

## B. CMS 1450/UB-92 Form

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## About the CMS-1450 / UB-92 Form

The CMS-1450 form, more commonly known as UB-92, serves the needs of many payers. Not all of the data elements need to be completed for every payer.

Data elements in the CMS uniform electronic billing specifications are consistent with the CMS-1450 form data set to the extent that one processing system can handle both. Definitions are also identical. However, due to the space constraints on the form, the electronic record contains more characters for some items than the corresponding items on the form

The revenue coding system for both Form CMS-1450 and the electronic specifications are identical.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the hard copy UB-92 or Form CMS-1450, CMS will accept claims of up to 9 pages. In addition, effective October 16, 2003, all state fields will be discontinued and reclassified as reserved for national assignment.

## Form Locator (FL) Fields

The following sections provide descriptions of the form locator (FL) fields and whether the information is required.

### FL1 - (Untitled)

#### **Provider Name, Address, and Telephone Number**

*Required.* The minimum entry is the provider's 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. Telephone and fax numbers are desirable.

### FL2 - (Untitled)

Not Required. This is one of the four fields which have not been assigned for national use.

### FL3 - Patient Control Number

*Required.* The patient’s unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payments

### FL4 - 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 digit classifies the type of care.
- The third digit indicates the sequence of this bill in this particular episode of care; also referred to as “Frequency” code.

#### First Digit - Type of Facility

1st Digit	Type of Facility
1	Hospital
2	Skilled Nursing
3	Home Health
4	Religious Non-Medical (Hospital)
5	Religious Non-Medical (Extended Card)
6	Intermediate Care
7	Clinic or Hospital Based Renal Dialysis Facility
8	Special Facility of Hospital ASC Surgery
9	Reserved for National Assignment

#### Second Digit - Classification (Except Clinics and Special Facilities)

2nd Digit	Classification	Definition
1	Inpatient (Part A)	
2	Hospital Based or Inpatient (Part B)	Includes Home Health Agency (HHA) visits under a Part B plan of treatment
3	Outpatient	Includes HHA visits under a Part A plan of treatment and use of HHA Durable Medical Equipment (DME) under Part A plan of treatment
4	Other (Part B)	Includes HHA medical and other health services not under a plan of treatment, Skilled Nursing Facility (SNF) diagnostic clinical laboratory services to “nonpatients” and referred diagnostic services
5	Intermediate Care – Level I	

2nd Digit	Classification	Definition
6	Intermediate Care – Level II	
7	Subacute Inpatient	Revenue code 19X required
8	Swing bed	Used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement
9	Reserved for National Assignment	

### Second Digit - Classification (Clinics Only)

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 (Part B)
5	Comprehensive outpatient Rehabilitation Facility (CORF)
6	Community Mental Health Center (CMHC)
7	Reserved for National Assignment
8	Reserved for National Assignment
9	Other

### Second Digit - Classification (Special Facilities Only)

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 Centers
5	Critical Access Hospital
6	Residential Facility
7	Reserved for National Assignment
8	Reserved for National Assignment
9	Other

### Third Digit - Frequency

The third digit, referred to as the Frequency code, indicates the sequence of this bill in this particular episode of care.

3rd Digit	Frequency	Definition
A	Admission/Election Notice	Use when a hospice or religious non-medical health care institution is submitting the Form CMS-1450 as an admission notice
B	Hospice/Medicare Coordinated Care Demonstrations/Revocation Notice	Use when the UB-92 is used as a Termination/Revocation of a hospice, Medicare coordinated care demonstration or religious non-medical health care institution election.
C	Hospice Change of Provider	Use when the Form CMS-1450 is used as a Notice of Change to the hospice provider.
D	Hospice/Medicare Coordinated Care Demonstration/Institution-Void/Cancel	Use when the UB-92 is used as a Notice of a Void/Cancel of a hospice, Medicare Coordinated Care Demonstration Entity, or Religious Non-medical Health Care Institution election
E	Hospice Change of Ownership	Use when the Form CMS-1450 is used for a Notice of Change in Ownership for the hospice.
F	Beneficiary Initiated Adjustment Claim	Use to identify adjustments initiated by the beneficiary. For intermediary use only.
G	Common Working File (CWF) Initiated Adjustment Claim	Use to identify adjustments initiated by CWF. For intermediary use only.
H	CMS Initiated Adjustment Claim	Use to identify adjustments initiated by CMS. For intermediary use only.
I	Internal Adjustment Claim (Other than provider or PRO)	This code is used to identify adjustments initiated by you. For intermediary use only.
J	Initiated Adjustment Claim – Other	Use to identify adjustments initiated by other entities. For intermediary use only.
K	Office of Inspector General (OIG) Initiated Adjustment Claim	Use to identify adjustments initiated by OIG. For intermediary use only.
M	Medicare Secondary Payer (MSP) Initiated Adjustment Claim	Use to identify adjustments initiated by MSP. For intermediary use only. <b>Note:</b> MSP takes precedence over other adjustment sources.
P	PRO Adjustment Claim	Use to identify an adjustment initiated as a result of a PRO review. For intermediary use only.
0	Nonpayment/zero claims	Use when the provider does not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The “through” date is the date of discharge.

3rd Digit	Frequency	Definition
1	Admit Through Discharge Claim	Use for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which the provider expects payments 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	Use for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment.
3	Interim – Continuing Claims (Not valid for PPS bills)	Use 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)	Use 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 is the date of discharge.
5	Late Charge Only	Use only for outpatient claims. Late charge bills are not accepted for Medicare inpatient or ASC claims.
7	Replacement of Prior Claim	Used by the provider when provider wants to correct (other than late charges) a previously submitted bill.
8	Void/Cancel of a Prior Claim	Use to indicate that this bill is an exact duplicate of an incorrect bill previously submitted.
9	Final Claim for Home Health PPS Episode	Use to indicate that the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

## FL5 - Federal Tax Number

Not Required

## FL6 - Statement Covers Period (From-Through)

*Required.* The beginning and ending dates of the period include on this bill are shown in numeric fields (MMDDYY). Days before the entitlement are not shown. Use the “From” date to determine timely filing.

## FL7 - Covered Days

*Required.* The total number of covered days during the billing period applicable to the cost report including lifetime reserve days elected for which Medicare payment is requested, is entered. This should be the total of accommodation units reported in FL46.

Covered days exclude any days classified as noncovered, as defined in FL8, leave of absence days, and the day of discharge or death.

The provider does not deduct any days for payment made in the following instances:

- Workers' Compensation
- Automobile medical, no-fault, liability insurance
- An EGHP for an ESRD beneficiary
- Employed beneficiaries and spouses age 65 or over
- An LGHP for disabled beneficiaries

## FL8 - Noncovered Days

*Required.* The total number of noncovered days during the billing period within the "From" and "Through" date that are no claimable as Medicare patient days on the cost report.

## FL9 - Coinsurance Days

*Required.* The 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 are shown for this billing period.

## FL10 - Lifetime Reserve Days

*Required.* The provider enters the number of lifetime reserve days applicable.

## FL11 - (Untitled)

Not Required. This is one of the seven fields which have not been assigned for national use.

**FL12 - Patient's Name**

*Required.* The patient's name is shown with the surname first, first name, and middle initial, if any.

**FL13 - Patient's Address**

*Required.* This item shows the patients' full mailing address including street number and name, post office box number or RFD, City, State, and Zip code.

**FL14 - Patient's Birthdate**

*Required.* The month, day, and year of birth is shown numerically as MMDDYYYY. If the date of birth was not obtained, the field will be zero filled.

**FL15 - Patient Sex**

*Required.* An "M" for male and an "F" for female. This item is used in conjunction with FL67-FL81 to identify inconsistencies.

