# CMS Manual System

## Pub 100-04 Medicare Claims Processing

**Transmittal 901**

**Department of Health & Human Services (DHHS)**

**Centers for Medicare & Medicaid Services (CMS)**

**Date: APRIL 7, 2006**

**Change Request 4384**

**SUBJECT: New National Uniform Billing Committee (NUBC) Codes and Other Chapter 25 Revisions -- Revision to the Internet-Only Manual**

**I. SUMMARY OF CHANGES:** New source of admission code "D" has been added. New patient status code 66 has been added. New condition codes "DR", "W0", 49, and 50 have been added. Removed all UB-92 version 6.0 record types information (section 90). New Occurrence Code "DR" has been added. New Occurrence Span Code "MR" has been added. Value Code 61's definition has been updated. Value codes Y1, Y2, Y3, and Y4 have been added. Revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 have been added/updated.

**NEW/REVISED MATERIAL**

**EFFECTIVE DATE: May 8, 2006**

**IMPLEMENTATION DATE: May 8, 2006**

*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/Table of Contents |
| D | 25/20.1/Decimal Data Elements |
| D | 25/20.2/Transmission Mode - Inbound X12N837 HIPAA Version Claim |
| D | 25/20.3/Free Billing Software |
| D | 25/20.4/External Keyshop or Imaging Processing |
| D | 25/20.5/Provider Direct Data Entry (DDE) |

| | |
|---|---|
| D | 25/20.6/Edits Performed by the FI |
| D | 25/20.7/Edits Performed by the Shared Systems |
| D | 25/20.8/Attachment Data Processing |
| D | 25/20.9/Related Internet Files Routinely Updated by CMS |
| D | 25/30.1/Transmission Mode - Outbound ANSI X12N 837 COB Transaction |
| D | 25/30.2/External Keyshop or Imaging Processing |
| D | 25/30.3/Summary of Process |
| D | 25/30.4/Generating an Outbound Coordination of Benefits (COB) ANSI X12N 837 (HIPAA version) When Required Data is Missing or Invalid |
| D | 25/30.5/Outreach |
| R | 25/60/60.1/Form Locators 1-20 |
| R | 25/60/60.2/Form Locators 21-30 |
| R | 25/60/60.3 - Form Locators 31-41 |
| R | 25/60/60.4 - Form Locator 42 |
| D | 25/90/Provider Electronic Billing File and Record Formats - UB-92 Version 6 |
| D | 25/90/90.1/Recommended Physical File Specifications - Magnetic Tape |
| D | 25/90/90.2/File Specifications – Media Other Than Magnetic Tape |
| D | 25/90/90.3/Record Specifications |
| D | 25/90.4/Key to Records |
| D | 25/90/90.5/Record Layouts |
| D | 25/100/Form CMS-1450, UB-92, ANSI X12N 837A 4010 and 3051 3A.01 Crosswalk of Data Elements |
| D | 25/110/Notes for Benefit Coordination |
| D | 25/120/Coordination of Benefits Records - COB - I/O Records |
| D | 25/130/Alphabetic Listing of Data Elements Used in UB-92 Version 6140 - Home Health Data Elements - Cross Reference |
| D | 25/140/Home Health Data Elements - Cross Reference |
| D | 25/Exhibit 1 - Heading Descriptions of Medicare Part A Claim/COB flat file layout (4010837i.xls) |
| | |

**III. FUNDING:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

**IV. ATTACHMENTS:**

Business Requirements
Manual Instruction

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

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 901 | Date: April 7, 2006 | Change Request 4384 |
|---|---|---|---|

**SUBJECT: New National Uniform Billing Committee (NUBC) Codes and Other Chapter 25 Revisions – Revision to the Internet-Only Manual**

## I. GENERAL INFORMATION

**A. Background:** The NUBC has approved new codes and other chapter 25 revisions are needed as a result of the ending of the contingency plan. All changes have been previously accomplished via change requests 3829, 3881, 4058, 4106, 4055, 3977, and 4210.

**B. Policy:** Per HIPAA, these NUBC codes are needed to process Medicare claims.

## II. BUSINESS REQUIREMENTS

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

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 4384.1 | Contractors and maintainers shall be in compliance with the instructions in Pub.100-04, *Medicare Claims Processing Manual*, Chapter 25, Sections 60.1, 60.2, 60.3, and 60.4. | X | X | | | X | | | | |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | None. | | | | | | | | | |

## IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: N/A

| X-Ref Requirement # | Instructions |
|---|---|
| | |

### B. Design Considerations: N/A

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | |

### C. Interfaces: N/A

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

### E. Dependencies: N/A

### F. Testing Considerations: N/A

## V. SCHEDULE, CONTACTS, AND FUNDING

| **Effective Date*:** May 8, 2006<br><br>**Implementation Date:** May 8, 2006<br><br>**Pre-Implementation Contact(s):** Matt Klischer (matthew.klischer@cms.hhs.gov)<br><br>**Post-Implementation Contact(s):** Matt Klischer (matthew.klischer@cms.hhs.gov) | **Medicare contractors shall implement these instructions within their current FY 2006 operating budget.** |
|---|---|

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

# Medicare Claims Processing Manual
## Chapter 25 - Completing and Processing *the Form CMS-1450* Data Set

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***(Rev.901, 04-07-06)***

Crosswalk to Old Manuals

10 - Reserved

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50.1 - Uniform Billing with Form CMS-1450

50.2 - Disposition of Copies of Completed Forms

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

60.1 - Form Locators 1-20
60.2 - Form Locators 21-30
60.3 - Form Locators 31-41
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60.5 - Form Locators 43-86

80 - Reserved

## 60.1 - Form Locators 1-20

*(Rev.901, Issued: 04-07-06, Effective: 05-08-06, Implementation: 05-08-06)*

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

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

**FL 2 - (Untitled)**

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

**FL 3 - Patient Control Number**

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

**FL 4 - Type of Bill**

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

**Code Structure**

**1st Digit-Type of Facility**

1. Hospital
2. Skilled Nursing
3. Home Health (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)
4. Religious Nonmedical (Hospital)
5. *Reserved for national assignment (*discontinued effective 10/1/05*)*.
6. Intermediate Care
7. Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8. Special facility or hospital ASC surgery (requires special information in second digit below).
9. Reserved for National Assignment

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

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

4. Other (Part B) - Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim. **NOTE: 24X is discontinued effective 10/1/05.**
5. Intermediate Care - Level I
6. Intermediate Care - Level II
7. *Reserved for national assignment (*discontinued effective 10/1/05*)*.
8. Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9. Reserved for National Assignment

