CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1767	**Date: JULY 10, 2009**
	Change Request 6561

SUBJECT: IOM Chapter 25 Revenue Code 076X Description Change

I. SUMMARY OF CHANGES: Chapter 25 Revenue Code 076X"s description is changing.

New/Revised Material
Effective Date: August 10, 2009
Implementation Date: August 10, 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	25/75.4/Form Locator 42

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: 1767	Date: July 10, 2009	Change Request: 6561

SUBJECT: IOM Chapter 25 Revenue Code 076X Description Change

Effective Date: **August 10, 2009**

Implementation Date: August 10, 2009

I. GENERAL INFORMATION

A. Background: Chapter 25 is being updated to clarify the revenue code 076X description per the National Uniform Billing Committee. There are no changes to the use of 076X.

B. Policy: N/A

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	
6561.1	Contractors shall be familiar with the updates in Chapter 25 subsection 75.4 (Form Locator 42).	X		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	
	None.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: for all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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Post-Implementation Contact(s): Matt Klischer, Matthew.Klischer@cms.hhs.gov, 410.786.7488

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements: 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),* include the following statement:

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.

75.4 - Form Locator 42

(Rev. 1767; Issued: 07-10-09; Effective/Implementation Date: 08-10-09)

FL 42 - Revenue Code

Required. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.

The biller must provide detail level coding for the following revenue code series:

0290s - Rental/purchase of DME

0304 - Renal dialysis/laboratory

0330s - Radiology therapeutic

0367 - Kidney transplant

0420s - Therapies

0520s - Type or clinic visit (RHC or other)

0550s - 590s - home health services

0624 - Investigational Device Exemption (IDE)

0636 - Hemophilia blood clotting factors

0800s - 0850s - ESRD services

9000 - 9044 - Medicare SNF demonstration project

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

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

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

0304 - rental and dialysis/laboratory,

0636 - hemophilia blood clotting factors,

0800s thru 0850s - ESRD services.

The remaining applicable codes are 0025, 0027, 0031-0032, 0038-0039, 0075, and 0082-0088.

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

The Hospice uses the following revenue codes to bill Medicare:

Code	Description	Standard Abbreviation
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	CTNS Home (A minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is 1 hour.
0655	Inpatient Respite Care	IP Respite
0656	General Inpatient Care	GNL IP
0657	Physician Services	PHY Ser (must be accompanied by a physician procedure code.)

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

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

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

Revenue Code	Description	
	1 - Reserved	
	2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
	3 - Home Health Prospective Payment System	HHS PPS (Health Resource Groups (HRG))
	4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (Case-Mix Groups (CMG))
	5 - Reserved	
	6 - Reserved	
	7 - Reserved	
	8 - Reserved	
	9 - Reserved	
003X to 006X	Reserved for National Assignment	
007X to 009X	Reserved for State Use until October 16, 2003. Thereafter, Reserved for National Assignment	

ACCOMMODATION REVENUE CODES (010X - 021X)

010X All Inclusive Rate

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

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

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

Revenue Code	Description

Routine service charges for single bedrooms.

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

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

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

Routine service charges incurred for accommodations with two beds.

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

Subcategory	Standard Abbreviations
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSYCH/2BED

Revenue Code	Description	
	5 - Hospice	HOSPICE/2BED
	6 - Detoxification	DETOX/2BED
	7 - Oncology	ONCOLOGY/2BED
	8 - Rehabilitation	REHAB/2BED
	9 - Other	OTHER/2BED

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

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

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

014X Private - (Deluxe) (Medical or General)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviations
0 - General Classification	ROOM-BOARD/ PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/ PVT/DLX

Revenue Code	Description	
	2 - OB	OB/ PVT/DLX
	3 - Pediatric	PEDS/ PVT/DLX
	4 - Psychiatric	PSYCH/ PVT/DLX
	5 - Hospice	HOSPICE/ PVT/DLX
	6 - Detoxification	DETOX/ PVT/DLX
	7 - Oncology	ONCOLOGY/ PVT/DLX
	8 - Rehabilitation	REHAB/ PVT/DLX
	9 - Other	OTHER/ PVT/DLX

015X Room & Board - Ward (Medical or General)

Routine service charges incurred for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

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

016X Other Room & Board (Medical or General)

Revenue Code	Description

Any routine service charges incurred for accommodations that cannot be included in the more specific revenue center codes

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

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

017X Nursery Charges for nursing care to newborn and premature infants in nurseries Subcategories 1-4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under State regulations or other statutes supersede the following guidelines. For example, some States may have fewer than four levels of care or may have multiple levels within a category such as intensive care.

Level I	Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).
Level II	Low birth-weight neonates who are not sick, but require frequent feeding and neonates who require more hours of nursing than do normal neonates (Continuing Care).
Level III	Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).
Level IV	Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).