**FL16 - Patient's Marital Status**

Not Required.

**FL17 - Admission Date**

*Required.* The month, day, and year of admission for inpatient care are shown numerically as MMDDYY.

**FL18 - Admission Hour**

Not Required.

## FL19 - Type of Admission/Visit

*Required on inpatient bills only.* This code indicates the admission's priority.

### Code Structure

Code	Admission/Visit Type	Definition
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. Patient admitted to first available accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	Newborn	Need to use a special source of admission codes.
5	Trauma Center	Centers licensed by the state
9	Information not available	The hospital cannot classify the type of admission. (Rarely used)

## FL20 - Source of Admission

*Required.* Source of admission or outpatient registration

Code	Source of Admission
1	Physician Referral
2	Clinic Referral
3	HMO referral
4	Transfer from a Hospital
5	Transfer from a SNF
6	Transfer from another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital
B	Transfer from another Home Health Agency
C	Readmission to Same Home Health Agency period
D-Z	Reserved for national assignment

## FL21 - Discharge Hour

Not Required

## FL22 - Patient Status

*Required for inpatient, outpatient, HHA, and SNF.*

Code	Patient Status
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF. (for swing bed, use code 61)
04	Discharged/transferred to an Intermediate Care Facility
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under care of HH
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
09	Admitted as an inpatient to this hospital <b>Note:</b> When a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.
20	Expired or did not recover
30	Still patient
40	Expired at home (hospice only)
41	Expired in medical facility
42	Expired, place unknown (hospice only)
43	Discharge/transferred to a federal facility
44-49	Reserved for national assignment
50	Hospice – home
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
62-70	Reserved for National Assignment
73-99	Reserved for National Assignment

## FL23 - Medical Record Number

*Required.* This is the number assigned to the patient's medical/health record by the provider. If the provider enters a number, you must carry the number through your system and return it to the provider.

## FL24-FL30 - Condition Codes

*Required.*

Code	Condition	Definition
02	Condition is employment related	Code indicates patient alleges that the medical condition in this episode of care is due to environments/events resulting from employment
04	Patient is HMO Enrollee	Bill submitted for information only
05	Lien has been filed	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 first 30 months; covered by employer group health insurance	Code indicates that Medicare may be a secondary insurer.
07	Treatment of nonterminal condition for hospice	Code indicates patient has elected hospice but the provider is not treating the terminal condition.
08	Beneficiary would not provide information concerning other insurance coverage	Same
09	Neither patient nor spouse employed	Patient and spouse have denied employment.
10	Patient and/or spouse is employed but no EGHP coverage exists	There is no group health insurance from an EGHP or other health insurance that covers the patient,
11	Disabled beneficiary but no LGHP	There is no group health insurance from an LGHP or other health insurance that covers the patient.
12-14	Payer codes	Reserved for internal use only by third party payer.
15	Clean claim delayed in HCFA (CMS) processing system (payer code only)	CMS delayed claim processing. Interest is applicable.
16	SNF Transition Exemption (Medicare payer only code)	Code indicates an exemption from the post-hospital requirements applies for this SNF stay or the qualifying stay dates are more than 30 days prior to admission.
20	Beneficiary requested billing	Provider realizes the services on this bill are not covered but the beneficiary has requested a formal determination.
21	Billing for denial notice	Provider realizes the services on this bill are not covered, but requests a denial notice from Medicare in order to bill Medicaid or other insurer.
26	VA eligible patient chooses to receive services in a Medicare certified facility	Same
27	Patient referred to a sole community hospital for a diagnostic lab test	Sole community hospital only.

Code	Condition	Definition
28	Patient and/or spouse's EGHP is secondary to Medicare	Code indicates that either the EGHP is a single employer plan and the employer has fewer than 20 full and part-time employees or the EGHP is multi-or multiple employers' 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	Code indicates that either the EGHP is a single employer plan and the employer has few than 100 full and part-time employees or the LGHP is a multi- or multiple employer plans 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 enrolled in qualified clinical trials.
31	Patient is a full-time day student	Same
32	Patient is a cooperative work study student	Same
33	Patient is a full-time night student	Same
34	Patient is a part-time student	Same
35		Reserved for national assignment
36	General Care Patient in a special unit	(Not used by hospitals under PPS) Patient placed in special unit in that no general beds were available.
37	Ward accommodation at patient's request	(Not used by hospitals under PPS) Patient assigned to ward.
38	Semi-private room not available	(Not used by hospitals under PPS) Patient assigned to ward; no semi-private room available.
39	Private room medical necessary	(Not used by hospitals under PPS) Assignment to private room was medically necessary.
40	Same day transfer	Patient transferred from one provider to another before midnight on the day of admission
41	Partial Hospitalization	For partial hospitalization. For outpatient this includes a variety of psychiatric programs
42	Continuing care not related to inpatient admission	Continuing care plan is not related to condition or diagnosis
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.
55	SNF bed not available	SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical appropriateness	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.

<b>Code</b>	<b>Condition</b>	<b>Definition</b>
57	SNF readmissions	Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Medicare+Choice Organization enrollee	Code indicates that the patient is a terminated enrollee in a Medicare+Choice Organization plan whose three-day inpatient hospital stay was waived.
59		Reserved for national assignment
60	Operating cost day outlier	Pricer indicates this bill is a length-of-stay outlier
61	Operating cost outlier	Pricer indicates this bill is a cost
62	PIP bill	Bill was paid under PIP
63	Payer only code	Code reserved for internal use only.
64	Other than clean claim	Claim is not "clean".
65	Non-PPS bill	Bill is not a PPS bill.
66	Provider does not wish cost outlier payment	Hospital paid under PPS and is not requesting additional payment as a cost outlier for this stay.
67	Beneficiary elects not to use Lifetime Reserve Days	Same
68	Beneficiary elects to use Lifetime Reserve Days	Same
69	IME/DGME/N&A payment only	A request for supplemental payment from Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health
70	Self-administered EPO	Code indicates the billing is for a dialysis patient who self-administers EPO.
71	Full Care in unit	Patient who receives staff-assisted dialysis services
72	Self-Care in unit	Patient who manages his/her own dialysis services without staff assistance.
73	Self-Care training	Billing is for special dialysis services where the patient and his/her helper were learning to perform dialysis.
74	Home	Billing for a patient who received dialysis services at home.
75	Home 100 percent payment	Not to be used for services after April 16, 1990
76	Back-up facility dialysis	Billing is for a home dialysis patient who received back-up dialysis in a facility
77	Provider accepts or is obligated/required due to a contractual arrangement by law to accept payment by a primary payer as payment in full.	No Medicare payment is due.
78	New coverage not implemented by HMO	Medicare newly covered service for which an HMO does not pay
79	CORF services provided off site	Occupational, physical, and speech therapy were provided off site.
A0	Special zip code reporting	Five digit zip code of the location from which the beneficiary is initially placed on board the ambulance.

