrences of the revenue code on RT 60 or 61 is being referenced. Valid values are 1 through 3.
- o COB record type sequence references the order of this record where there are multiple occurrences (one claim line can generate multiple RT62's). Valid values are 1 through 4.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '62'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Revenue Code	9(4)	R	28	31
6	Remarks Code 1	X(4)	L	32	35
7	Remarks Code 2	X(4)	L	36	39
8	Remarks Code 3	X(4)	L	40	43
9	Remarks Code 4	X(4)	L	44	47
10	Remarks Code 5	X(4)	L	48	51
11	Remarks Code 6	X(4)	L	52	55
12	Remarks Code 7	X(4)	L	56	59
13	Remarks Code 8	X(4)	L	60	63
14	Remarks Code 9	X(4)	L	64	67
15	Remarks Code 10	X(4)	L	68	71
16	Revenue Code Sequence	9	R	72	72
17	COB Record Type Sequence	9	R	73	73
18	Filler (National Use)	X(119)		74	192

NOTE: All RT 62 records for the Primary Payer should be followed by all RT 62 for the Secondary Payer, followed by all RT 62 for the Tertiary Payer. All RT 62 for each payer should be organized in numerical sequence.

ANCILLARY OR OP REASON CODES

RECORD TYPE 63

***** MANDATORY RECORD IF LINE LEVEL REASON CODES ARE PRESENT *****

- o May follow RT 60, RT 61, RT 62, or RT 63.
- o Use RT 63 for IP ancillary or OP line level reason codes.
- o RT 63 should use the same sequence number as the corresponding RT 60 or RT 61.
- o The sequence number RT 63 can be from 001 to 999.
- o The payer sequence >01' would represent the Primary payer, payer sequence >02' would represent the Secondary payer, and payer sequence >03' would represent the Tertiary Payer.
- o The revenue code sequence shows which of the three occurrences of revenue code on RT 60 or 61 is being referenced. Valid values are 1 through 3.
- o COB record type sequence references the order of this record where there are multiple occurrences (one claim line can generate multiple RT 63's). Valid values are 1 through 4.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type 63	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Revenue Code	9(4)	R	28	31
6	Group Code	X(2)	L	32	33
7	Reason Code 1	X(3)	L	34	36
8	Adjustment Amount 1	9(7)V99S	R	37	45
9	Adjustment Quantity 1	9(5)S	R	46	50
10	Reason Code 2	X(3)	L	51	53
11	Adjustment Amount 2	9(7)V99S	R	54	62
12	Adjustment Quantity 2	9(5)S	R	63	67
13	Reason Code 3	X(3)	L	68	70
14	Adjustment Amount 3	9(7)V99S	R	71	79
15	Adjustment Quantity 3	9(5)S	R	80	84
16	Reason Code 4	X(3)	L	85	87
17	Adjustment Amount 4	9(7)V99S	R	88	96
18	Adjustment Quantity 4	9(5)S	R	97	101
19	Reason Code 5	X(3)	L	102	104
20	Adjustment Amount 5	9(7)V99S	R	105	113
21	Adjustment Quantity 5	9(5)S	R	114	118
22	Reason Code 6	X(3)	L	119	121
23	Adjustment Amount 6	9(7)V99S	R	122	130
24	Adjustment Quantity 6	9(5)S	R	131	135
25	Revenue Code Sequence	9	R	136	136
26	COB Record Type Sequence	9	R	137	137
27	Filler (National Use)	X(55)		138	192

NOTE: All RT 63 records for the Primary Payer should be followed by all RT 63 for the Secondary payer followed by all RT 63 for the Tertiary Payer. All RT 63 for each payer should be organized in numerical sequence.