**2nd Digit-Classification (Clinics Only)**

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

7-8. Reserved for National Assignment

9. OTHER

**2nd Digit-Classification (Special Facilities Only)**

1. Hospice (Nonhospital Based)
2. Hospice (Hospital Based)
3. Ambulatory Surgical Center Services to Hospital Outpatients
4. Free Standing Birthing Center
5. Critical Access Hospital

6-8. Reserved for National Assignment

9. OTHER

**3rd Digit-Frequency - Definition**

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

| | | |
|---|---|---|
| | Ownership | Change in Ownership for the hospice. |
| F | Beneficiary Initiated Adjustment Claim | Used to identify adjustments initiated by the beneficiary. For FI use only. |
| G | CWF Initiated Adjustment Claim | Used to identify adjustments initiated by CWF. For FI use only. |
| H | CMS Initiated Adjustment Claim | Used to identify adjustments initiated by CMS. For FI use only. |
| I | FI Adjustment Claim (Other than QIO or Provider | Used to identify adjustments initiated by the FI. For FI use only |
| J | Initiated Adjustment Claim-Other | Used to identify adjustments initiated by other entities. For FI use only. |
| K | OIG Initiated Adjustment Claim | Used to identify adjustments initiated by OIG. For FI use only. |
| M | MSP Initiated Adjustment Claim | Used to identify adjustments initiated by MSP. For FI use only. Note: MSP takes precedence over other adjustment sources. |
| P | QIO Adjustment Claim | Used to identify an adjustment initiated as a result of a QIO review. For FI use only. |
| 0 | Nonpayment/Zero Claims | Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The “Through” date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care. |
| 1 | Admit Through Discharge Claim | The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP. |
| 2 | Interim-First Claim | Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. For HHAs, used for the submission of original or replacement RAPs. |
| 3 | Interim-Continuing Claims (Not valid for PPS Bills) | Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later. |
| 4 | Interim-Last Claim (Not valid for PPS Bills) | This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The “Through” date of this bill (FL 6) is the discharge for this treatment. |

| | | |
|---|---|---|
| 5 | Late Charge Only | Used for outpatient claims only. Late charges are not accepted for Medicare inpatient, home health, or Ambulatory Surgical Center (ASC) claims. |
| 7 | Replacement of Prior Claim | This is used to correct a previously submitted bill. The provider applies this code to the corrected or "new" bill. |
| 8 | Void/Cancel of a Prior Claim | The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information. |
| 9 | Final Claim for a Home Health PPS Episode | This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment. |

**Bill Type Codes and Allowable Provider Numbers**
The following table lists "Type of Bill," FL4, codes by Provider Number Range(s). For a definition of each facility type, see the Medicare State Operations Manual.

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

85X Critical Access Hospital 1300-1399

**FL 5 - Federal Tax Number**

Not Required.

**FL 6 - Statement Covers Period (From-Through)**

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

**FL 7 - Covered Days**

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

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

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

See Chapter 3 for the special situations requiring that no program payment bills show an entry of covered days in FL 7.

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

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

**FL 8 – Non-covered Days**

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

Non-covered days include:

- Days for which no Part A payment can be made because the services rendered were furnished without cost or will be paid for by the VA. (See Chapter 28.)
- Days for which no Part A payment can be made because payment will be made under a National Institutes of Health grant;

Days after the date covered services ended, such as non-covered level of care, or emergency services after the emergency has ended in non-participating institutions;

- Days for which no Part A payment can be made because the patient was on a leave of absence and was not in the hospital.
- Days for which no Part A payment can be made because a hospital whose provider agreement has terminated, expired, or been cancelled may be paid only

for covered inpatient services during the limited period following such termination, expiration, or cancellation. All days after the expiration of the period are non-covered. See Chapter 3 for determining the effective date of the limited period and for billing for Part B services; and

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

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

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

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

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

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

**FL 9 - Coinsurance Days**

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

**FL 10 - Lifetime Reserve Days**

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

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

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

**FL 11 - (Untitled)**

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

**FL 12 - Patient’s Name**

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

**FL 13 - Patient’s Address**

**Required**. The provider enters the patient’s full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.

**FL 14 - Patient’s Birth Date**

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

**FL 15 - Patient's Sex**

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

**FL 16 - Patient's Marital Status**

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

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

**FL 17 - Admission Date**

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

**FL 18 - Admission Hour**

Not Required.

**FL 19 - Type of Admission/Visit**

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

Code Structure:

1 Emergency - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2 Urgent- The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3 Elective - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4 Newborn - Use of this code necessitates the use of a Special Source of Admission codes.
5 Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.
6-8 Reserved for National Assignment
9 Information Not Available – Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.

**FL 20 – Source of Admission**

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

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

| | | |
|---|---|---|
| 1 | Physician Referral | **Inpatient**: The patient was admitted to this facility upon the recommendation of their personal physician.<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral). |
| 2 | Clinic Referral | **Inpatient**: The patient was admitted to this facility upon the recommendation of this facility's clinic physician.<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician. |
| 3 | HMO Referral | **Inpatient**: The patient was admitted to this facility upon the recommendation of a HMO physician.<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a HMO physician. |
| 4 | Transfer from a Hospital<br>*(different facility *)* | **Inpatient**: The patient was admitted to this facility as a transfer from a *different* acute care facility where they were an inpatient<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a *different* acute care facility.<br>** For transfers from hospital inpatient in the same facility, see code D.* |
| 5 | Transfer from a SNF | **Inpatient**: The patient was admitted to this facility as a transfer from a SNF where they were an inpatient.<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where they are an inpatient. |
| 6 | Transfer from Another Health Care Facility | **Inpatient**: The patient was admitted to this facility from a health care facility other than an acute care facility or SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a non-skilled level of care.<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where they are an inpatient. |
| 7 | Emergency Room | **Inpatient**: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.<br>**Outpatient**: The patient received services in this facility's emergency department. |
| 8 | Court/Law Enforcement | **Inpatient**: The patient was admitted to this facility upon the direction of a court of law, or upon the request |

| | | |
|---|---|---|
| | | of a law enforcement agency representative.<br>**Outpatient**: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. |
| 9 | Information Not Available | **Inpatient**: The means by which the patient was admitted to this facility is not known.<br>**Outpatient**: For Medicare outpatient bills, this is not a valid code. |
| A | Transfer from a Critical Access Hospital (CAH) | **Inpatient**: The patient was admitted to this facility as a transfer from a CAH where they were an inpatient.<br>**Outpatient**: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient is an inpatient. |
| B | Transfer From Another Home Health Agency | The patient was admitted to this home health agency as a transfer from another home health agency |
| C | Readmission to Same Home Health Agency | The patient was readmitted to this home health agency within the same home health episode period. |
| *D* | *Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer* | *The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.* |
| *E*-Z | | Reserved for national assignment. |

## 60.2 - Form Locators 21-30

***(Rev.901, Issued: 04-07-06, Effective: 05-08-06, Implementation: 05-08-06)***

**FL 21 – Discharge Hour**

Not Required.