<b>Code</b>	<b>Condition</b>	<b>Definition</b>
A3	Special Federal funding	Code is designed for uniform use by State uniform billing committee.
A5	Disability	Same as above
A6	PPV/Medicare Pneumonia/Influenza 100%	Paid under a special Medicare program provision.
A7	Induced abortion-danger to life	An abortion was performed to avoid danger to a women's life.
A8	Induced abortion – victim of rape/incest	Discontinued October 1, 2002.
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
AB	Abortion performed due to incest	Self-explanatory
AC	Abortion performed due to serious fetal genetic defect, deformity, or abnormality	Self-explanatory
AD	Abortion performed due to a life endangering physical condition caused by, arising from or exacerbated by the pregnancy itself	Self-explanatory
AE	Abortion performed due to physical health of mother that is not life endangering	Self-explanatory
AF	Abortion performed due to emotional/psychological health of the mother	Self-explanatory
AG	Abortion performed due to social economic reasons	Self-explanatory
AH	Elective abortion	Self-explanatory
AI	Sterilization	Self-explanatory
AJ	Payer responsible for co-payment	Self-explanatory
AK	Air ambulance required	For ambulance claims
AL	Specialized treatment bed unavailable	For ambulance claims
AM	Non-emergency medically necessary stretcher transport required	For ambulance claims
AN-AZ		Reserved for national assignment
B0	Medicare Coordinate Care Demonstration Program	Self-explanatory
B1	Beneficiary is ineligible for Demonstration Program	Full definition pending

Code	Condition	Definition
B2	Critical Access Hospital Ambulance Attestation	Attestation that CAH meets the criteria for exemption from the ambulance fee schedule.
B3	Pregnancy indicator	Indicates patient is pregnant.
B4-BZ	Reserved for National Assignment	
M0	All-inclusive rate for outpatient	Payer only code. Used by a CAH electing to be paid an all-inclusive rate for outpatient services
M1	Roster billed influenza virus vaccine or pneumonia vaccine	Payer only code. For providers that mass immunize.
M2	HHA payment significantly exceeds total charge	Payer only code. Charges in excess of covered billed charges.
C1	Approved as billed	PRO review and fully approved all days and any outliers.
C3	Partial approval	PRO review and some portion of stay denied
C4	Admission denied	PRO review and none of stay was medically necessary.
C5	Postpayment review	PRO review after admission stay
C6	Preadmission or preprocedure	PRO authorized admission but has not reviewed the services provided.
C7	Extended authorization	PRO authorized admission for an extended length of time but has not reviewed the services provided.
D0	Changes to service date	Self-explanatory
D1	Changes to charges	Self-explanatory
D2	Changes to revenue codes/HCPCs/rate codes	Changes in codes
D3	Second or subsequent interim PPS bill	Self-explanatory
D4	Change in ICD-9-CM diagnosis and/or procedure code	Change in codes
D5	Cancel to correct HICN or provider ID	Cancel only to correct an HICN or provider ID number
D6	Cancel only to repay a duplicate or OIG overpayment	Self-explanatory
D7	Change to make Medicare the secondary payer	Self-explanatory
D8	Change to make Medicare the primary payer	Self-explanatory
D9	Any other change	Self-explanatory
E0	Change in patient status	Self-explanatory
E1-E9		Reserved for national assignment
G0	Distinct medical visit	Report this code when multiple medical visits occurred on the same day in the same revenue. Each visit was distinct.
G1-G9		Reserved for national assignment

Code	Condition	Definition
H0	Delayed filing, statement of intent submitted specially	Code indicates that Statement of Intent was submitted within the qualifying period to identify the existence of another third party liability situation.

## FL31 - (Untitled)

Not required.

## FL32-FL35 - Occurrence Codes and Dates

*Required.* Event codes are two alphanumeric characters, and dates are shown as six numeric digits (MMDDYY).

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**Note:** Occurrence and occurrence span codes are mutually exclusive.  
Occurrence codes values are 01 through 69 and A0 through L9.

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Code	Occurrence	Definition
01	Accident/Medical coverage	Available medical payment coverage. Include date of accident/injury
02	No-fault insurance involved, including auto accident/other	State has applicable no-fault or liability laws (legal basis for settlement without admission or proof of guilt)
03	Accident/Tort Liability	Third party's action may involve a civil court process in an attempt to require payment by third party.
04	Accident/employment related	Date of accident related to patient's employment
05	Accident/No medical or liability coverage	There is no medical payment or third-party liability coverage. Include date of accident/injury
11	Onset of symptoms/illness	When the patient first became aware of symptoms/illness
12	Date of onset for a chronically dependent individual	HHA claim only. This is the first month of the 3 month period immediately prior to eligibility under respite care benefit
16	Date of last therapy	Last day of physical, occupational or speech therapy.
18	Date of retirement, patient beneficiary	Self-explanatory
19	Date of retirement ,spouse	Self-explanatory
20	Guarantee of payment began	Part A claim only. Date provider began claiming payment under the guarantee of payment provision.
21	UR notice received	Part A SNF claims only. Admission or further stay was not medically necessary.
22	Date active care ended	Date covered level of care ended. Code is not required if code "21" is used.

23	Date of cancellation of hospice election period	For intermediary use only
24	Date insurance denied	Receipt date of denial of coverage by a higher priority payer
25	Date benefits terminated by primary payer	Date on which coverage no longer available to patient.
26	Date SNF bed available	Date SNF bed available to hospital inpatient.
27	Date of hospice certification or re-certification	Date of certification for hospice benefit period.
28	Date CORF plan established or last reviewed	Date the plan of treatment was established or reviewed for CORF care.
29	Date OPT plan established or last reviewed	Date a plan was established or last reviewed for OPT.
30	Date outpatient speech pathology plan established or last reviewed	Date a plan was established or last reviewed for outpatient speech therapy.
31	Date beneficiary notified of intent to bill (accommodations)	Date of notice provided by the hospital to the patient that inpatient care is not longer required.
32	Date beneficiary notified of intent to bill (procedures or treatments)	Date of notice provided to the beneficiary that requested care may not be reasonable or necessary under Medicare.
33	First day of the Medicare coordination period for ESRD, beneficiaries covered by an EGHP	Required only for ESRD beneficiaries.
34	Date of election of extended care services	Date the guest elected to receive extended care services
35	Date treatment started for physical therapy	Self-explanatory
36	Date of inpatient hospital discharge for transplant procedure	Date of discharge for inpatient in which patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
37	Date of inpatient hospital discharge, non-covered transplant patient	Date of discharge for inpatient which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
41	Date of first test for pre-admission testing	Date on which the first outpatient diagnostic test was performed as part of a PAT program.
42	Date of discharge	(hospice claims only) Date beneficiary terminated his/her election to receive benefits.
43	Schedule date of canceled surgery	Date for which ambulatory surgery was scheduled.
44	Date treatment started for occupational therapy	Self-explanatory
45	Date treatment started for speech therapy	Self-explanatory
46	Date treatment started for cardiac rehabilitation	Self-explanatory
47	Date cost outlier status begins	First day the inpatient cost outlier threshold is reached.

48-49		Payer codes
A1	Birthdate – Insured A	Birth date of insured in whose name the insurance is carried.
A2	Effective date – insured A policy	First date the insurance is in force.
A3	Benefits exhausted	Last date for which benefits are available and after which no payment can be made.
A4	Split bill date	Date patient became Medicaid eligible due to medically needy spend down. Also called “split bill date”.
B1	Birthdate – Insured B	Birth date of individual in whose name the insurance is carried.
B2	Effective date – insured B policy	First date the insurance is in force.
B3	Benefits exhausted	Last date for which benefits are available and after which no payment can be made.
C1	Birthdate – Insured C	Birth date of insured in whose name the insurance is carried.
C2	Effective date – insured C policy	First date the insurance is in force.
C3	Benefits exhausted	Last date for which benefits are available and after which no payment can be made.
C4-C9	Reserved for National Assignment	
D0-D9	Reserved for National Assignment	

## FL36 - Occurrence Span Code and Dates

*Required.* Event codes are two alphanumeric characters, and dates are shown numerically as MMDDYY.

**Note:** Occurrence and occurrence span codes are mutually exclusive. Occurrence span codes values are 70 through 99 and M0 through Z9.

Code	Occurrence Span	Definition
70	Qualifying stay dates	Part A claims for SNF level care only Hospital stay of at least 3 days which qualifies the patient for payment of SNF level of care
71	Nonutilization dates (for payer use on hospital bills only)	PPS inlier stays for which beneficiary had exhausted all regular days and/or coinsurance days.
72	Prior stay dates	Part A claims only. Code indicates from/through dates given by the patient for any hospital stay that ended within 60 days of this hospital or SNF admission.

