CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1555	**Date: JULY 18, 2008**
	Change Request 6116

SUBJECT: Revision of the Requirements for Denial of Payment for New Admissions (DPNA) for Skilled Nursing Facility (SNF) Billing

I. SUMMARY OF CHANGES: This instruction implements new coding requirements for SNF providers billing services during a DPNA period.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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

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

R/N/D	Chapter / Section / Subsection / Title
R	6/Table of Contents
R	6/40/40.8/Billing in Benefits Exhaust and No-Payment Situations
R	6/50/SNF Payment Bans, or Denial of Payment for New Admissions (DPNA)
R	6/50/50.1/Effect on Utilization Days and Benefit Period
R	6/50/50.2/Billing When Ban on Payment Is In Effect
R	6/50/50.2.1/Effect of an Appeal to a DPNA on Billing Requirements During the Period a SNF is Subject to a DPNA
R	6/50/50.2.2/Provider Liability Billing Instructions
R	6/50/50.2.3/Beneficiary Liability Billing Instructions
R	6/50/50.3.1/Tracking the Benefit Period
R	6/50/50.4/Conducting Resident Assessments
R	6/50/50.6/FI/A/B MAC Responsibilities
R	25/75/75.3/Form Locators 31-41

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

Pub. 100-04	Transmittal: 1555	Date: July 18, 2008	Change Request: 6116

SUBJECT: Revision of the Requirements for Denial of Payment for New Admissions (DPNA) for Skilled Nursing Facility (SNF) Billing

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Current Medicare instructions for denial of payment for new admissions or DPNA billing reside in sections 50-50.7 of Chapter 6 (SNF Inpatient Part A Billing) of the Medicare Claims Processing Manual. These instructions provide billing guidance for SNF providers when subject to a payment ban. In addition, direction on billing for readmissions, for those patients in which the DPNA would not be applicable, resides in these sections.

Medicare policy indicates that beneficiaries admitted before the effective date of the denial of payment and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are not considered new admissions, and are not subject to the denial of payment upon return.

Medicare instructions previously indicated that providers shall append a condition code 57 (SNF readmission) for those patients in which the DPNA does not apply. However, the definition for condition code 57 indicates the patient previously received Medicare covered SNF care within 30 days of this readmission and would not necessarily apply in all payment ban situations. For example, a readmission could apply to patients that resided in the SNF prior to the imposition of the ban, whether on private pay or covered under another insurer, then went out to a hospital for a qualifying stay and returned directly back to the SNF upon discharge of the hospital. If the patient, in this scenario, did not receive Medicare SNF covered care within 30 days of the readmission then the condition code 57 would not be appropriate.

Therefore, CMS is updating DPNA instructions to require SNF providers to append occurrence span code 80 (definition below), for same-SNF readmissions, to indicate the most recent prior same-SNF stays dates of the patient prior to their discharge to the hospital for a qualifying hospital stay. As long as the patient resides in the SNF prior to the imposition of a payment ban and the patient discharges to the hospital then directly back to the same SNF from the hospital the claim would be considered a readmission for DPNA purposes and a payment ban will not be applicable. In addition, if the patient resides in the SNF prior to the imposition of the ban and goes on a leave of absence (LOA), the patient will not be subject to a ban upon their return to the SNF should a payment ban be applicable during their return. Providers must be sure to bill the LOA period on their claim.

Occurrence Span Code: 80
Title: Prior Same-SNF Stay Dates for Payment Ban Purposes
Definition: The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.

B. Policy: Under the Act at §§1819(h) and 1919(h) and CMS' regulations at 42 CFR 488.417, CMS may impose a denial of payment for new admissions (DPNA) against a SNF when a facility is not in substantial compliance with requirements of participation.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6116.1	Medicare systems shall accept occurrence span code 80 for reporting prior same-SNF stay dates.						X				
6116.2	Medicare contractors shall follow the instruction indicated in Chapter 6, section 50.6 of this manual for determining readmission status during payment ban periods.	X		X							
6116.3	Medicare contractors shall ensure local edits are in place to identify claims from providers subject to a payment ban, and make individual determinations on affected SNF claims.	X		X							
6116.4	Medicare contractors shall reject SNF claims subject to a payment ban.	X		X							
6116.5	Medicare contractors shall bypass local payment ban edits for claims that are not subject to a payment ban.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6116.6	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. 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 one 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.	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 (for claims processing guidance); Julie Stankivic, Julie.Stankivic@cms.hhs.gov (for DPNA policy guidance)