CLAIM CONTROL TOTALS

RECORD TYPE 92

***** MANDATORY RECORD *****

- o May follow RT 90, RT 91 or RT 92.
- o May be followed by RT 20, 92, 93 or RT 95
- o This Record Type is used ONLY for OUT Bound COB Bills
- o If there is an Inpatient DRG bill, RT 51 and 61 will not be present because the DRG amount paid is at a claim level, rather than at an individual revenue code level.
- o Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

	FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	THRU
	1	Record Type '92'	XX	L	1	2
	2	Sequence Number	99	R	3	4
	3	Patient Control Number	X(20)	L	5	24
N1	4	Current DCN/ICN	X(23)	L	25	47
	5	Filler - (National Use)	X(6)		48	53
N2	6	Total Submitted Charges	9(8)V99S	R	54	63
N3	7	Total Non-covered Charges	9(8)V99S	R	64	73
	8	Total Charges Allowed	9(8)V99S	R	74	83
	9	Total Medicare Reimbursement	9(8)V99S	R	84	93
	10	Total Amount Medicare Paid Provider	9(8)V99S	R	94	103
	11	Total Amount Paid Beneficiary	9(8)V99S	R	104	113
N4	12	Total Medicare Days Utilized	9(4)	R	114	117
	13	DRG/APC Assigned via Grouper	999	R	118	120
	14	DRG/APC Amount Applied via Pricer	9(8)V99S	R	121	130
	15	DRG Outlier Amount	9(8)V99S	R	131	140
	16	Total Denied Charges	9(8)V99S	R	141	150
	17	Cost Report Days	999S	R	151	153
	18	Lifetime Psychiatric Days	999S	R	154	156
N5	19	Claim Status	XX	L	157	158
	20	Reimbursement Rate (%)	9(4)V999	R	159	165
	21	Claim Paid Date (CCYYMMDD)	9(8)	R	166	173
	22	Filler (National Use)	X(19)		174	192

N1 NOTE: This is the claim ICN/DCN currently being processed.

N2 NOTE: Sum of RT 90 FL 13/15

N3 NOTE: Sum of RT 90 FL 14/16

N4 NOTE: Same as RT 30 FL 20-covered days

N5 NOTE: Claim Status Codes--Refer to ANSI X12 codes.

ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

NOTE: ALL DATE FORMATS SHOULD BE (CCYYMMDD).

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

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

*Not required for Medicare

	Data Element	Definition	Record	Field
	Date of Receipt	The date the file was received from the submitter. This is to be entered by the receiver of the file.	01	19
	Date of Service	The date the indicated out-patient service was processed in a series of bills.	61	13
	Destination Address	Address of the institution or home where patient transported by ambulance.	75-01	21-25
		Name	75-01	21
		Place	75-01	22
		City	75-01	23
		State	75-01	24
		Zip Code	75-01	25
	Discharge Date	Date that the patient was discharged from most recent inpatient care.	71	30
*	Discharge Hour	Hour that the patient was discharged from inpatient care. Use hour in military time (00 to 23). If hour not known, use 99. Default to spaces if not applicable (e.g., outpatient).	20	22
	Discipline	Code indicating discipline(s) ordered by physician: SN = Skilled Nursing PT = Physical Therapy ST = Speech language Pathology OT = Occupational Therapy MS = Medical Social Worker AI = Home Health Aide CR = Cardiac Rehabilitation RT = Respiratory (Inhalation) Therapy PS = Psychiatric Services For RT 77, AI (Home Health Aide) is not a valid code.	72 77	4 5
	Drugs Administered (Narrative)	Identifies medications administered as part of a psychiatric services plan of treatment.	77-R	23
	Drug Units	Number of standard units from the National Drug Code (NDC) administered to the patient. For example, if the standard dosage for the drug is 10 mg and 40 mg was administered, enter 0004 as the value in this field.	76-M Two additional iterations in related locations on RT 76, format type M, fields 10-11.	6
	Employer Location	The specific location for the employer of the individual identified in RT 30.	21 21 31	5-8 12-15 10-13

*Not required for Medicare

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

*Not required for Medicare

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

*Not required for Medicare

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

* Not required for Medicare

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

*Not required for Medicare

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

*Not required by Medicare

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

*Not required for Medicare

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

*Not required for Medicare

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

*Not required for Medicare

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

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