73	First/last visit	Actual dates of the first and last visit occurring in this billing period where these dates are different from those in FL6.
74	Noncovered level of care	From/through dates for a period of at a noncovered level of care in an otherwise covered stay.
75	SNF level of care	From/through dates for a period of SNF level of care during an inpatient hospital stay.
76	Patient liability	From/through dates for a period of noncovered care for which the hospital is permitted to charge the beneficiary.
77	Provider liability – utilization charged	From/through dates for a period of noncovered care for which the provider is liable.
78	SNF prior stay dates	Part A claims only. From/through dates given by the patient for a SNF stay that ended within 60 days of this hospital or SNF admission.
79	Payer code	For payer use only.
M0	PRO/UR stay dates	If a code "C3" is in FL24-FL30, the from and through dates of the approved billing period are here.
M1	Provider liability – no utilization	From/through dates of a period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable.
M2	Dates of inpatient respite care	From/through dates of a period of intermediate level of care
M4	Residential level of care	From and through dates of a period of residential care
M5-WZ	Reserved for National Assignment	

## FL37 - Internal Control Number (ICN)/Document Control Number (DCN)

*Required.* The control number assigned to the original bill needs to be documented in this field. All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted.

## FL38 - (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address

Not Required.

## FL39-FL41 - Value Codes and Amounts

*Required.* Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric characters, and each value allows up to nine numeric digits.

Negative amounts are not allowed except in FL41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents.

If more than one value code is shown for a billing period, codes are shown in ascending alphanumeric sequence. There are four lines of data, line "A" through line "D".

Code	Title	Definition
04	Inpatient professional component charges which are combined billed	Code indicates the amount shown is the sum of the inpatient professional component charges which are combined billed. (Used only by some all-inclusive rate hospitals)
05	Professional component included in charges and also billed separately to Carrier	Code indicates the charges shown are included in billing charges (column 53) but a separate billing for them will also be made to the Carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the bill for physician's services is processed by the Carrier. These charges are also deducted when computing interim payment.
06	Medicare Part A and Part B blood deductible	Code indicates the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint.
08	Medicare lifetime reserve amount for first calendar year in billing period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission.
09	Medicare coinsurance amount for first calendar year in billing period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the first calendar year of the billing period times the applicable coinsurance rate. This code is not used on Part B bills.
10	Medicare lifetime reserve amount for second calendar year in the billing period.	Code indicates the amount shown is the product of the number of lifetime reserve days used in the 2nd calendar year of the billing period times the applicable lifetime reserve rate. The code is used only for stays spanning two calendar years when lifetime reserve days were used in the year of discharge.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
11	Medicare Coinsurance Amount for second calendar year in billing period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the second calendar year of the billing period the applicable coinsurance rate. This code is used only for stays spanning two calendar years when coinsurance days were used in the year of discharge. This code is not used on Part B bills.
12	Working aged beneficiary/spouse with an EGHP	Code indicates the amount shown is that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to cover. If six zeros are entered in the amount field, the provider is claiming a conditional payment because the EGHP has denied coverage.
13	ESRD beneficiary in a Medicare coordination period with an EGHP	Code indicates the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD beneficiary that the provider is applying to covered Medicare charges on the bill.
14	No-Fault, including auto/other insurance	Code indicates the amount shown is that portion of a higher priority no-fault including auto/other insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros are entered in the amount field, the provider is claiming a conditional payment because the other insurance has denied coverage or there has been a substantial delay in its payment.
15	Worker's Compensation	Codes indicates the amount shown is that portion of a higher priority WC payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. If six zeros are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in the other payer's payment.
16	PHS, other Federal agency	Code indicates the amount shown is 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.
17	Operating Outlier amount	Codes indicates the amount shown is 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.
18	Operating disproportionate share amount	(Not reported by providers). Report operating indirect medical education amount applicable with this code. Use the amount indicated in the pricer.
19	Operating indirect medical education amount	(Not reported by providers). Report operating indirect medical education amount applicable with this code. Use the amount indicated in the pricer.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
31	Patient liability amount	Code indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered 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.
37	Pints of blood furnished	Code indicates the total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced.
38	Blood deductible pints	Code indicates the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of blood replaced	Code indicates the total number of pints of blood which were donated on the patient's behalf.
40	New coverage not implemented by HMO	(For inpatient services only). Code indicates the amount shown for inpatient charges covered by HMO.
41	Black lung	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. If six zeros are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment.
42	Veterans Affairs	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill.
43	Disable beneficiary under age 65 with LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill.
44	Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received	Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.
46	Number of grace days	A code "C3" or "C4" is in FL24-FL30 (condition code) indicating that the PRO has denied all or a portion of the billing period.
47	Any liability insurance	Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
48	Hemoglobin reading	Code indicates the latest hemoglobin reading taken during this billing cycle. This is usually reported in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.
49	Hematocrit reading	Code indicates the latest hematocrit reading taken during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.
50	Physical therapy visits	Code indicates the number of physical therapy visits from onset through this billing period.
51	Occupational therapy visits	Code indicates the number of occupational therapy visits from onset through this billing period.
52	Speech therapy visits	Code indicates the number of speech therapy visits from onset through this billing period.
53	Cardiac rehabilitation visits	Code indicates the number of cardiac rehabilitation visits from onset 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 of 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)	Number of skilled hours during the billing period. Count only hours spent in the home. Exclude travel time. Report in hours.
57	Home health aide-home visit hours (HHA only)	Number of hours of home health aide services provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in hours.
58	Arterial blood gas (PO2/PA2)	Code indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy.
59	Oxygen saturation (O2 Sat/oximetry)	Code indicates oxygen saturation at the beginning of each reporting period for oxygen therapy.
60	HHA branch MSA	Code indicates MSA in which HHS branch is located.
61	Location where service is furnished (HHA and hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered.
62-65	Payer codes only	
66	Medicaid 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.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
68	Number of units of EPO provided during the billing period	Self-explanatory. Reported in whole units.
69	State charity care percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number.
70	Interest amount	(For internal use by third party payers only)
71	Funding of ESRD networks	(For internal use by third party payers only)
72	Flat rate surgery charge	Code indicates the amount of the standard charge for outpatient surgery where the hospital has such a charging structure.
75	Gramm/Rudman/Hollings	(For internal use by third party payers only)
76	Provider's interim rate	(For internal use by third party payers only) Report the provider's percentage of billed charges interim rate during this period.
77-79	Payer codes	
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 assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount assumed by the provider to be applied to the patient's coinsurance amount involving the indicated payer.
A3	Estimated responsibility Payer A	The amount estimated by the provider to 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.
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.
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 reason.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A8-A9		Reserved for National Assignment
AA	Regulatory surcharges, assessments, allowances or health care related taxes Payer A	Self-explanatory
AB	Other assessments or allowances (e.g., Medical Education), Payer A	Self-explanatory

Code	Title	Definition
AC-AZ		Reserved for National Assignment
		NOTE: B1-C0 is the same as Payer A except for Payer B. C1-DZ is the same as Payer A except for Payer C E0-F0 is the same as Payer A except for Payer D F1-GB is the same as Payer A except for Payer E
GC-GZ		Reserved for National Assignment
H0-WZ		Reserved for National Assignment
X0-ZZ		Reserved for National Assignment

## FL42 - Revenue Code

*Required.* For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL42. Zero level billing is encouraged for all services which do not require HCPC codes.