Post-Implementation Contact(s): Appropriate Regional Office
http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) 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.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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(Rev. 1555, 07-18-08)

Transmittals for Chapter 6

Crosswalk to Old Manuals

50.2.1 – Effect of an Appeal to a DPNA on Billing Requirements During the Period a SNF is Subject to a DPNA

50.6 - *FI/A/B MAC* Responsibilities

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

An SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

An SNF must submit a benefits exhaust bill monthly for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insure, or private payer. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim. These bills are required in order to extend the beneficiary's applicable benefit period posted in the Common Working File (CWF). Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary. ***NOTE**: Part B 22x bill types must be submitted after the benefits exhaust claim has been submitted and processed.*

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type. ***NOTE**: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 no payment claims.*

If a facility has a separate, distinct non-skilled area or wing then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no-

payment bills would not be required. In addition, SNF CB legislation for therapy services would not apply for these beneficiaries.

No-payment bills are not required for non-skilled beneficiary admissions. As indicated above, they are only required for beneficiaries that have previously received covered care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

NOTE: Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 in addition to an appropriate room & board revenue code only. No further ancillary services need be billed on these claims.

SNF providers and FIs shall follow the billing guidance provided below for the proper billing of benefits exhaust bills and no-payment bills.

1) SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:

a) Full or partial benefits exhaust claim.

i) Bill Type = Use appropriate covered bill type (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available.

iii) Patient Status Code = Use appropriate code.

b) Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.

i) Bill Type = Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB. **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).
ii) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.

iii) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.

iv) Patient Status Code = 30 (still patient).

c) Benefits exhaust claim with a patient discharge.

i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (**NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date active care ended.

iii) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

a) Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.
iv) Occurrence Span Code 74 = include the statement covers period of this claim.

v) Condition Code 21 (billing for denial).

vi) Patient Status Code = Use appropriate code.

b) Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months but must be as often as necessary to meet timely filing guidelines.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Occurrence Span Code 74 = include the statement covers period of this claim.

v) Condition Code 21 (billing for denial).

vi) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: No pay bills may span both provider and Medicare fiscal year end dates.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-04 (CMS-1450) Data Set" for further information about billing, as it contains UB-04 data elements and the corresponding fields in the electronic record.

50 - SNF Payment Bans, or Denial of Payment for New Admissions (DPNA)

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Under the Act at §§1819(h) and 1919(h) and CMS' regulations at 42 CFR 488.417, CMS may impose a denial of payment for new admissions (DPNA) against a SNF when a facility is not in substantial compliance with requirements of participation. *To understand the effect on coverage of SNF services*, see the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §§20.3 – 20.3.1.6.

50.1 - Effect on Utilization Days and Benefit Period

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Payment sanctions are applied to days that would otherwise be Part A-payable; i.e., the care is covered but no payment will be made to the provider. Therefore, if the Medicare participating SNF assumes responsibility for the beneficiary's costs during the sanction period, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.

In situations where the beneficiary is subject to the payment ban, but the provider fails to issue the proper beneficiary liability notice, the provider is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts. These days will be charged against the beneficiary's utilization as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.).

If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

50.2 - Billing When Ban on Payment Is In Effect

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Beneficiaries admitted before the effective date of the denial of payment and taking temporary leave, whether to receive inpatient hospital care, outpatient services or as therapeutic leave, are not considered new admissions, and are not subject to the denial of

payment upon return. This policy applies even if there are multiple hospitalizations and returns to the SNF during the period sanctions are in effect.