Subcategory	Standard Abbreviations
0 - Classification	NURSERY
1 - Newborn - Level I	NURSERY/LEVEL I
2 - Newborn - Level II	NURSERY/LEVEL II

3 - Newborn - Level III	NURSERY/LEVEL III
4 - Newborn - Level IV	NURSERY/LEVEL IV
9 - Other	NURSERY/OTHER

018X Leave of Absence

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

NOTE: Charges are billable for codes 2 - 5.

Subcategory	**Standard Abbreviations**
0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - Reserved	
2 - Patient Convenience -Charges billable	LOA/PT CONV CHGS BILLABLE
3 - Therapeutic Leave	LOA/THERAP
4 – RESERVED	Effective 4/1/04
5 - Hospitalization	LOA/HOSPITALIZATION Effective 4/1/04
9 - Other Leave of Absence	LOA/OTHER

019X Sub-acute Care

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

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

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

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

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

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

Usage Note: Revenue code 019X may be used in multiple types of bills. However, if bill type X7X is used in Form Locator 4, Revenue Code 019X must be used. (**Note:** Bill Type X7X to be DISCONTINUED as of 10/1/05.)

020X Intensive Care

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

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

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

9 - Other Sub-acute Care	ICU/OTHER

021X Coronary Care

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

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

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

Code Description

ANCILLARY REVENUE CODES (022X - 099X)

022X Special Charges

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

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

Subcategory	**Standard Abbreviations**
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG

3 - U.R. Service Charge	UR CHARGE
4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

023X Incremental Nursing Care Charges

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

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

024X All Inclusive Ancillary

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

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

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

025X Pharmacy

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

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

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

026X IV Therapy

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

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

Subcategory	**Standard Abbreviations**

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

027X Medical/Surgical Supplies (Also see 062X, an extension of 027X)

Code indicates charges for supply items required for patient care.

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

Subcategory	**Standard Abbreviations**
0 – General Classification	MED-SUR SUPPLIES
1 – Non--sterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 – Oxygen - Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

028X Oncology

Code indicates charges for the treatment of tumors and related diseases.

Subcategory	**Standard Abbreviations**

0 – General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

029X Durable Medical Equipment (DME) (Other Than Rental)

Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	**Standard Abbreviations**
0 – General Classification	MED EQUIP/DURAB
1 – Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHA's Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

030X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	**Standard Abbreviations**
0 – General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 – Non-routine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMATOLOGY
6 - Bacteriology &	LAB/BACT-MICRO

Microbiology	
7 – Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

031X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

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

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify.

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

033X Radiology - Therapeutic

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

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

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

034X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify.

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

035X Computed Tomographic (CT) Scan

Charges for CT scans of the head and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

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

036X Operating Room Services

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

Rationale: Permits identification of particular services.

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

037X Anesthesia

Charges for anesthesia services in the hospital.

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

diagnostic service as part of the charge for the diagnostic service.

Subcategory	Standard Abbreviations
0 - General Classification	ANESTHESIA
1 - Anesthesia Incident to RAD	ANESTHE/INCIDENT RAD
2 - Anesthesia Incident to Other Diagnostic Services	ANESTHE/INCIDENT ODX
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

038X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

Subcategory	Standard Abbreviations
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED
2 - Whole Blood	BLOOD/WHOLE
3 – Plasma	BLOOD/PLASMA
4 – Platelets	BLOOD/PLATELETS
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives Cryopricipitates)	BLOOD/DERIVATIVES
9 - Other Blood	BLOOD/OTHER

039X Blood Storage and Processing

Charges for the storage and processing of whole blood

Subcategory	Standard Abbreviations
0 - General Classification	BLOOD/STOR-PROC

	1 - Blood Administration (e.g., Transfusions	BLOOD/ADMIN
	9 - Other Processing and Storage	BLOOD/OTHER STOR

040X Other Imaging Services

	Subcategory	**Standard Abbreviations**
	0 - General Classification	IMAGE SERVICE
	1 - Diagnostic Mammography	MAMMOGRAPHY
	2 - Ultrasound	ULTRASOUND
	3 - Screening Mammography	SCR MAMMOGRAPHY/GEN MAMMO
	4 - Positron Emission Tomography	PET SCAN
	9 - Other Imaging Services	OTHER IMAG SVS

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

ICD-9

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

041X Respiratory Services

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

Rationale: Permits identification of particular services.

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

042X Physical Therapy

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

Rationale: Permits identification of particular services.

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

043X Occupational Therapy

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

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

044X Speech-Language Pathology

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

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

045X Emergency Room

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

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

Reconciliation Act (COBRA) of 1985).

Subcategory	Standard Abbreviations
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical screening services	ER/EMTALA
2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6 - Urgent Care	URGENT CARE
9 - Other Emergency Room	OTHER EMER ROOM

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

Usage Notes

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

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

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

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

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

046X Pulmonary Function

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

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

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

047X Audiology

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

Rationale: Permits identification of particular services.