Code	Title/Definition
0001	<b>Total Charge</b> For use on paper claims only. For electronic transactions, report the total charge in the appropriate data segment/field.
001X	Reserved for internal payer use
002X	<b>Health Insurance Prospective Payment System</b> Subcategory 0 – Reserved 1 – Reserved 2 – Skilled Nursing Facility PPS 3 – Home Health PPS 4 – Inpatient Rehabilitation Facility PPS 5-9 – Reserved
003X to 006X	Reserved for national assignment
007X to 009X	Reserved for state use.
010X	<b>All Inclusive Rate</b> 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 0 – All-inclusive room and board plus ancillary 1 – All-inclusive room and board

<b>Code</b>	<b>Title/Definition</b>
011X	<p><b>Room &amp; Board – Private</b> (Medical or General)  Routine service charges for single bed rooms. Most payers require private rooms to be separately identified.</p> <p>Subcategory  0 – General Classification  1 – Medical/Surgical/Gyn  2 – OB  3 – Pediatric  4 – Psychiatric  5 – Hospice  6 0 Detoxification  7 – Oncology  8 – Rehabilitation  9 – Other</p>
012X	<p><b>Room &amp; Board – Semi-private two bed</b> (Medical or General)  Routine service chares incurred for accommodations with two beds. Most payers require that semi-private rooms be identified.</p> <p>Subcategory  0 – General Classification  1 – Medical/Surgical/Gyn  2 – OB  3 – Pediatric  4 – Psychiatric  5 – Hospice  6 – Detoxification  7 – Oncology  8 – Rehabilitation  9 – Other</p>
013X	<p><b>Semi-Private – Three and Four Beds</b></p> <p>Subcategory  0 – General Classification  1 – Medical/Surgical/Gyn  2 – OB  3 – Pediatric  4 – Psychiatric  5 – Hospice  6 – Detoxification  7 – Oncology  8 – Rehabilitation  9 – Other</p>

Code	Title/Definition
014X	<p><b>Private (Deluxe)</b>  Deluxe rooms are accommodations with amenities substantially in excess of that provider to other patients...</p> <p>Subcategory  0 – General Classification  1 – Medical/Surgical/Gyn  2 – OB  3 – Pediatric  4 – Psychiatric  5 – Hospice  6 – Detoxification  7 – Oncology  8 – Rehabilitation  9 – Other</p>
015X	<p><b>Room &amp; Board Ward (Medical or General)</b>  Routine service charge for accommodations with five or more beds.</p> <p>Subcategory  0 – General Classification  1 – Medical/Surgical/Gyn  2 – OB  3 – Pediatric  4 – Psychiatric  5 – Hospice  6 – Detoxification  7 – Oncology  8 – Rehabilitation  9 – Other</p>
016X	<p><b>Other Room &amp; Board</b>  Any routine service charges for accommodations that cannot be included in the more specific revenue codes.</p> <p>Subcategory  0 – General Classification  4 – Sterile Environment  7 – Self Care  9 - Other</p>
017X	<p><b>Nursery</b>  Charges for nursing care to newborn and premature infants in nurseries.</p> <p>Subcategory  0 – General Classification  1 – Newborn, Level I – Routine care  2 – Newborn, Level II – Low-birth-weight neonates who are not sick but require frequent feeding and care  3 – Newborn , Level III – Sick neonates who do not require intensive care, but require 6-12 hours of nursing care  4 – Newborn, Level IV – Constant nursing and continuous cardiopulmonary and other support for severely ill infants  9 – Other</p>

<b>Code</b>	<b>Title/Definition</b>
018X	<p><b>Leave of Absence</b>            Charges (including zero charges) for holding a room while the patient is temporarily away from the provider. Charges are billable for codes 2-5.            Subcategory            0 – General Classification            1 – Reserved            2 – Patient Convenience            3 – Therapeutic Leave            4 – ICF Mentally Retarded – any reason            5 – Nursing Home (hospitalization)            9 – Other leave of absence</p>
019X	<p><b>Subacute Care</b>            Subcategory            0 – General Classification            1 – Subacute Care, Level I – Skilled Care (minimal nursing intervention)            2 – Subacute Care, Level II – Comprehensive Care (Moderate to extensive nursing intervention)            3 – Subacute Care, Level III – Complex Care (Moderate to extensive nursing intervention)            4 – Subacute Care, Level IV – Intensive Care (Extensive nursing and technical intervention)            9 – Other Subacute Care</p>
020X	<p><b>Intensive Care</b>            Subcategory            0 – General Classification            1 – Surgical            2 – Medical            3 – Pediatric            4 – Psychiatric            6 – Intermediate ICU            7- Burn Care            8 – Trauma            9 – Other Intensive Care</p>
021X	<p><b>Coronary Care</b>            Subcategory            0 – General Classification            1 – Myocardial infarction            2 – Pulmonary Care            3 – Heart Transplant            4 – Intermediate CCU            9 – Other Coronary Care</p>

<b>Code</b>	<b>Title/Definition</b>
022X	<p><b>Special Charges</b> Some hospitals prefer to break out charges that are normally considered part of routine services.</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Admission Charge</li> <li>2 – Technical Support Charge</li> <li>3 – U.R. Service Charge</li> <li>4 – Late Discharge, medically necessary</li> <li>9 – Other Special Charge</li> </ul>
023X	<p><b>Incremental Nursing Charge Rate</b> Charge for nursing service assessed in addition to room and board</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Nursery</li> <li>2 – OB</li> <li>3 – ICU (includes transitional care)</li> <li>4 – CCU (includes transitional care)</li> <li>5 – Hospice</li> <li>9 – Other</li> </ul>
024X	<p><b>All Inclusive Ancillary</b> A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Basic</li> <li>2 – Comprehensive</li> <li>3 – Specialty</li> <li>9 – Other All Inclusive Ancillary</li> </ul>
025X	<p><b>Pharmacy</b> Code indicates the charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Generic Drugs</li> <li>2 – Nongeneric Drugs</li> <li>3 – Take Home Drugs</li> <li>4 – Drugs Incident to Other Diagnostic Services</li> <li>5 – Drugs Incident to Radiology</li> <li>6 – Experimental Drugs</li> <li>7 – Nonprescription</li> <li>8 – IV Solutions</li> <li>9 – Other Pharmacy</li> </ul>

<b>Code</b>	<b>Title/Definition</b>
026X	<b>IV Therapy</b> Code indicates the administration of intravenous solution by specialty trained personnel to individuals requiring such treatment. Subcategory 0 – General Classification 1 – Infusion Pump 2 – IV Therapy/Pharmacy Services 3 – IV Therapy/Drug/Supply/Delivery 4 – IV Therapy/Supplies 9 – Other IV Therapy
027X	<b>Medical/Surgical Supplies</b> Subcategory 0 – General Classification 1 – Nonsterile Supply 2 – Sterile Supply 3 – Take Home Supplies 4 – Prosthetic/Orthotic Devices 5 – Pacemaker 6 – Intraocular Lens 7 – Oxygen-Take Home 8 – Other Implants
028X	<b>Oncology</b> Subcategory 0 – General Classification 9 – Other Oncology
029X	<b>Durable medical Equipment (DME) (Other than Rental)</b> Equipment that can stand repeated use. Subcategory 0 – General Classification 1 – Rental 2 – Purchase of new DME 3 – Purchase of used DME 4 – Supplies/Drugs for DME Effectiveness (HHAs only) 9 – Other Equipment
030X	<b>Laboratory</b> Subcategory 0 – General Classification 1 – Chemistry 2 – Immunology lab 3 – Renal patient (Home) 4 – Nonroutine Dialysis 5 – Hematology 6 – Bacteriology & Microbiology 7 – Urology 9 – Other Laboratory