When determining if the beneficiary was admitted prior to the imposition of the ban, the actual status of the beneficiary rather than the primary payor is the determining factor. Therefore, there may be situations where the beneficiary is a private pay patient or a dual eligible who was receiving Medicaid benefits prior to the imposition of the payment ban. If this private pay patient or dual eligible goes to the hospital for needed care, and meets the Medicare Part A criteria *for SNF coverage* upon return to the SNF, the readmission is exempt from the denial of payment sanction. When billing for a readmission that is NOT subject to the payment ban, providers must *enter occurrence span code 80, Prior Same-SNF Stay Dates for Payment Ban Purposes, on the claim to identify the prior same-SNF stay dates, in addition to reporting any LOA and prior hospital stay dates, using occurrence span codes, that may affect the contractors determination of payment ban exemption status. See Chapter 25 of this manual for occurrence span code titles and definitions.*

50.2.1 – *Effect of an Appeal to a DPNA on Billing During the Period the SNF is Subject to a DPNA*

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

In those situations where the SNF decides to appeal the imposition of a DPNA, it must still bill the program as set forth in the instructions below.

50.2.2 - Provider Liability Billing Instructions

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

The SNF must file a covered bill with the FI using occurrence span code 77 that indicates the facility is liable for the services *in situations where the SNF failed to issue the proper beneficiary liability notice* and any applicable copayments will be charged to the beneficiary's Part A benefit period. Furthermore, the sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of provider liable days reported in the occurrence span code 77. See §60 of Chapter 1 in this manual for detailed instructions on nonpayment billing requirements.

When the SNF is liable for the Part A stay, the SNF is required to provide all necessary covered Part A services, including those services such as therapies and radiology mandated under consolidated billing. For example, if the beneficiary goes to the hospital for a non-emergency chest x-ray, the SNF will be responsible for the outpatient hospital radiology and any ambulance charges. In this case, the SNF may not charge the beneficiary or family members for any services that, in the absence of a payment

sanction, would have been covered under the Part A PPS payment.

50.2.3 - Beneficiary Liability Billing Instructions

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

The SNF *shall* file a non-payment bill for noncovered Part A services, using *condition code 21 that* indicates beneficiary liability. Services that would have been eligible for Part A benefits in the absence of sanctions cannot be billed as Part B charges. However, the SNF may directly bill the beneficiary, family members or other third party insurers for services provided to that beneficiary.

50.3.1 - Tracking the Benefit Period

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

SNF days during the sanction period will be used to track breaks in the spell of illness if a beneficiary's care in the SNF meets the skilled level of care *requirements*. If the patient is receiving a skilled level of care the benefit period cannot end. Therefore, it *will* be tracked in CWF.

50.4 – Conducting Resident Assessments

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

The imposition of sanctions does not waive the SNF's responsibility to perform assessments in accordance with the clinical schedule defined in the SOM. Comprehensive admission assessments are still due within 14 days of admission to the SNF. Facility staff must also maintain the schedule for quarterly and annual assessments, and perform SCSAs and SCPAs when clinically appropriate.

Medicare-required assessments are also necessary for all beneficiaries in the SNF whose stays are not subject to the payment ban. If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, *no payment is made and the SNF must submit a claim using the HIPPS default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.*

Part A benefits are NOT available for beneficiaries admitted after the effective date of the payment ban. Therefore, the facility is not required to perform Medicare PPS assessments. Medicare payments can begin no earlier than the date the sanction is lifted. For Medicare PPS assessment scheduling purposes, the date the sanction is lifted should be considered day 1. In this case, if the sanctions are lifted effective June 15, the assessment reference date for the Medicare 5-day assessment must be set between June 15 and June 22 (i.e., the eighth day of the covered stay).

An SNF may choose to perform the Medicare-required assessments during the sanction period, but is not required to do so. Generally, a facility should continue to do the Medicare PPS assessments if SNF staff believe the sanction was in error and may be lifted retroactively. In this case, the SNF would be able to bill Medicare at the correct RUG rate.