**FL 22 – Patient Status**

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

| **Code** | **Structure** |
|---|---|
| 01 | Discharged to home or self care (routine discharge) |
| 02 | Discharged/transferred to a short-term general hospital for inpatient care. |
| 03 | Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). *S*ee Code 61 below. |
| 04 | Discharged/transferred to an ICF |
| 05 | Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05).<br>Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions. |
| 06 | Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective |

| Code | Structure |
| --- | --- |
| | 2/23/05). |
| 07 | Left against medical advice or discontinued care |
| 08 | Discharged/transferred to home under care of a home IV drug therapy provider. To be DISCONTINUED effective 10/1/05. |
| *09 | Admitted as an inpatient to this hospital |
| 10-19 | Reserved for National Assignment |
| 20 | Expired (or did not recover - Religious Non Medical Health Care Patient) |
| 21-29 | Reserved for National Assignment |
| 30 | Still patient or expected to return for outpatient services |
| 31-39 | Reserved for National Assignment |
| 40 | Expired at home (Hospice claims only) |
| 41 | Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only) |
| 42 | Expired - place unknown (Hospice claims only) |
| 43 | Discharged/transferred to a federal health care facility. (effective 10/1/03) Usage note: Discharges and transfers to a government operated health care facility. |
| 44-49 | Reserved for national assignment |
| 50 | Discharged/transferred to Hospice - home |
| 51 | Discharged/transferred to Hospice - medical facility |
| 52-60 | Reserved for national assignment |
| 61 | Discharged/transferred within this institution to a hospital based Medicare approved swing bed. |
| 62 | Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital |
| 63 | Discharged/transferred to long term care hospitals |
| 64 | Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare |
| 65 | Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital. |
| *66* | *Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)* |
| 67-70 | Reserved for national assignment |
| 71 | Discharged/transferred to another institution for outpatient services (discontinued effective October 1, 2003) |
| 72 | Discharged/transferred to this institution for outpatient services (discontinued effective October 1, 2003) |
| 73-99 | Reserved for national assignment |

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

**FL 23 - Medical Record Number**

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

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

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

| Code | Title | Definition |
|---|---|---|
| 02 | Condition is Employment Related | Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment. (See Chapter 28.) |
| 03 | Patient Covered by Insurance Not Reflected Here | Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill. |
| 04 | Information Only Bill | Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan (such as Medicare+Choice) and the hospital expects to receive payment from the plan. |
| 05 | Lien Has Been Filed | The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient. |
| 06 | ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance | Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 18 month of end stage renal disease entitlement. |
| 07 | Treatment of Non-terminal Condition for Hospice Patient | The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment. |
| 08 | Beneficiary Would Not Provide Information Concerning Other Insurance Coverage | The beneficiary would not provide information concerning other insurance coverage. The FI develops to determine proper payment. (See Chapter 28 for development guidelines.) |
| 09 | Neither Patient Nor Spouse is Employed | In response to development questions, the patient and spouse have denied employment. |
| 10 | Patient and/or Spouse is Employed but no EGHP Coverage Exists | In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient. |

| Code | Title | Definition |
| --- | --- | --- |
| 11 | Disabled Beneficiary But no Large Group Health Plan (LGHP) | In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP. |
| 12-14 | Payer Codes | Codes reserved for internal use only by third party payers. The CMS will assign as needed for FI use. Providers will not report. |
| 15 | Clean Claim Delayed in CMS's Processing System (Medicare Payer Only Code) | The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to CPEP/CPT standards. (See Chapter 1.) |
| 16 | SNF Transition Exemption (Medicare Payer Only Code) | An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date. |
| 17 | Patient is Homeless | The patient is homeless. |
| 18 | Maiden Name Retained | A dependent spouse entitled to benefits who does not use her husband's last name. |
| 19 | Child Retains Mother's Name | A patient who is a dependent child entitled to benefits that does not have its father's last name. |
| 20 | Beneficiary Requested Billing | Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.) |
| 21 | Billing for Denial Notice | The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers. |
| 26 | VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility | Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility. |
| 27 | Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test | (Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule. |
| 28 | Patient and/or Spouse's EGHP is Secondary to Medicare | In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health |

| Code | Title | Definition |
|---|---|---|
| | | insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees. |
| 29 | Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare | In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part time employees; or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees. |
| 30 | Qualifying Clinical Trials | Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial. |
| 31 | Patient is a Student (Full-Time - Day) | Patient declares that they are enrolled as a full-time day student. |
| 32 | Patient is a Student (Cooperative/Work Study Program) | Patient declares that they are enrolled in a cooperative/work study program. |
| 33 | Patient is a Student (Full-Time - Night) | Patient declares that they are enrolled as a full-time night student. |
| 34 | Patient is a Student (Part-Time) | Patient declares that they are enrolled as a part-time student. |
| **Accommodations** | | |
| 35 | Reserved for National Assignment | Reserved for National Assignment. |
| 36 | General Care Patient in a Special Unit | (Not used by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available.<br>Accommodation charges for this period are at the prevalent semi-private rate. |
| 37 | Ward Accommodation at Patient's Request | (Not used by hospitals under PPS.) The patient was assigned to ward |

| Code | Title | Definition |
|---|---|---|
| | | accommodations at their own request. This must be supported by a written request in the provider's files. (See the Benefit Policy Manual, Chapter 1.) |
| 38 | Semi-private Room Not Available | (Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private accommodations were not available. |

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

| Code | Title | Definition |
|---|---|---|
| 39 | Private Room Medically Necessary | (Not used by hospitals under PPS.) The patient needed a private room for medical reasons. |
| 40 | Same Day Transfer | The patient was transferred to another participating Medicare provider before midnight on the day of admission. |
| 41 | Partial Hospitalization | The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol). (See the Benefit Policy Manual, Chapter 6 for a description of coverage.) |
| 42 | Continuing Care Not Related to Inpatient Admission | Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services. |
| 43 | Continuing Care Not Provided Within Prescribed Post Discharge Window | Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window. |
| 44 | Inpatient Admission Changed to Outpatient | For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. Effective April 1, 2004 |
| 45 | | Reserved for national assignment |
| 46 | Non-Availability Statement on File | A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital. |