<b>Code</b>	<b>Title/Definition</b>
031X	<b>Laboratory Pathological</b> Tests on tissues and cultures. Subcategory 0 – General Classification 1 – cytology 2 – Histology 4 – Biopsy 9 - Other
032X	<b>Radiology – Diagnostic</b> Includes taking, processing, examining, and interpreting radiographs and fluorographs. Subcategory 0 – General Classification 1 – Angiocardiology 2 – Arthrography 3 – Arteriography 4 – Chest X-ray 9 – Other
033X	<b>Radiology – Therapeutic</b> Includes injection or ingestion of radioactive substances. Subcategory 0 – General Classification 1 – Chemotherapy – Injected 2 – Chemotherapy – oral 3 – Radiation Therapy 4 – Chemotherapy – IV 9 – Other
034X	<b>Nuclear Medicine</b> Subcategory 0 – General Classification 1 – Diagnostic 2 – Therapeutic 9 – Other
035X	<b>CT Scan</b> Due to coverage limitations, some insurers require that the specific test be identified. Subcategory 0 – General Classification 1 – Head Scan 2 – Body Scan 0 – Other CT Scan
036X	<b>Operating Room</b> Subcategory 0 – General Classification 1 – Minor Surgery 2 – Organ Transplant – other than kidney 7 – Kidney Transplant 9 – Other

<b>Code</b>	<b>Title/Definition</b>
037X	<b>Anesthesia</b> Subcategory 0 – General Classification 1 – Anesthesia Incident to Radiology 2 – Anesthesia Incident to other Diagnostic Services 4 – Acupuncture 9 – Other Anesthesia
038X	<b>Blood</b> Charges for blood must be separately identified. Subcategory 0 – General Classification 1 – Packed Red Cells 2 – Whole Blood 3 – Plasma 4 – Platelets 5 – leucocytes 6 – Other Components 7 – Other Derivatives (Cryoprecipitates) 9 – Other
039X	<b>Blood Storage and processing</b> Subcategory 0 – General Classification 1 – Blood Administration (transfusion) 9 – Other Processing & Storage
040X	<b>Other Imaging Services</b> Subcategory 0 – General Classification 1 – Diagnostic mammography 2 – Ultrasound 3 – Screening Mammography 4 – Positron Emission Tomography 9 – Other Imaging Services
041X	<b>Respiratory Services</b> Subcategory 0 – General Classification 1 – Inhalation Services 2 – Hyperbaric Oxygen Therapy 9 – Other Respiratory Services
042X	<b>Physical Therapy</b> Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities. Subcategory 0 – General classification 1 – Visit Charge 2 – Hourly charge 3 – Group Rate 4 – Evaluation or Re-evaluation 9 – Other Physical Therapy

<b>Code</b>	<b>Title/Definition</b>
043X	<p><b>Occupational Therapy</b>            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.</p> <p>Subcategory            0 – General Classification            1 – Visit Charge            2 – Hourly Charge            3 – Group Rate            4 – Evaluation or Re-evaluation            9 – Other</p>
044X	<p><b>Speech-Language Pathology</b>            Subcategory            0 – General Classification            1 – Visit Charge            2 – Hourly Charge            3 – Group Rate            4 – Evaluation or Re-evaluation            9 – Other</p>
045X	<p><b>Emergency Room</b>            Under the provisions of EMTALA (Emergency Medical Treatment and Active Labor Act), 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.            Observation or "hold beds" are not reported under this code. They are reported under revenue code 762.</p> <p>Subcategory            0 – General Classification            1 – EMTALA Emergency Medical screening services            2 – ER beyond EMTALA Screening            6 – Urgent Care            9 - Other</p>
046X	<p><b>Pulmonary Function</b>            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.</p> <p>Subcategory            0 – General Classification            9 – Other</p>

<b>Code</b>	<b>Title/Definition</b>
047X	<p><b>Audiology</b> Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.</p> <p>Subcategory 0 – General Classification 1 – Diagnostic 2 – Treatment 9 – Other Audiology</p>
048X	<p><b>Cardiology</b> Subcategory 0 – General Classification 1 – Cardiac Cath Lab 2 – Stress Test 3 – Echocardiology 9 – Other</p>
049X	<p><b>Ambulatory Surgical Care</b> Subcategory 0 – General Classification 9 – Other</p>
050X	<p><b>Outpatient Services</b> 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.</p> <p>Subcategory 0 – General 9 – Other</p>
051X	<p><b>Clinic</b> Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.</p> <p>Subcategory 0 – General Classification 1 – Chronic Pain Center</p>
052X	<p><b>Free-Standing Clinic</b> Subcategory 0 – General Classification 1 – Rural Health – Clinic 2 – Rural Health – Home 3 – Family Practice Clinic 6 – Urgent Care Clinic 9 – Other</p>
053X	<p><b>Osteopathic Services</b> Subcategory 0 – General Classification 1 – Osteopathic Therapy 9 – Other</p>

<b>Code</b>	<b>Title/Definition</b>
054X	<p><b>Ambulance</b>  Subcategory  0 – General Classification  1 – Supplies  2 – Medical Transport  3 – Heart Mobile  4 – Oxygen  5 – Air Ambulance  6 – Neo-natal Ambulance  7 – Pharmacy  8 – Telephone Transmission EKG  9 – Other</p>
056X	<p><b>Medical Social Services</b>  Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation to patients on any basis.  Subcategory  0 – General Classification  1 – Visit Charge  2 – Hourly Charge  9 – Other</p>
057X	<p><b>Home Health Aide (Home Health)</b>  Subcategory  0 – General Classification  1 – Visit charge  2 – Hourly charge  9 – Other</p>
058X	<p><b>Other Visits (Home Health)</b>  Code indicates the charges by an HHA for visits other than physical therapy, occupational therapy, or speech therapy, which must be specifically identified.  Subcategory  0 – General Classification  1 – Visit Charge  2 – Hourly Charge  3 – Assessment  9 – Other</p>
059X	<p><b>Units of Service (Home Health)</b>  This revenue code is used by an HHA that bills on the basis of units of service.  Subcategory  0 – General Classification  9 – Home Health other</p>
060X	<p><b>Oxygen (Home Health)</b>  Subcategory  0 – General Classification  1 – Oxygen – Stat/Equip/Suppl or Cont.  2 – Oxygen – Stat/Equip/Suppl under 1 LPM  3 – Oxygen – Stat/Equip/Over 4 LPM  4 – Oxygen – Portable Add-on</p>

<b>Code</b>	<b>Title/Definition</b>
061X	<b>Magnetic Resonance Technology (MRT)</b> Subcategory 0 – General Classification 1 – Brain 2 – Spinal Cord 3 – Reserved 4 – MRI – Other 5 – MRA Head and Neck 6 – MRA – Lower Extremities 7 – Reserved 8 – MRA – Other 9 – Other MRI
062X	<b>Medical/Surgical Supplies – Extension of 027X</b> Subcategory 1 – Supplies Incident to Radiology 2 – Supplies Incident to Other Diagnostic Services 3 – Surgical Dressings 4 – Investigational Device
063X	<b>Pharmacy – Extension of 025X</b> Subcategory 0 – Reserved 1 – Single Source Drug 2 – Multiple Source Drug 3 – Restrictive Prescription 4 – Erythroepoetin (EPO) less than 10,000 units 5 – Erythroepoetin (EPO) 10,000 or more units 6 – Drugs requiring detailed coding* 7 – Self-administrable Drugs  *Revenue code 636 relates to HCPCS code, so HCPCS is the recommended code to be used in FL44. The specified units of service to be reported are to be in hundreds rounded to the nearest hundred.
064X	<b>Home IV Therapy Services</b> Subcategory 0 – General Classification 1 - Nonroutine Nursing Central Line 2 – IV Site Care, Central Line 3 – IV Start/Change Peripheral Line 4 – Nonroutine Nursing, Peripheral Line 5 – Training patient/Caregiver Central line 6 – Training Disabled Patient, Central line 7 – Training Patient/Caregiver, Peripheral Line 8 – Training, Disabled Patient, Peripheral Line 9 – Other