When the SNF does not receive timely notification that a payment ban has been lifted, and staff is unaware of the need to start the Medicare-Required schedule (the beneficiary meets all applicable eligibility and coverage requirements), the SNF shall bill the Medicare 5-day and 14 day assessment using the HIPPS code generated by the 14-day OBRA required assessment. If the SNF did not perform any assessments with an assessment reference date during the assessment window for the Medicare-Required 5-day or 14 day assessment, the SNF shall bill the default rate for those covered days associated with the assessment. Where the SNF did not perform an assessment with an ARD that fell in the applicable Medicare-Required Assessment window for the 30, 60 and 90-day Medicare-Required Assessments it shall bill the default rate. If the SNF did perform an assessment, including a SCSA, where the ARD fell in the window of a 30, 60 or 90-day Medicare-Required Assessment (including grace days), the SNF shall bill using the HIPPS code generated from the assessment in accordance with the payment policies found in Chapter 28 of the Provider Reimbursement Manual. The date the sanction is lifted is Day 1 for purposes of the Medicare assessment schedule.

***NOTE**: In order to bill with the default code the beneficiary must at least meet the requirements for SNF coverage.*

***EXAMPLE 1**: The SNF is notified on June 15th that its payment ban was lifted effective June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the 5-day Medicare-Required Assessment for up to 14 days. Day 15 is day 1 for purposes of starting the Medicare-required assessment schedule and a 5-day Medicare required assessment shall be performed.*

***EXAMPLE 2:** The SNF is notified on August 15 that its payment ban was lifted on June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA Assessment. The initial OBRA assessment shall be used to bill the 5-day Medicare required assessment and the 14-day Medicare required assessment. The 30-day assessment shall be billed through day 44 at the default rate. Day 45 is day 1 for purposes of starting the Medicare- required assessment schedule and a 5-day Medicare required assessment shall be performed.*

50.6 - *FI/A/B MAC* Responsibilities

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

The FI/A/B/MACs will receive notices from the CMS Regional Office when sanctions havebeen imposed or lifted and in some cases when sanctions are proposed. The CMS'primary objective is always to bring the facility into compliance. In many cases, enforcement activity does not go beyond the notice of intent. *Contractors shall* initiate action only when notified that sanctions have been imposed.

Upon notification that a sanction is imposed, contractors shall identify claims affected with *admission* dates on and after the *effective* date of the sanction. Overpayments for claims erroneously paid should be recovered and CWF properly updated to reflect the payment ban action. Claims for new admissions should be denied from the date of admission through the last date of the sanction period.

In addition, contractors shall determine whether claims with admission dates after the effective date of the sanctions qualify for readmission status, as defined in the previous sections, and are not subject to a payment ban. Contractors shall bypass local payment ban edits for claims that are not subject to a payment ban when dates associated with occurrence span code 80, Prior Same-SNF stay for payment ban purposes, indicates the beneficiary resided in the SNF prior to the imposition of the ban. (See §50.2 above for further payment ban bypassing criteria for hospitalizations and LOAs)

75.3 - Form Locators 31-41

(Rev. 1555; Issued: 07-18-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

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

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

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

Due to the varied nature of Occurrence and Occurrence Span Codes, provisions have been made to allow the use of both type codes within each. The Occurrence Span Code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as 10 Occurrence Codes to be utilized. With respect to Occurrence Codes, complete field 31a - 34a (line level) before the "b" fields. Occurrence and Occurrence Span codes are mutually exclusive. An example of Occurrence Code use: A Medicare beneficiary was confined in hospital from January 1, 2005 to January 10, 2005, however, his Medicare Part A benefits were exhausted as of January 8, 2005, and he was not entitled to Part B benefits. Therefore, Form Locator 31 should contain code A3 and the date 010805.

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

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

Code	Title	Definition
01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
02	No-Fault Insurance Involved - Including Auto Accident/Other	Date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).

Code	Title	Definition
03	Accident/Tort Liability	Date of an accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Date of an accident that relates to the patient's employment.
05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08		Reserved for national assignment.
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.
11	Onset of Symptoms/Illness	(Outpatient claims only.) Date that the patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual (CDI)	(HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.
13-15		Reserved for national assignment
16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).
17	Date Outpatient Occupational	The date the occupational therapy plan was

Code	Title	Definition
	Therapy Plan Established or Reviewed	established or last reviewed.
18	Date of Retirement Patient/Beneficiary	Date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision.
21	UR Notice Received	(Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary.
22	Date Active Care Ended	Date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period. For FI Use Only. Providers Do Not Report.	Code is not required if code "21" is used.
24	Date Insurance Denied	Date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available	The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	The date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit

