

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1775	Date: July 24, 2009
	Change Request 6478

SUBJECT: Point of Origin Codes Update to the UB-04 (CMS-1450) Manual Code List

I. SUMMARY OF CHANGES: This instruction adds two new valid point of origin codes to Chapter 25, Completing and Processing the Form CMS-1450 Data Set.

New / Revised Material

Effective Date: October 1, 2007

Implementation Date: January 4, 2010

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

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

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	25/75.1/Form Locators 1-15

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

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SUBJECT: Point of Origin Codes Update to the UB-04 (CMS-1450) Manual Code List

Effective Date: October 1, 2007

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: The following point of origin (formerly source of admission) codes, created by the National Uniform Billing Committee (NUBC), will be accepted into the Fiscal Intermediary Standard System (FISS):

E – Transfer from Ambulatory Surgical Center; and

F – Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in Hospice Program.

See Chapter 25, Completing and Processing the Form CMS-1450 Data Set, for further information on these codes.

B. Policy: Field Locator 15 of the UB-04 and its electronic equivalence is a required field on all institutional inpatient claims and outpatient registrations for diagnostic testing services. This code indicates the point of patient origin for the admission or visit of the claim being billed.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	R H I I S S	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
6478.1	Medicare systems shall accept Point of Origin (previously named Source of Admission) codes E and F.						X				COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				F I S S	M C S	V M S	C W F	
6478.2	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X		X					

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office.

<http://www.cms.hhs.gov/MyHealthMyMedicare/Downloads/regionalmap.pdf> or Medicare Administrative Contractor Project Officer

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

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

Section B: For *Medicare Administrative Contractors (MACs)*:

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

75.1 - Form Locators 1-15

(Rev. 1775, Issued: 07-24-09, Effective: 10-01-07, Implementation: 01-04-10)

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

Required. The minimum entry is the provider name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

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

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

FL 3a - Patient Control Number

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

FL 3b – Medical/Health Record Number

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

FL 4 - Type of Bill

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

Code Structure

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

- 1 Hospital
- 2 Skilled Nursing
- 3 Home Health (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)
- 4 Religious Nonmedical (Hospital)

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

6 Intermediate Care

7 Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).

8 Special facility or hospital ASC surgery (requires special information in second digit below).

9 Reserved for National Assignment

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

1 Inpatient (Part A)

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

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

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

5 Intermediate Care - Level I

6 Intermediate Care - Level II

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

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

9 Reserved for National Assignment

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

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

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

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

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

A	Admission/Election Notice	Used when the hospice or Religious Non-medical Health Care Institution is submitting Form CMS-1450 as an Admission Notice.
B	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation Notice	Used when the Form CMS-1450 is used as a notice of termination/revocation for a previously posted Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.
C	Hospice Change of Provider Notice	Used when Form CMS-1450 is used as a Notice of Change to the hospice provider.
D	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel	Used when Form CMS-1450 is used as a Notice of a Void/Cancel of Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.
E	Hospice Change of Ownership	Used when Form CMS-1450 is used as a Notice of Change in Ownership for the hospice.

F	Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For FI use only.
G	CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For FI use only.
H	CMS Initiated Adjustment Claim	Used to identify adjustments initiated by CMS. For FI use only.
I	FI Adjustment Claim (Other than QIO or Provider)	Used to identify adjustments initiated by the FI. For FI use only.
J	Initiated Adjustment Claim-Other	Used to identify adjustments initiated by other entities. For FI use only.
K	OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For FI use only.
M	MSP Initiated Adjustment Claim	Used to identify adjustments initiated by MSP. For FI use only. Note: MSP takes precedence over other adjustment sources.
P	QIO Adjustment Claim	Used to identify an adjustment initiated as a result of a QIO review. For FI use only.
0	Nonpayment/Zero Claims	Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care.
1	Admit Through Discharge Claim	The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2	Interim-First Claim	Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment. For HHAs, used for the submission of original or replacement RAPs.