<b>Code</b>	<b>Title/Definition</b>
065X	<b>Hospice Services</b> Subcategory 0 – General Classification 1 – Routine Home Care 2 – Continuous Home Care 3 – Reserved 4 – Reserved 5 – Inpatient Respite Care 6 – General Inpatient Care (non respite) 7 – Physician Services 8 – Hospice Room and Board 9 – Other
066X	<b>Respite Care (HHA only)</b> Subcategory 0 – General Classification 1 – Hourly Charge/Nursing 2 - Hourly Charge/Aide/Homemaker/Companion 3 – Daily Respite Charge 9 - Other
067X	<b>Outpatient Special Residence Charges</b> Subcategory 0 – General Classification 1 – Hospital Based 2 – Contracted 9 – Other
068X	<b>Trauma Response</b> Subcategory 0 – Not used 1 – Level I 2 – Level II 3 – Level III 4 – Level IV 9 – Other
069X	Not Assigned
070X	<b>Cast Room</b> Charges for services related to the application, maintenance, and removal of casts. Subcategory 0 – General Classification 9 – Other
071X	<b>Recovery Room</b> Subcategory 0 – General Classification 9 – Other

<b>Code</b>	<b>Title/Definition</b>
072X	<p><b>Labor Room/Delivery</b> Charges for labor and delivery room services are provided by specially trained nursing personnel to include prenatal, assistance during delivery and postnatal care.</p> <p>Subcategory 0 – General Classification 1 – Labor 2 – Delivery 3 – Circumcision 4 – Birthing Center 9 – Other</p>
073X	<p><b>EKG/ECG (Electrocardiogram)</b> Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.</p> <p>Subcategory 0 – General Classification 1 – Holter Monitor 2 – Telemetry 9 - Other</p>
074X	<p><b>EEG Electroencephalogram</b> 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.</p> <p>Subcategory 0 – General Classification 9 - Other</p>
075X	<p><b>Gastro-Intestinal Services</b> Procedure room charges for endoscopic procedures not performed in an operating room.</p> <p>Subcategory 0 – General Classification 9 – Other Gastro-Intestinal</p>

<b>Code</b>	<b>Title/Definition</b>
076X	<p><b>Treatment or Observation Room</b>            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 reasons for observation must be stated in the orders for observation.            Payers should establish written guidelines which identify coverage of observation services. Only 762 should be used for observation services.            Subcategory            0 – General Classification            1 – Treatment Room            2 – Observation Room            9 – Other Treatment Room</p>
077X	<p><b>Preventative Care Services</b>            Charges for the administration of vaccines.            Subcategory            0 – General Classification            1 – Vaccine Administration            9 - Other</p>
078X	<p>Telemedicine            Future Medicare Demonstration project</p>
079X	<p><b>Extra-Corporeal Shock Wave Therapy</b> (formerly Lithotripsy)            Subcategory            0 – General Classification            0 - Other</p>
080X	<p><b>Inpatient Renal Dialysis</b>            Subcategory            0 – General Classification            1 – Inpatient Hemodialysis            2 – Inpatient Peritoneal (Non-CAPD)            3 – Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)            4 – Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)            9 – Other Inpatient Dialysis</p>

<b>Code</b>	<b>Title/Definition</b>
081X	<p><b>Organ Acquisition</b>  The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation. Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level. Note: Revenue code 814 is used only when costs incurred for an organ search does not result in an eventual organ acquisition and transplantation.</p> <p>Subcategory  0 – General Classification  1 – Living Donor  2 – Cadaver Donor  3 – Unknown Donor  4 – Unsuccessful Organ Search Donor Bank Charge  9 – Other Organ Donor</p>
082X	<p><b>Hemodialysis – Outpatient or Home Dialysis</b>  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. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.</p> <p>Subcategory  0 – General Classification  1 – Hemodialysis/Composite or other rate  2 – Home Supplies  3 – Home Equipment  4 – Maintenance 100%  5 – Support Services  9 – Other Hemodialysis Outpatient</p>
083X	<p><b>Peritoneal Dialysis – Outpatient or Home</b>  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.</p> <p>Subcategory  0 – General Classification  1 – Peritoneal/Composite or other rate  2 – Home supplies  3 – Home Equipment  4 – Maintenance 100%  5 – Support Services  9 – Other Peritoneal Dialysis</p>

Code	Title/Definition
084X	<p><b>Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient</b>  A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.  Subcategory  0 – General Classification  1 – CAPD/Composite or other rate  2 – Home Supplies  3 – Home Equipment  4 – Maintenance 100%  5 – Support Services  9 – Other CAPD Dialysis</p>
085X	<p><b>Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient</b>  A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.  Subcategory  0 – General Classification  1 – CCPD/Composite or other rate  2 – Home Supplies  3 – Home Equipment  4 – Maintenance 100%  5 – Support Services  9 – Other CCPD Dialysis</p>
086X	Reserved for Dialysis (National Assignment)
087X	Reserved for Dialysis (State Assignment)
088X	<p><b>Miscellaneous Dialysis</b>  Charges for dialysis services not identified elsewhere.  Subcategory  0 – General Classification  1 – Ultra Filtration  2 – Home Dialysis Aid Visit  9 – Miscellaneous Dialysis Other</p>
089X	Reserved for National Assignment
090X	<p><b>Behavior Health Treatments/Services</b>  Subcategory  0 – General Classification  1 – Electroshock Treatment  2 – Milieu Therapy  3 – Play Therapy  4 – Activity Therapy  5 – Intensive Outpatient Services – Psychiatric  6 – Intensive Outpatient Services – Chemical Dependency  7 – Community Behavioral Health Program (Day Treatment)  8 – Reserved for National Use  9 – Reserved for National Use</p>

Code	Title/Definition
091X	<p><b>Behavioral Health Treatment/Services – Extension of 090X</b> Code indicates charges for providing nursing care and professional services for emotionally disturbed patient. This includes patients admitted for diagnosis and those admitted for treatment.</p> <p>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. Note: Medicare does not recognize codes 912 and 913 services under its partial hospitalization program.</p> <p>Subcategory 0 – Reserved for National Use 1 – Rehabilitation 2 – partial Hospitalization – Less Intensive 3 – Partial Hospitalization – Intensive 4 – Individual Therapy 5 – Group Therapy 6 – Family Therapy 7 – Bio Feedback 8 – Testing 9 – Other Behavior Health Treatments/Services</p>
092X	<p><b>Other Diagnostic Services</b> Subcategory 0 – General Classification 1 – Peripheral Vascular Lab 2 – Electromyogram 3 – Pap Smear 4 – Allergy Test 5 – Pregnancy Test 9 – Other Diagnostic Service</p>
093X	<p><b>Medical Rehabilitation Day Program</b> Medical rehabilitation services as contracted with a payer and/or certified by the State. Services may include physical therapy, occupational therapy, and speech therapy. The subcategories of 93X are designed as zero-billed revenue codes (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 therapy revenue codes as normal. Subcategory 1 – Half Day 2 – Full Day</p>