Code	Title	Definition
		periods.
28	Date CORF Plan Established or Last Reviewed	The date a plan of treatment was established or last reviewed for CORF care.
29	Date OPT Plan Established or Last Reviewed	The date a plan was established or last reviewed for OPT.
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	The date a plan was established or last reviewed for outpatient speech pathology.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date the hospital notified the beneficiary that the beneficiary does not (or no longer) requires inpatient care and that coverage has ended.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be reasonable or necessary under Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	The first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.
34	Date of Election of Extended Care Services	The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
35	Date Treatment Started for Physical Therapy	The date the provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)	The date of discharge for a hospital stay in which the patient received a covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. **NOTE:** When the patient received a covered and a non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital	The date of discharge for an inpatient hospital

Code	Title	Definition
	Discharge - Patient Received Non-covered Transplant	stay during which the patient received a non-covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs.
38	Date treatment started for Home IV Therapy	Date the patient was first treated at home for IV therapy (Home IV providers - bill type 85X).
39	Date discharged on a continuous course of IV therapy	Date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers- bill type 85X).
40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test was performed as a part of a PAT program. This code may be used only if a date of admission was scheduled prior to the administration of the test(s).
42	Date of Discharge	(Hospice claims only.) The date on which a beneficiary terminated their election to receive hospice benefits from the facility rendering the bill. The frequency digit should be 1 or 4.
43	Scheduled Date of Cancelled Surgery	The date for which outpatient surgery was scheduled.
44	Date Treatment Started for Occupational Therapy	The date the provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	The date the provider initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	The date the provider initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	*Code indicates that this is the first day after the day the cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular, coinsurance and/or lifetime reserve days available beginning on this*

Code	Title	Definition
		date to allow coverage of additional daily charges for the purpose of making a cost outlier payment.
48-49	Payer Codes	For use by third party payers only. The CMS assigns for FI use. Providers do not report these codes.
50-69		Reserved for State Assignment. Discontinued Effective October 16, 2003.
A1	Birth Date-Insured A	The birth-date of the insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy	The first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer A.
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as “Split Bill Date”). Effective 10/1/03.
A5-AZ		Reserved for national assignment
B1	Birth Date-Insured B	The birth-date of the individual in whose name the insurance is carried.
B2	Effective Date-Insured B Policy	The first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer B.
B4-BZ		Reserved for national assignment
C1	Birth Date-Insured C	The birth-date of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	The first date the insurance is in force.

Code	Title	Definition
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer C.
C4-CZ		Reserved for National Assignment.
D0-DQ		Reserved for National Assignment.
DR		Reserved for Disaster Related Code
DS-DZ		Reserved for National Assignment
E0		Reserved for National Assignment
E1	Birth Date-Insured D	Discontinued 3/1/07.
E2	Effective Date-Insured D Policy	Discontinued 3/1/07.
E3	Benefits Exhausted	Discontinued 3/1/07.
E4-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Birth Date-Insured E	Discontinued 3/1/07.
F2	Effective Date-Insured E Policy	Discontinued 3/1/07.
F3	Benefits Exhausted	Discontinued 3/1/07.
F4-FZ		Reserved for national assignment
G0		Reserved for national assignment
G1	Birth Date-Insured F	Discontinued 3/1/07.
G2	Effective Date-Insured F Policy	Discontinued 3/1/07.
G3	Benefits Exhausted	Discontinued 3/1/07.
G4-LZ		Reserved for national assignment
M0-		See instructions in FLs 35 and 36 –

Code	Title	Definition
MQ		Occurrence Span Codes and Dates
MR		Reserved for Disaster Related Code
MS-ZZ		Reserved for national assignment

FLs 35 and 36 - Occurrence Span Code and Dates

Required For Inpatient.

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

Code Structure

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Non-utilization Dates (For Payer Use on Hospital Bills Only)	The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates	(Part A claims only.) The From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.
74	Non-covered Level of Care	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient

Code	Title	Definition
		hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, but not valid for HHA under PPS.
75	SNF Level of Care	The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLs 24-30). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care.
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability- Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.