| Code | Title | Definition |
| --- | --- | --- |
| 47 | | Reserved for TRICARE |
| 48 | Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs) | Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents. |
| *49* | *Product replacement within product lifecycle* | *Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.* |
| *50* | *Product replacement for known recall of a product* | *Manufacturer or FDA has identified the product for recall and therefore replacement.* |
| *51*-54 | | Reserved for national assignment |
| 55 | SNF Bed Not Available | The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available. |
| 56 | Medical Appropriateness | The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period. |
| 57 | SNF Readmission | The patient previously received Medicare covered SNF care within 30 days of the current SNF admission. |
| 58 | Terminated Managed Care Organization Enrollee | Code indicates that patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived. |
| 59 | Non-primary ESRD Facility | Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. Effective 10/01/04 |
| 60 | Operating Cost Day Outlier | Day Outlier obsolete after FY 1997. (Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. The FI indicates the cost outlier portion paid value code 17. |
| 61 | Operating Cost Outlier | (Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI indicates the operating cost outlier portion paid in value code 17. |
| 62 | PIP Bill | (Not reported by providers.) Bill was paid under PIP. The FI records this from its system. |
| 63 | Payer Only Code | Reserved for internal payer use only. CMS |

| Code | Title | Definition |
|---|---|---|
| | | assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment |
| 64 | Other Than Clean Claim | (Not reported by providers.) The claim is not “clean.” The FI records this from its system. |
| 65 | Non-PPS Bill | (Not reported by providers.) Bill is not a PPS bill. The FI records this from its system for non-PPS hospital bills. |
| 66 | Hospital Does Not Wish Cost Outlier Payment | The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.) |
| 67 | Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days | The beneficiary elects not to use LTR days. |
| 68 | Beneficiary Elects to Use Lifetime Reserve (LTR) Days | The beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts. |
| 69 | IME/DGME/N&A Payment Only | Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health. |
| 70 | Self-Administered Epoetin (EPO) | The billing is for a home dialysis patient who self-administers EPO. |
| 71 | Full Care in Unit | The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility. |
| 72 | Self-Care in Unit | The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility. |
| 73 | Self-Care Training | The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis. |
| 74 | Home | The bill is for a patient who received dialysis services at home. |
| 75 | Home 100-percent | (Not to be used for services Payment furnished 4/16/90, or later.) The bill is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100-percent program. |
| 76 | Back-up In-Facility Dialysis | The bill is for a home dialysis patient who received back-up dialysis in a facility. |
| 77 | Provider Accepts or is | The provider has accepted or is |

| Code | Title | Definition |
|---|---|---|
| | Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full | obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due. |
| 78 | New Coverage Not Implemented by HMO | The bill is for a newly covered service under Medicare for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.) |
| 79 | CORF Services Provided Off-Site | Physical therapy, occupational therapy, or speech pathology services were provided off-site. |
| *80* | *Home Dialysis-Nursing Facility* | *Home dialysis furnished in a SNF or Nursing Facility.* |
| 8*1*-99 | | Reserved for State assignment. Discontinued Effective October 16, 2003. |

**Special Program Indicator Codes Required**

The only special program indicators that apply to Medicare are:

| | | |
|---|---|---|
| A0 | Special ZIP Code Reporting | Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance. |
| A3 | Special Federal Funding | This code is for uniform use by State uniform billing committees. |
| A5 | Disability | This code is for uniform use by State uniform billing committees. |
| A6 | PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment | Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services. |
| A7 | | Reserved for national assignment (Discontinued 10/1/02) |
| A8 | Induced Abortion - Victim of Rape/Incest | Self-explanatory. Discontinued 10/01/02 Reserved for national assignment |
| A9 | Second Opinion Surgery | Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply. |
| AA | Abortion Performed due to Rape | Self-explanatory – Effective 10/1/02 |
| AB | Abortion Performed due to Incest | Self-explanatory – Effective 10/1/02 |
| AC | Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality | Self-explanatory – Effective 10/1/02 |
| AD | Abortion Performed due to a Life Endangering Physical | Self-explanatory – Effective 10/1/02 |

| Code | Title | Definition |
|---|---|---|
| | Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself | |
| AE | Abortion Performed due to Physical Health of Mother that is not Life Endangering | Self-explanatory – Effective 10/1/02 |
| AF | Abortion Performed due to Emotional/psychological Health of the Mother | Self-explanatory – Effective 10/1/02 |
| AG | Abortion Performed due to Social Economic Reasons | Self-explanatory – Effective 10/1/02 |
| AH | Elective Abortion | Self-explanatory – Effective 10/1/02 |
| AI | Sterilization | Self-explanatory – Effective 10/1/02 |
| AJ | Payer Responsible for Copayment | Self-explanatory – Effective 4/1/03 |
| AK | Air Ambulance Required | For ambulance claims. Air ambulance required – time needed to transport poses a threat – Effective 10/16/03 |
| AL | Specialized Treatment/bed Unavailable | For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate facility. – Effective 10/16/03 |
| AM | Non-emergency Medically Necessary Stretcher Transport Required | For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective 10/16/03 |
| AN | Preadmission Screening Not Required | Person meets the criteria for an exemption from preadmission screening. Effective 1/1/04 |
| AO-AZ | | Reserved for national assignment |
| B0 | Medicare Coordinated Care Demonstration Program | Patient is participant in a Medicare Coordinated Care Demonstration. |
| B1 | Beneficiary is Ineligible for Demonstration Program | Full definition pending |
| B2 | Critical Access Hospital Ambulance Attestation | Attestation by Critical Access Hospital that it meets the criteria for exemption from the Ambulance Fee Schedule |
| B3 | Pregnancy Indicator | Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable Law. – Effective 10/16/03 |
| B4 | Admission Unrelated to Discharge | Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004. Effective January 1, 2005 |
| B5-BZ | | Reserved for national assignment |
| M0-M9 | Payer Only Codes | |

| Code | Title | Definition |
|---|---|---|
| M0 | All-Inclusive Rate for Outpatient | Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services. |
| M1 | Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV) | Code indicates the influenza virus vaccine or pneumococcal pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize. |
| M2 | HHA Payment Significantly Exceeds Total Charges | Used when payment to an HHA is significantly in excess of covered billed charges. |
| **QIO Approval Indicator Codes** | | |
| C1 | Approved as Billed | Claim has been reviewed by the QIO and has been fully approved including any outlier. |
| C3 | Partial Approval | The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code "77" in FL 36 or code "46" in FL 39-41). |
| C4 | Admission Denied | The patient's need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary. |
| C5 | Post-payment Review Applicable | Any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed. |
| C6 | Preadmission/Pre-procedure | The QIO authorized this admission/procedure but has not reviewed the services provided. |
| C7 | Extended Authorization | The QIO has authorized these services for an extended length of time but has not reviewed the services provided. |
| Claim Change Reasons | | |
| D0 | Changes to Service Dates | Self explanatory |
| D1 | Changes to Charges | Self explanatory |
| D2 | Changes to Revenue Codes/HCPCS/HIPPS Rate Code | Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44) |
| D3 | Second or Subsequent Interim PPS Bill | Self-explanatory |
| D4 | Changes In ICD-9-CM | Use for inpatient acute care hospital, long- |