3	Interim-Continuing Claims (Not valid for PPS Bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4	Interim-Last Claim (Not valid for PPS Bills)	This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The “Through” date of this bill (FL 6) is the discharge for this treatment.
5	Late Charge Only	When the provider submits late charges on bills to the FI as bill type XX5, these bills contain only additional charges.
7	Replacement of Prior Claim	This is used to correct a previously submitted bill. The provider applies this code to the corrected or “new” bill.
8	Void/Cancel of a Prior Claim	The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code “7” (Replacement of Prior Claim) is being submitted showing corrected information.
9	Final Claim for a Home Health PPS Episode	This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

Bill Type Codes

The following lists “Type of Bill,” FL4 codes. For a definition of each facility type, see the Medicare State Operations Manual.

Bill Type Code

011X Hospital Inpatient (Part A)

012X Hospital Inpatient Part B

013X Hospital Outpatient

014X Hospital Other Part B

018X Hospital Swing Bed

- 021X SNF Inpatient
- 022X SNF Inpatient Part B
- 023X SNF Outpatient
- 028X SNF Swing Bed
- 032X Home Health
- 033X Home Health
- 034X Home Health (Part B Only)
- 041X Religious Nonmedical Health Care
Institutions
- 071X Clinical Rural Health
- 072X Clinic ESRD
- 073X Federally Qualified Health Centers
- 074X Clinic OPT
- 075X Clinic CORF
- 076X Community Mental Health Centers
- 081X Nonhospital based hospice
- 082X Hospital based hospice
- 083X Hospital Outpatient (ASC)
- 085X Critical Access Hospital

FL 5 - Federal Tax Number

Required. The format is NN-NNNNNNNN.

FL 6 - Statement Covers Period (From-Through)

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

FL 7

Not Used.

FL 8 - Patient's Name

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

FL 9 - Patient's Address

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

FL 10 - Patient's Birth Date

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

FL 11 - Patient's Sex

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

FL 12 - Admission Date

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

FL 13 - Admission Hour

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

FL 14 - Type of Admission/Visit

Required on inpatient bills only. This is the code indicating priority of this admission.

Code Structure:

- 1 Emergency - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.

- 2 Urgent- The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
- 3 Elective - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
- 4 Newborn
- 5 Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.
- 6-8 Reserved for National Assignment
- 9 Information Not Available

FL 15 – Point of Origin for Admission or Visit

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

Code Structure:

- | | | |
|---|--|---|
| 1 | Non-Health Care Facility Point of Origin (Physician Referral) | Inpatient: The patient was admitted to this facility upon an order of a physician. |
| | <u>Usage note:</u> Includes patients coming from home, a physician's office, or workplace. | Outpatient: The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). Includes non-emergent self referrals. |
| 2 | Clinic | Inpatient: The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic. |
| | | Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services. |
| 3 | | Reserved for national assignment. |
| 4 | Transfer from a Hospital (Different Facility) | Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or an outpatient. |
| | <u>Usage Note:</u> Excludes Transfers from | Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a |

	Hospital Inpatient in the Same Facility (See Code D).	physician of a different acute care facility. * For transfers from hospital inpatient in the same facility, see code D.
5	Transfer from a SNF or Intermediate Care Facility (ICF)	Inpatient: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF or ICF where he or she was a resident.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. Outpatient: The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.
7	Emergency Room (ER)	Inpatient: The patient was admitted to this facility after receiving services in this facility's emergency room department. <u>Usage Note: Excludes</u> patients who came to the ER from another health care facility.
		Outpatient: The patient received unscheduled services in this facility's emergency department and discharged without an inpatient admission. Includes self-referrals in emergency situations that require immediate medical attention.
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. <u>Usage Note:</u> Includes transfers from incarceration facilities.
		Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	Inpatient: The means by which the patient was admitted to this facility is not known. Outpatient: For Medicare outpatient bills, this is not a valid code.

A		Reserved for national assignment.
B	Transfer From Another Home Health Agency	The patient was admitted to this home health agency as a transfer from another home health agency
C	Readmission to Same Home Health Agency	The patient was readmitted to this home health agency within the same home health episode period.
D	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer	The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
E	Transfer from Ambulatory Surgery Center	<p><i><u>Inpatient:</u> This patient was admitted to this facility as a transfer from an ambulatory surgery center.</i></p> <p><i><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.</i></p>
F	Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program	<p><i><u>Inpatient:</u> The patient was admitted to this facility as a transfer from hospice.</i></p> <p><i><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.</i></p>
G-Z		Reserved for national assignment.