Code	Title	Definition
80	*Prior Same-SNF Stay Dates for Payment Ban Purposes*	*The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.*
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5-ZZ		Reserved for National Assignment

FL 37 - (Untitled)

Not used. Data entered will be ignored.

FL 38 - Responsible Party Name and Address

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

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

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

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

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

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

Code	Title	Definition
		on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
15	Worker's Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where

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

Code	Title	Definition
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at State level.
25	Offset to the Patient-Payment Amount – Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount – Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount – Vision and Eye Services	Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount – Dental Services	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount – Chiropractic Services	Chiropractic Services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
31	Patient Liability Amount	The FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount – Podiatric Services	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount – Other Medical Services	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount – Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers

Code	Title	Definition
		Period).
36		Reserved for national assignment.
37	*Units of Blood Furnished*	The total number of *units* of whole blood or packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete *units* rounded upwards, e.g., 1 1/4 *units* is shown as 2. This entry serves as a basis for counting *units* towards the blood deductible.
38	Blood Deductible *Units*	The number of unreplaced deductible *units* of blood *furnished for which the patient is responsible.* If all deductible *units* furnished have been replaced, no entry is made.
39	*Units* of Blood Replaced	The total number of *units* of blood that were donated on the patient's behalf. Where one *unit* is donated, one *unit* is considered replaced. If arrangements have been made for replacement, *units* are shown as replaced. Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced *units*), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by Managed Care Plan	(For inpatient service only.) Inpatient charges covered by the Managed Care Plan. (The hospital uses this code when the bill includes inpatient charges for newly covered services that are not paid by the Managed Care Plan. It must also report condition codes 04 and 78.)
41	Black Lung (BL)	That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure

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

Code	Title	Definition
		payment.
48	Hemoglobin Reading	The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.
49	Hematocrit Reading	The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.
50	Physical Therapy Visits	The number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	The number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	The number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.
54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law.
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse – Home Visit Hours (HHA only)	The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. It excludes travel

Code	Title	Definition
		time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.)
57	Home Health Aide – Home Visit Hours (HHA only)	The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (The number is rounded to the nearest whole hour.)

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

					1	3		

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

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

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

						5	7

A reading of 100 percent is shown as:

					1	0	0

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

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

	3	1	0	6	0		

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

					5	0	0	0

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

Code	Title	Definition
		codes.
80	Covered days	The number of days covered by the primary payer as qualified by the payer.
81	Non-Covered Days	Days of care not covered by the primary payer.
82	Co-insurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness.
83	Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
84-99		Reserved for national assignment.
A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.
A4	Covered Self-Administrable Drugs – Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for

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

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

Code	Title	Definition
		For Part A coinsurance amounts use Value Codes 8-11.
C3	Estimated Responsibility Payer C	Amount the provider estimates will be paid by the indicated payer.
C4-C6		Reserved for national assignment
C7	Co-payment Payer C	The amount the provider assumes is applied to the patient's co-payment amount involving the indicated payer.
C8-C9		Reserved for national assignment
CA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer C	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
CC-CZ		Reserved for national assignment
D0-D2		Reserved for national assignment
D3	Patient Estimated Responsibility	The amount estimated by the provider to be paid by the indicated patient
D4	Clinical Trial Number Assigned by NLM/NIH.	8-digit, numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of "99999999" if the trial does not have an 8-digit www.clinicaltrials.gov registry number. Effective 10/1/07.
D5-DQ		Reserved for national assignment
DR		Reserved for disaster related code
DS-DZ		Reserved for national assignment
FC	*Patient Paid Amount*	*The amount the provider has received*

Code	Title	Definition
		from the patient toward payment of this bill.
FD	*Credit Received from the Manufacturer for a Replaced Medical Device*	*The amount the provider has received from a medical device manufacturer as credit for a replaced device.*
E0-G7		Reserved for national assignment
G8	Facility Where Inpatient Hospice Service is Delivered	MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. Report the dollar portion of the form locator right justified to the left of the dollar/cents delimiter. Effective 1/1/08.
G9-Y0		Reserved for national assignment
Y1	Part A Demonstration Payment	This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
Y2	Part B Demonstration Payment	This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

Code	Title	Definition
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ		Reserved for national assignment