| Code | Title | Definition |
|---|---|---|
| | Diagnosis and/or Procedure Code | term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF). |
| D5 | Cancel to Correct HICN or Provider ID | Cancel only to delete an incorrect HICN or Provider Identification Number. |
| D6 | Cancel Only to Repay a Duplicate or OIG Overpayment | Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.) |
| D7 | Change to Make Medicare the Secondary Payer | Self-explanatory |
| D8 | Change to Make Medicare the Primary Payer | Self-explanatory |
| D9 | Any Other Change | Self-explanatory |
| *DA – DQ* | | *Reserved for national assignment* |
| *DR* | *Disaster related* | *Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.* |
| *DS – DZ* | | *Reserved for national assignment* |
| E0 | Change in Patient Status | Self-explanatory |
| E1 – *FZ* | | Reserved for national assignment |
| G0 | Distinct Medical Visit | Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0. |
| G1 – GZ | | Reserved for national assignment |
| H0 | Delayed Filing, Statement Of Intent Submitted | Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation. |
| M0 | All Inclusive Rate for | Used by a Critical Access Hospital electing to |

| Code | Title | Definition |
|---|---|---|
| | Outpatient Services (Payer Only Code) | be paid an all-inclusive rate for outpatient. |
| N0-OZ | | Reserved for national assignment |
| P0-PZ | | Reserved for national assignment. FOR PUBLIC HEALTH DATA REPORTING ONLY |
| Q0-*V*Z | | Reserved for national assignment. |
| *W0* | *United Mine Workers of America (UMWA) Demonstration Indicator* | *United Mine Workers of America (UMWA) Demonstration Indicator ONLY* |
| *W1-ZZ* | | *Reserved for national assignment.* |

## *60.3 - Form Locators 31-41*

***(Rev.901, Issued: 04-07-06, Effective: 05-08-06, Implementation: 05-08-06)***

**FL 31 - (Untitled)**

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

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

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

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

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

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

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

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

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

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

| 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. (See Chapter 28.) |
| 05 | Accident/No Medical or Liability Coverage | Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury. |
| 06 | Crime Victim | Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties. |
| 07-08 | | Reserved for national assignment. |
| 09 | Start of Infertility Treatment Cycle | Code indicating the date of start of infertility treatment cycle. |
| 10 | Last Menstrual Period | Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition. |
| 11 | Onset of Symptoms/Illness | (Outpatient claims only.) Date that the patient first became aware of symptoms/illness. |
| 12 | Date of Onset for a Chronically Dependent Individual (CDI) | (HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit. |
| 13-15 | | Reserved for national assignment |
| 16 | Date of Last Therapy | Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy). |
| 17 | Date Outpatient Occupational Therapy Plan Established or Reviewed | The date the occupational therapy plan was established or last reviewed. |
| 18 | Date of Retirement Patient/Beneficiary | Date of retirement for the patient/beneficiary. |
| 19 | Date of Retirement Spouse | Date of retirement for the patient's spouse. |
| 20 | Guarantee of Payment Began | (Part A hospital claims only.) Date on which the hospital begins claiming payment under |

| Code | Title | Definition |
|---|---|---|
| | | the guarantee of payment provision. (See the Financial Management Manual, Chapter 3.) |
| 21 | UR Notice Received | (Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See Chapter 3.) |
| 22 | Date Active Care Ended | (SNF claims only.) Date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used. |
| 23 | Date of Cancellation of Hospice Election Period. For 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 periods. |
| 28 | Date CORF Plan Established or Last Reviewed | The date a plan of treatment was established or last reviewed for CORF care. (See Chapter 5). |
| 29 | Date OPT Plan Established or Last Reviewed | The date a plan was established or last reviewed for OPT. (See Chapter 5). |
| 30 | Date Outpatient Speech Pathology Plan Established or Last Reviewed | The date a plan was established or last reviewed for outpatient speech pathology. (See Chapter 5). |
| 31 | Date Beneficiary Notified of Intent to Bill (Accommodations) | The date the hospital notified the beneficiary that the beneficiary does not (or no longer) require a covered level of inpatient care. |
| 32 | Date Beneficiary Notified of Intent to Bill (Procedures or Treatments) | The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be |

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

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

| 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-D*Q* | | 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 | The birth date of the individual in whose name the insurance is carried. |
| E2 | Effective Date-Insured D Policy | A code indicating the first date insurance is in force. |
| E3 | Benefits Exhausted | Code indicating the last date for which benefits are available and after which no payment can be made to payer D. |
| E4-EZ | | Reserved for national assignment |
| F0 | | Reserved for national assignment |
| F1 | Birth date-Insured E | The birth date of the individual in whose name the insurance is carried. |
| F2 | Effective Date-Insured E Policy | A code indicating the first date insurance is in force. |
| F3 | Benefits Exhausted | Code indicating the last date for which benefits are available and after which no payment can be made to payer E. |
| F4-FZ | | Reserved for national assignment |
| G0 | | Reserved for national assignment |
| G1 | Birth date-Insured F | The birth date of the individual in whose name the insurance is carried. |
| G2 | Effective Date-Insured F Policy | A code indicating the first date insurance is in force. |
| G3 | Benefits Exhausted | Code indicating the last date for which benefits are available and after which no payment can be made to payer F. |
| G4-GZ | | Reserved for national assignment |
| H0-HZ | | Reserved for national assignment |
| J0-LZ | | Reserved for State assignment. Discontinued Effective October 16, 2003. |
| M0-ZZ | | See instructions in Form Locator 36 – Occurrence Span Codes and Dates |

**FL 36 - Occurrence Span Code and Dates**

Required For Inpatient.

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

**Code Structure**

| Code | Title | Definition |
|---|---|---|
| 70 | Qualifying Stay Dates | (Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim. |
| 70 | Non-utilization Dates (For Payer Use on Hospital Bills Only) | The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report. |
| 71 | Hospital Prior Stay Dates | (Part A claims only.) The From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission. |
| 72 | First/Last Visit | The actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period. |
| 74 | Non-covered Level of Care | The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, but not valid for HHA under PPS. |
| 75 | SNF Level of Care | The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLs 24-30). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care. |
| 76 | Patient Liability | The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.) |