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

048X Cardiology

Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

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

9 - Other Cardiology	OTHER CARDIOL

049X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by any other category.

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

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

050X Outpatient Services

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

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

051X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	**Standard Abbreviations**
0 – General Classification	CLINIC
1 – Chronic Pain Center	CHRONIC PAIN CL
2 - Dental Clinic	DENTAL CLINIC
3 - Psychiatric Clinic	PSYCH CLINIC
4 - OB-GYN Clinic	OB-GYN CLINIC

5 - Pediatric Clinic	PEDS CLINIC
6 - Urgent Care Clinic	URGENT CLINIC
7 - Family Practice Clinic	FAMILY CLINIC
9 - Other Clinic	OTHER CLINIC

052X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	**Standard Abbreviations**
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic (Effective 7/1/06 will be changed to: Clinic visit by member to RHC/FQHC)	RURAL/CLINIC
2 - Rural Health-Home (Effective 7/1/06 will be changed to: Home visit by RHC/FQHC practitioner)	RURAL/HOME
3 - Family Practice	FR/STD FAMILY CLINIC
4 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF	
5 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility	
6 - Urgent Care Clinic	FR/STD URGENT CLINIC
7 - Effective 7/1/06 - RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area	
8 - Effective 7/1/06 - Visit by RHC/FQHC practitioner to other	

non RHC/FQHC site (e.g. scene of accident)

9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

053X Osteopathic Services

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

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

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

054X Ambulance

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

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

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

EKG

9 - Other Ambulance	OTHER AMBULANCE

055X Skilled Nursing

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

Subcategory	**Standard Abbreviations**
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

056X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	**Standard Abbreviations**
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

057X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	**Standard Abbreviations**
0 - General Classification	AIDE/HOME HEALTH

1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

058X Other Visits (Home Health)

Code indicates charges by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	**Standard Abbreviations**
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
3 - Assessment	VISIT/HOME HLTH/ASSES
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

059X Units of Service (Home Health)

This revenue code is used by an HHA that bills on the basis of units of service.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory	**Standard Abbreviations**
0 - General Classification	UNIT/HOME HEALTH
9 – Reserved (effective 10/1/07)	

060X Oxygen (Home Health)

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

If a beneficiary had purchased a stationary oxygen system, oxygen concentrator or portable equipment, current revenue codes 0292 or 0293 apply. DME (other than oxygen systems) is billed under current revenue codes 0291, 0292, or 0293.

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

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

061X Magnetic Resonance Technology (MRT)

Code indicates charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

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

062X Medical/Surgical Supplies - Extension of 027X

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

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

063X Pharmacy - Extension of 025X

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

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

NOTE: (a) Charges for drugs and biologicals (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) requiring specific identifications

as required by the payer (effective 10/1/04). If HCPCs are used to describe the drug, enter the HCPCS code in Form Locator 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).

064X Home IV Therapy Services

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

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

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

065X Hospice Services

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

Rationale: The level of hospice care that is provided each day during a hospice

election period determines the amount of Medicare payment for that day.

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

066X Respite Care (HHA Only)

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

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

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

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

068X Trauma Response

Charges for a trauma team activation.

Subcategory	Standard Abbreviations
0 - Not Used	
1 - Level I	TRAUMA LEVEL I
2 - Level II	TRAUMA LEVEL II
3 - Level III	TRAUMA LEVEL III
4 - Level IV	TRAUMA LEVEL IV
9 - Other Trauma Response	TRAUMA OTHER

Usage Notes:

1. To be used by trauma center/hospitals as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

2. Revenue Category 068X is used for patients for whom a trauma activation occurred. A trauma team activation/response is a “Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival.”

3. Revenue Category 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X revenue code reported.

4. Revenue Category 068X is not limited to admitted patients.

5. Revenue Category 068X must be used in conjunction with FL 19 Type of Admission/Visit code 05 (“Trauma Center”), however FL 19 Code 05 can be used alone.

Only patients for who there has been **pre-hospital** notification, who meet either local, State or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are "drive-by" or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.

6. Levels I, II, III or IV refer to designations by the State or local government authority or as verified by the American College of Surgeons.

7. Subcategory 9 is for sate or local authorities with levels beyond IV.

069X Not Assigned

070X Cast Room

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

Rationale: Permits identification of this service, if necessary.

Subcategory	**Standard Abbreviations**
0 - General Classification	CAST ROOM
9 - Reserved (effective 10/1/07)	

071X Recovery Room

Rationale: Permits identification of particular services, if necessary.