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

| Code | Title | Definition |
|---|---|---|
| | | effective October 16, 2003 |

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

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

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

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

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

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

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

| Code | Title | Definition |
|---|---|---|
| 01 | Most Common Semi-Private Rate | To provide for the recording of hospital's most common semi-private rate. |
| 02 | Hospital Has No Semi-Private Rooms | Entering this code requires $0.00 amount. |
| 03 | | Reserved for national assignment |
| 04 | Inpatient Professional Component Charges Which Are Combined Billed | The sum of the inpatient professional component charges that are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. **(Used only by some all-inclusive rate hospitals.)** |

| Code | Title | Definition |
|---|---|---|
| 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.<br>The hospital uses this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47. |
| 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.<br>If all deductible pints have been replaced, this code is not to be used.<br>When the hospital gives a discount for un-replaced deductible blood, it shows charges after the discount is applied. |
| 07 | | Reserved for national assignment |
| 08 | Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period | The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission. (See Chapter .3) |
| 09 | Medicare Coinsurance Amount in the First Calendar Year in Billing Period | The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. (See Chapter 3.) The provider may not use this code on Part B bills.<br>For Part B coinsurance use value codes A2, B2 and C2. |
| 10 | Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing | The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable |

| Code | Title | Definition |
|---|---|---|
| | Period | 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 on Part B bills. |
| 12 | Working Aged Beneficiary Spouse With an EGHP | That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.) |
| 13 | ESRD Beneficiary in a Medicare Coordination Period With an EGHP | That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.) |
| 14 | No-Fault, Including Auto/Other Insurance | That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. (See Chapter 28.) If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim |
| 15 | Worker's Compensation | That portion of a higher priority WC insurance |

| Code | Title | Definition |
|---|---|---|
| | (WC) | payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. (See Chapter 28.). Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. |
| 16 | PHS, Other Federal Agency | That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges.<br>**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. |
| 24 | Medicaid Rate Code | Medicaid-eligibility requirements to be determined at State level. |
| 25 | Offset to the Patient- | Prescription drugs paid for out of a long-term care |

| Code | Title | Definition |
|---|---|---|
| | Payment Amount – Prescription Drugs | facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 26 | Offset to the Patient-Payment Amount – Hearing and Ear Services | Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 27 | Offset to the Patient-Payment Amount – Vision and Eye Services | Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 28 | Offset to the Patient-Payment Amount – Dental Services | Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 29 | Offset to the Patient-Payment Amount – Chiropractic Services | Chiropractic Services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 31 | Patient Liability Amount | The FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments. |
| 32 | Multiple Patient Ambulance Transport | If more than one patient is transported in a single ambulance trip, report the total number of patients transported. |
| 33 | Offset to the Patient-Payment Amount – Podiatric Services | Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 34 | Offset to the Patient-Payment Amount – Other Medical Services | Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 35 | Offset to the Patient-Payment Amount – Health Insurance Premiums | Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period). |
| 36 | | Reserved for national assignment. |
| 37 | Pints of Blood Furnished | The total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible. |
| 38 | Blood Deductible Pints | The number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. |

| Code | Title | Definition |
|---|---|---|
| 39 | Pints of Blood Replaced | The total number of pints of blood that were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. (See Chapter 3.) Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory). |
| 40 | New Coverage Not Implemented by HMO | (For inpatient service only.) Inpatient charges covered by the HMO. (The hospital uses this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO. It must also report condition codes 04 and 78.) |
| 41 | Black Lung (BL) | That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim. (See Chapter 28.) |
| 42 | Veterans Affairs (VA) | That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. (Any payment must conform to Chapter 28.) |
| 43 | Disabled Beneficiary Under Age 65 With LGHP | That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable |

| Code | Title | Definition |
|---|---|---|
| | | had it filed a proper claim. (See Chapter 28.) |
| 44 | Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received | That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due. (See Chapter 28.) |
| 45 | Accident Hour | The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter. |
| 46 | Number of Grace Days | If a code "C3" or "C4" is in FL 24-30, indicating that the QIO has denied all or a portion of this billing period, the provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient's post discharge. The field contains one numeric digit. |
| 47 | Any Liability Insurance | That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer's payment. (See Chapter 28.) |
| 48 | Hemoglobin Reading | The latest hemoglobin reading taken during this billing cycle. The provider reports in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, it uses the position to the right of the delimiter for the third digit. *Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken **before** the start of the billing period.* |
| 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. |

| Code | Title | Definition |
|---|---|---|
| 53 | Cardiac Rehabilitation Visits | The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period. |
| 54 | Newborn birth weight in grams | Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law. |
| 55 | Eligibility Threshold for Charity Care | Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care. |
| 56 | Skilled Nurse – Home Visit Hours (HHA only) | The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.) |
| 57 | Home Health Aide – Home Visit Hours (HHA only) | The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the 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.

| Code | Title | Definition |
|---|---|---|
| 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 | Location Where Service is Furnished (HHA and Hospice) | MSA number *or Core Based Statistical Area (CBSA) number* (or rural State code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.<br>For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim. |
| 62 | HH Visits – Part A (Internal Payer Use Only) | The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act. |
| 63 | HH Visits – Part B (Internal Payer Use Only) | The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act. |
| 64 | HH Reimbursement – Part A (Internal Payer Use Only) | The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act. |
| 65 | HH Reimbursement – Part B (Internal Payer Use Only) | The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by |

| Code | Title | Definition |
|---|---|---|
| | | §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. |
| 73-74 | Payer Codes | (For use by third party payers only.) |
| 75 | Gramm/Rudman/Hollings | (For third party payer internal use only.) The contractor reports the amount of sequestration. |
| 76 | Provider's Interim Rate | (For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home |

| 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. health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: |

| | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | | | | 5 | 0 | 0 | 0 |

| Code | Title | Definition |
| --- | --- | --- |
| 77 | Medicare New Technology Add-On Payment | Code indicates the amount of Medicare additional payment for new technology. |
| 78-79 | Payer Codes | Codes reserved for internal use only by third party payers. The CMS assigns as needed. Providers do not report payer codes. |
| 80-99 | | Reserved for State use. Discontinued, Effective October 16, 2003. |
| A0 | Special Zip Code Reporting | Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance. |
| A1 | Deductible Payer A | The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. |
| A2 | Coinsurance Payer A | The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11. |
| A3 | Estimated Responsibility Payer A | Amount the provider estimates will be paid by the indicated payer. |
| 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, Chapter 6.) |
| A5 | Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient | The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637. |
| A6 | Covered Self-Administrable Drugs – Diagnostic Study and Other | The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637. |
| A7 | Co-payment A | The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer. |
| A8 | Patient Weight | Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05) |
| A9 | Patient Height | Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05) |
| AA | Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A | The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003 |
| AB | Other Assessments or Allowances (e.g., Medical Education) Payer A | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003 |
| AC-AZ | | Reserved for national assignment. |
| B1 | Deductible Payer B | The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. |

| Code | Title | Definition |
|---|---|---|
| B2 | Coinsurance Payer B | The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11. |
| B3 | Estimated Responsibility Payer B | Amount the provider estimates will be paid by the indicated payer. |
| B4-B6 | | Reserved for national assignment |
| B7 | Co-payment Payer B | The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer. |
| B8-B9 | | Reserved for national assignment |
| BA | Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer B | The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03 |
| BB | Other Assessments or Allowances (e.g., Medical Education) Payer B | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated |
| BC-C0 | | Reserved for national assignment |
| C1 | Deductible Payer C | The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. (**Note:** Medicare blood deductibles should be reported under Value Code 6.) |
| C2 | Coinsurance Payer C | The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11. |
| C3 | Estimated Responsibility Payer C | Amount the provider estimates will be paid by the indicated payer. |
| C4-C6 | | Reserved for national assignment |
| C7 | Co-payment Payer C | The amount the provider assumes is applied to the patient's co-payment amount involving the indicated payer. |
| C8-C9 | | Reserved for national assignment |
| CA | Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer C | The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03 |
| 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 |

| Code | Title | Definition |
| --- | --- | --- |
| CC-CZ | | Reserved for national assignment |
| D0-D2 | | Reserved for national assignment |
| D3 | Estimated Responsibility Patient | Amount the provider estimates will be paid by the indicated patient. |
| D4-D*Q* | | Reserved for national assignment |
| *DR* | | *Reserved for disaster related code* |
| *DS-DZ* | | *Reserved for national assignment* |
| E0 | | Reserved for national assignment |
| E1 | Deductible Payer D | The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. |
| E2 | Coinsurance Payer D | The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. |
| E3 | Estimated Responsibility Payer D | Amount the provider estimates will be paid by the indicated payer. |
| E4-E6 | | Reserved for national assignment |
| E7 | Co-payment Payer D | The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer. |
| E8-E9 | | Reserved for national assignment |
| EA | Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer D | The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03 |
| EB | Other Assessments or Allowances (e.g., Medical Education) Payer D | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003 |
| EC-EZ | | Reserved for national assignment |
| F0 | | Reserved for national assignment |
| F1 | Deductible Payer E | The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. |
| F2 | Coinsurance Payer E | The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. |
| F3 | Estimated Responsibility Payer E | Amount the provider estimates will be paid by the indicated payer. |
| F4-F6 | | Reserved for national assignment |
| F7 | Co-payment Payer E | The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer. |
| F8-F9 | | Reserved for national assignment |
| FA | Regulatory Surcharges, | The amount of regulatory surcharges, |

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

| Code | Title | Definition |
|---|---|---|
| | | *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).* |
| *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* |

## 60.4 - Form Locator 42

***(Rev.901, Issued: 04-07-06, Effective: 05-08-06, Implementation: 05-08-06)***

**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<br>For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, FIs report the total charge in the appropriate data segment/field | |
| 001X | Reserved for Internal Payer Use | |
| 002X | Health Insurance Prospective Payment System (HIPPS) | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - Reserved | |
| | 1 - Reserved | |
| | 2 - Skilled Nursing Facility Prospective Payment System | SNF PPS (RUG) |
| | 3 - Home Health Prospective Payment System | HHS PPS (HRG) |
| | 4 - Inpatient Rehabilitation Facility Prospective Payment System | IRF PPS (CMG) |
| | 5 - Reserved | |
| | 6 - Reserved | |
| | 7 - Reserved | |
| | 8 - Reserved | |
| | 9 - Reserved | |
| 003X to 006X | Reserved for National Assignment | |
| 007X to 009X | Reserved for State Use until October 16, 2003. Thereafter, Reserved for National Assignment | |

**ACCOMMODATION REVENUE CODES (010X - 021X)**

010X All Inclusive Rate

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

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

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

Routine service charges for single bedrooms.

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

| Subcategory | Standard Abbreviations |
|---|---|
| 0 - General Classification | ROOM-BOARD/PVT |
| 1 - Medical/Surgical/Gyn | MED-SUR-GY/PVT |
| 2 - OB | OB/PVT |
| 3 - Pediatric | PEDS/PVT |

| Revenue Code | Description | |
|---|---|---|
| | 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)<br>Routine service charges incurred for accommodations with two beds.<br>Rationale: Most third party payers require that semi-private rooms be identified. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | ROOM-BOARD/SEMI |
| | 1 - Medical/Surgical/Gyn | MED-SUR-GY/2BED |
| | 2 - OB | OB/2BED |
| | 3 - Pediatric | PEDS/2BED |
| | 4 - Psychiatric | PSYCH/2BED |
| | 5 - Hospice | HOSPICE/2BED |
| | 6 - Detoxification | DETOX/2BED |
| | 7 - Oncology | ONCOLOGY/2BED |
| | 8 - Rehabilitation | REHAB/2BED |
| | 9 - Other | OTHER/2BED |
| 013X | Semi-private - three and Four Beds (Medical or General)<br>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)<br>Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | ROOM-BOARD/ PVT/DLX |
| | 1 - Medical/Surgical/Gyn | MED-SUR-GY/ PVT/DLX |
| | 2 - OB | OB/ PVT/DLX |
| | 3 - Pediatric | PEDS/ PVT/DLX |
| | 4 - Psychiatric | PSYCH/ PVT/DLX |
| | 5 - Hospice | HOSPICE/ PVT/DLX |

| Revenue Code | Description | |
|---|---|---|
| | 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)<br>Routine service charges incurred for accommodations with five or more beds.<br>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)<br>Any routine service charges incurred for accommodations that cannot be included in the more specific revenue center codes<br>Rationale: Provides the ability to identify services as required by payers or individual institutions.<br>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<br>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

| Revenue Code | Description | |
|---|---|---|
| | 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<br>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<br>Effective 4/1/04 |
| | 9 - Other Leave of Absence | LOA/OTHER |
| 019X | Sub-acute Care<br>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 |

| Revenue Code | Description | |
|---|---|---|
| | 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

| Revenue Code | Description | |
|---|---|---|
| | 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 |

| Revenue Code | Description | |
|---|---|---|
| | 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<br>Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.<br>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)<br>Code indicates charges for supply items required for patient care.<br>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<br>Code indicates charges for the treatment of tumors and related diseases. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 – General Classification | ONCOLOGY |

| Revenue Code | Description | |
|---|---|---|
| | 9 - Other Oncology | ONCOLOGY/OTHER |
| 029X | Durable Medical Equipment (DME) (Other Than Rental)<br>Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).<br>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<br>Charges for the performance of diagnostic and routine clinical laboratory tests.<br>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 & Microbiology | LAB/BACT-MICRO |
| | 7 – Urology | LAB/UROLOGY |
| | 9 - Other Laboratory | LAB/OTHER |
| 031X | Laboratory Pathological<br>Charges for diagnostic and routine laboratory tests on tissues and culture.<br>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<br>Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting radiographs and fluorographs.<br>Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify. | |

| Revenue Code | Description | |
|---|---|---|
| | **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<br>Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.<br>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<br>Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.<br>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<br>Charges for CT scans of the head and other parts of the body.<br>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 |

| Revenue Code | Description | |
|---|---|---|
| | 9 - Other CT Scans | CT SCAN/OTHER |
| 036X | Operating Room Services<br>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.<br>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<br>Charges for anesthesia services in the hospital.<br>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<br>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 |

| Revenue Code | Description | |
|---|---|---|
| 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 |

| Revenue Code | Description | |
|---|---|---|
| 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 | |

| Revenue Code | Description | |
|---|---|---|
| | properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.<br>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<br>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<br>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<br>Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.<br>Rationale: Permits identification of particular items for payers. Under the | |