Subcategory	**Standard Abbreviations**
0 - General Classification	RECOVERY ROOM
9 - Reserved (effective 10/1/07)	

072X Labor Room/Delivery

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

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

Subcategory	**Standard Abbreviations**

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

073X Electrocardiogram (EKG/ECG)

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

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

074X Electroencephalogram (EEG)

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

Subcategory	**Standard Abbreviations**
0 - General Classification	EEG
9 - Reserved (effective 10/1/07)	

075X Gastro-Intestinal Services

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

Subcategory	**Standard Abbreviations**
0 - General Classification	GASTR-INTS SVS

9 - Reserved (effective 10/1/07)

076X *Specialty Services*

Charges for *patients requiring treatment room services or patients placed under observation*. *FL 76 – Patient's Reason for Visit should be reported in conjunction with 0762.* Only 0762 should be used for observation services.

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

Subcategory	**Standard Abbreviations**
0 - General Classification	*SPECIALTY SVC*
1 - Treatment Room	TREATMENT RM
2 – Observation *Hours*	OBSERVATION
9 – Other *Specialty Services*	OTHER *SPECIALTY SVC*

077X Preventative Care Services

Charges for the administration of vaccines.

Subcategory	**Standard Abbreviations**
0 - General Classification	PREVENT CARE SVS
1 - Vaccine Administration	VACCINE ADMIN
9 – Reserved (effective 10/1/07)	

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

Subcategory	Standard Abbreviations

	0 - General Classification	TELEMEDICINE
	9 – Reserved (effective 10/1/07)	

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

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

Subcategory	**Standard Abbreviations**
0 - General Classification	ESWT
9 – Reserved (effective 10/1/07	

080X Inpatient Renal Dialysis

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

Rationale: Specific identification required for billing purposes.

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

081X Organ Acquisition

The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation.

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

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

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

082X Hemodialysis - Outpatient or Home Dialysis

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

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

	9 – Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X Peritoneal Dialysis - Outpatient or Home

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

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

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

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

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

085X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient

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

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

086X Reserved for Dialysis (National Assignment)

087X Reserved for Dialysis (National Assignment)

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

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

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

089X Reserved for National Assignment

090X Behavior Health Treatments/Services (Also see 091X, an extension of 090X)

Subcategory	Standard Abbreviations

0 - General Classification	BH
1 - Electroshock Treatment	BH/ELECTRO SHOCK
2 - Milieu Therapy	BH/MILIEU THERAPY
3 - Play Therapy	BH/PLAY THERAPY
4 - Activity Therapy	BH/ACTIVITY THERAPY
5 – Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
6 – Intensive Outpatient Services-Chemical Dependency	BH/INTENS OP/CHEM DEP
7 – Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY
8 – Reserved for National Use	
9 – Reserved for National Use	

091X Behavioral Health Treatment/Services-Extension of 090X

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

Subcategories 0912 and 0913 are designed as zero-billed revenue codes (no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract.

Subcategory	**Standard Abbreviations**
0 – Reserved for National Assignment	
1 - Rehabilitation	BH/REHAB
2 - Partial Hospitalization* - Less Intensive	BH/PARTIAL HOSP
3 - Partial Hospitalization* - Intensive	BH/PARTIAL INTENSIVE
4 - Individual Therapy	BH/INDIV RX
5 - Group Therapy	BH/GROUP RX

6 - Family Therapy	BH/FAMILY RX
7 - Bio Feedback	BH/BIOFEED
8 - Testing	BH/TESTING
9 – Other Behavior Health Treatments/Services	BH/OTHER

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

092X Other Diagnostic Services

Code indicates charges for other diagnostic services not otherwise categorized.

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

093X Medical Rehabilitation Day Program

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

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

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

Code indicates charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
6 - Complex Medical Equipment Routine	COMPLX MED EQUIP-ROUT
7 - Complex Medical Equipment Ancillary	COMPLX MED EQUIP-ANC
8 – Pulmonary Rehabilitation (effective 10/1/07 – not used by Medicare)	PULMONARY REHAB
9 - Other Therapeutic Services	ADDITIONAL RX SVS

095X Other Therapeutic Services-Extension of 094X

Charges for other therapeutic services not otherwise categorized

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

096X Professional Fees

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

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

097X Professional Fees - Extension of 096X

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

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

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT

3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 – EKG	PRO FEE/EKG
6 – EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

099X Patient Convenience Items

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

Rationale: Permits identification of particular services as necessary.

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

100X Behavioral Health Accommodations

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

Subcategory	**Standard Abbreviations**

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

101X TO 209X Reserved for National Assignment

210X Alternative Therapy Services

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

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

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

211X to 300X Reserved for National Assignment

310X Adult Care - Effective April 1, 2003

Charges for personal, medical, psycho-social, and/or therapeutic services in a

special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADLs)

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

311X to 899X Reserved for National Assignment

9000 to 9044 Reserved for Medicare Skilled Nursing Facility Demonstration Project

9045 - 9099 Reserved for National Assignment