**Revenue Code** **Description**

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.

| Revenue Code | Description | |
|---|---|---|
| | 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 |

| Revenue Code | Description | |
|---|---|---|
| | 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<br>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<br>Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.<br>Rationale: This is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes. | |
| | **Subcategory** | **Standard Abbreviations** |

| Revenue Code | Description | |
|---|---|---|
| | 0 - General Classification | OSTEOPATH SVS |
| | 1 - Osteopathic Therapy | OSTEOPATH RX |
| | 9 - Other Osteopathic Services | OTHER OSTEOPATH |

054X Ambulance

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

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

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

055X Skilled Nursing

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

| Subcategory | Standard Abbreviations |
|---|---|
| 0 - General Classification | SKILLED NURSING |
| 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)

| Revenue Code | Description | |
|---|---|---|
| | Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.<br>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)<br>Code indicates charges by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.<br>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)<br>This revenue code is used by an HHA that bills on the basis of units of service.<br>Rationale: This breakdown is necessary for Medicare home health billing requirements. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | UNIT/HOME HEALTH |
| | 9 - Home Health Other Units | UNIT/HOME HLTH/OTHER |
| 060X | Oxygen (Home Health)<br>Code indicates charges by a home health agency for oxygen equipment supplies or contents, excluding purchased equipment.<br>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.<br>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 |

**Revenue Code** | **Description**

**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 |

| Revenue Code | Description |
|---|---|

**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 |

| Revenue Code | Description | |
|---|---|---|
| | 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)<br>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<br>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<br>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:<br>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.<br>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.”<br>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. | |

| Revenue Code | Description | |
|---|---|---|
| | 4. Revenue Category 068X is not limited to admitted patients.<br>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.<br>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.<br>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.<br>7. Subcategory 9 is for sate or local authorities with levels beyond IV. | |
| 069X | Not Assigned | |
| 070X | Cast Room<br>Charges for services related to the application, maintenance and removal of casts.<br>Rationale: Permits identification of this service, if necessary. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | CAST ROOM |
| | 9 - Other Cast Room | OTHER CAST ROOM |
| 071X | Recovery Room<br>Rationale: Permits identification of particular services, if necessary. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | RECOVERY ROOM |
| | 9 - Other Recovery Room | OTHER RECOV RM |
| 072X | Labor Room/Delivery<br>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.<br>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) | |

| Revenue Code | Description | |
|---|---|---|
| | Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | EKG/ECG |
| | 1 – Holter Monitor | HOLTER MONT |
| | 2 - Telemetry | TELEMETRY |
| | 9 - Other EKG/ECG | OTHER EKG-ECG |
| 074X | Electroencephalogram (EEG) | |
| | Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | EEG |
| | 9 - Other EEG | OTHER EEG |
| 075X | Gastro-Intestinal Services | |
| | Procedure room charges for endoscopic procedures not performed in an operating room. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | GASTR-INTS SVS |
| | 9 - Other Gastro-Intestinal | OTHER GASTRO-INTS |
| 076X | Treatment or Observation Room | |
| | Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 0762 should be used for observation services.<br>Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. The reason for observation must be stated in the orders for observation. Payer should establish written guidelines that identify coverage of observation services. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | TREATMENT/OBSERVATION RM |
| | 1 - Treatment Room | TREATMENT RM |
| | 2 - Observation Room | OBSERVATION RM |
| | 9 – Other Treatment Room | OTHER TREATMENT RM |
| 077X | Preventative Care Services | |
| | Charges for the administration of vaccines. | |

| Revenue Code | Description | |
|---|---|---|
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | PREVENT CARE SVS |
| | 1 - Vaccine Administration | VACCINE ADMIN |
| | 9 – Other | OTHER PREVENT |
| 078X | Telemedicine - Future use to be announced - Medicare Demonstration Project | |
| | Subcategory | Standard Abbreviations |
| | 0 - General Classification | TELEMEDICINE |
| | 9 – Other Telemedicine | TELEMEDICINE/OTHER |
| 079X | Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)<br>Charges related to Extra-Corporeal Shock Wave Therapy (ESWT).. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | ESWT |
| | 9 – Other ESWT | ESWT/OTHER |
| 080X | Inpatient Renal Dialysis<br>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).<br>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<br>The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.<br>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.<br>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 |

| Revenue Code | Description | |
|---|---|---|
| | 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 |

| Revenue Code | Description | |
|---|---|---|
| | 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<br>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<br>Charges for dialysis services not identified elsewhere.<br>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 | <u>Behavior Health Treatments/Services (Also see 091X, an extension of 090X)</u> | |
| | **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 | <u>Behavioral Health Treatment/Services-Extension of 090X</u> | |

| Revenue Code | Description | |
|---|---|---|
| | 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.<br>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<br>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<br>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) | |

| Revenue Code | Description | |
|---|---|---|
| | Code indicates charges for other therapeutic services not otherwise categorized. | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - General Classification | OTHER RX SVS |
| | 1 - Recreational Therapy | RECREATION RX |
| | 2 - Education/Training (includes diabetes related dietary therapy) | EDUC/TRAINING |
| | 3 - Cardiac Rehabilitation | CARDIAC REHAB |
| | 4 - Drug Rehabilitation | DRUG REHAB |
| | 5 - Alcohol Rehabilitation | ALCOHOL REHAB |
| | 6 - Complex Medical Equipment Routine | COMPLX MED EQUIP-ROUT |
| | 7 - Complex Medical Equipment Ancillary | COMPLX MED EQUIP-ANC |
| | 9 - Other Therapeutic Services | ADDITIONAL RX SVS |
| 095X | Other Therapeutic Services-Extension of 094X | |
| | Charges for other therapeutic services not otherwise categorized | |
| | **Subcategory** | **Standard Abbreviations** |
| | 0 - Reserved | |
| | 1 - Athletic Training | ATHLETIC TRAINING |
| | 2 - Kinesiotherapy | KINESIOTHERAPY |
| 096X | Professional Fees | |
| | 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 | |

| Revenue Code | Description | |
|---|---|---|
| | **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<br>Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.<br>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<br>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<br>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).<br>Alternative therapy is intended to enhance and improve standard medical treatment. The following revenue codes(s) would be used to report services in | |

| Revenue Code | Description | |
|---|---|---|
| | 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<br>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 | |