<b>Code</b>	<b>Title/Definition</b>
094X	<p><b>Other Therapeutic Services</b>  Subcategory  0 – General Classification  1 – Recreational Therapy  2 – Education/Training (includes diabetes related dietary therapy)  3 – Cardiac Rehabilitation  4 – Drug Rehabilitation  5 – Alcohol Rehabilitation  6 – Complex Medical Equipment Routine  7 – Complex Medical Equipment Ancillary  9 – Other Therapeutic Services</p>
095X	<p><b>Other Therapeutic Services (An extension of 94X)</b>  Subcategory  0 – Reserved  1 – Athletic Training  2 - Kinesiotherapy</p>
096X	<p><b>Professional Fees</b>  Charges for medical professional 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  0 – General Classification  1 – Psychiatric  2 – Ophthalmology  3 – Anesthesiologist (MD)  4 – Anesthetist (CRNA)  9 – Other Professional Fees</p>
097X	<p><b>Professional Fees (Extension of 96X)</b>  Subcategory  1 – Laboratory  2 – Radiology – Diagnostic  3 – Radiology – Therapeutic  4 – Radiology – Nuclear Medicine  5 – Operating Room  6 – Respiratory Therapy  7 – Physical Therapy  8 – Occupational Therapy  9 – Speech Pathology</p>

<b>Code</b>	<b>Title/Definition</b>
099X	<p><b>Patient Convenience Items</b> Charges for items that are generally considered by the third party payers as strictly convenience items and are not covered. This code permits identification of particular services as necessary.</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Cafeteria/Guest Tray</li> <li>2 – Private Linen Service</li> <li>3 – Telephone/Telegraph</li> <li>4 – TV/Radio</li> <li>5 – Nonpatient Room Rentals</li> <li>6 – Late discharge Charge</li> <li>7 – Admission Kits</li> <li>8 – Beauty Shop/Barber</li> <li>9 – Other Patient Convenience Items</li> </ul>
100X	<p><b>Behavioral Health Accommodations</b> Routine service charges incurred for accommodations at specified behavior health facilities</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Residential Treatment – Psychiatric</li> <li>2 – Residential Treatment – Chemical Dependency</li> <li>3 – Supervised Living</li> <li>4 – Halfway House</li> <li>5 – Group Home</li> </ul>
101X to 209X	Reserved for National Assignment
210X	<p><b>Alternative Therapy Services</b> Alternative therapy is intended to enhance and improve standard medical treatment. The following revenue codes would be used to report services in a separately designated alternative inpatient/outpatient unit.</p> <p>Subcategory</p> <ul style="list-style-type: none"> <li>0 – General Classification</li> <li>1 – Acupuncture</li> <li>2 – Accupressure</li> <li>3 – Massage</li> <li>4 – Reflexology</li> <li>5 – Biofeedback</li> <li>6 – Hypnosis</li> <li>9 – Other Alternative Therapy Services</li> </ul>
211X to 300X	Reserved for National Assignment

Code	Title/Definition
310X	Adult Care 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 0 – Not used 1 – Adult Day Care, Medical and Social – Hourly 2 – Adult Day Care, Social – Hourly 3 – Adult Day Care, Medical and Social – Day 4 – Adult Day Care, Social – Daily 5 – Adult Foster Care – Daily 9 – Other Adult Care
311X to 899X	Reserved for National Assignment
9000 to 9044	Reserved for Medicare Skill Nursing Facility Demonstration project
9045 to 9099	Reserved for National Assignment

## FL43 - Revenue Description

Not required. A narrative description or standard abbreviation for each revenue code in FL42 is shown on the adjacent line in FL43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individual described on each bill.

Home Health Agencies identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding.

## FL44 - HCPCS/Rates

*Required.* When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient or SNF bills, the accommodation rate is shown here.

## FL45 - Service Date

*Required. Except* Indian Health Service hospitals and other hospitals located in American Samoa, Guam and Saipan, the line item dates of service is required with every HCPCS code.

## FL46 - Service Units

*Required.* Generally, the entries in this column quantify services by revenue category, for example, number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.

Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable for the following:

Service Type	Units/Quantity
Accommodations	100s – 150s, 200s, 210s (days)
Blood	380s (pints)
DME	290s (rental months)
Emergency Room	450, 452, and 459 (HCPCS code definition for visit or procedure)
Clinic	510s and 520s (HCPCS code definition for visit or procedure)
Dialysis Treatments	800s (sessions or days)
Orthotic/prosthetic devices)	264 (items)
Outpatient therapy visits	410, 420, 430, 440, 480, 910, and 943. Units are equal to the number of times the procedure/service being reported was performed)
Outpatient clinical diagnostic laboratory tests	– 30X-31X (tests)
Radiology	32X, 34X, 35X, 40X, 61X, and 333 (HCPCS code definition of tests or services)
Oxygen	600s (rental months, feet or pounds)
Hemophilia blood clotting factors	636

Up to seven (7) numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.

## FL47 - Total Charges

*Required.* The total charges for the billing period are summed by revenue code (FL42) or in the case of revenue codes requiring HCPCS by procedure code entered on the adjacent line n FL47. The last revenue code entered in FL42 is "0001" which represents the grand total of all covered and non-covered charges billed. FL47 totals on the adjacent line. Each line allows up to nine numeric digits.

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

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional component is not consistent for all payers; that is, where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

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

## FL48 - Non-Covered Charges

*Required.* The total non-covered charges pertaining to the related revenue code in FL42 are entered here.

## FL49 - Untitled

Not Required. This is one of the four fields which have not been assigned.

## **FL50A, B, C - Payer identification**

*Required.* If Medicare is the primary payer, “Medicare” is entered on line A. If Medicare is entered, the provider has developed for other insurance and has determined that Medicare is the primary. All additional entries across line A (FL51-FL55) supply information needed by the payer named in FL50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on Line A and enters Medicare information on lines B or C, as appropriate.

## **FL51A, B, C - Provider Number**

*Required.* This is the six-digit number assigned by Medicare. It must be entered on the same line as “Medicare” in FL50.

## **FL52A, B, C - Release of Information**

*Required.* A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file. Note: The back of Form HCFA-1450 contains a certification that all necessary release statements are on file.

## **FL53A, B, C - Assignment of Benefits Certification Indicator**

Not Required.

## **FL54A, B, C - Prior Payments**

*Required.* For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column. Part A home health DME cost sharing amounts collected from the patient are also reported in this item.

## **FL55A, B, C - Estimated Amount Due**

Not Required.

**FL56 - (Untitled)**

Not Required. This is one of the seven fields which have not been assigned for national use.

**FL57 - (Untitled)**

Not Required. This is one of the seven fields which have not been assigned for national use.

**FL58A, B, C - Insured's Name**

*Required.* On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL50-FL54, the provider enters the patient's Name as shown on his Health Insurance card or other Medicare notice. All additional entries across that line (FL59-FL66) pertain to the person named in FL58.

**FL59A, B, C - Patient's Relationship to Insured**

*Required.* If the provider is claiming a payment under any of the circumstances described in the second paragraph of FL58A, B or C, it may enter the code indicating the relationship of the patient to the identified insured, if this information is available.

Code	Relationship	Definition
01	Spouse	
04	Grandfather or Grandmother	
05	Grandson or Granddaughter	
07	Nephew or Niece	
10	Foster child	
15	Ward	Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order
17	Stepson or Stepdaughter	
18	Self	
19	Child	
20	Employee	
21	Unknown	
22	Handicapped Dependent	
23	Sponsored Dependent	
24	Dependent of Minor Dependent	

Code	Relationship	Definition
29	Significant Other	
32	Mother	
33	Father	
36	Emancipated Minor	
39	Organ Donor	
40	Cadaver Donor	
41	Injured Plaintiff	
43	Child Where Insured Has No Financial Responsibility	
53	Life Partner	
G8	Other Relationship	

## FL60A, B, C - Certificate/Social Security Number/Hi Claim/Identification Number

*Required.* The provider enters the patients' Medicare Health Insurance Claim Number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, EOMB, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the SSO. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL50-FL54, the provider enters the patient's HICN; that is, if Medicare is primary payer, in FL60A.

## FL61A, B, C - Group Name

*Required.* Where the provider is claiming a payment under the circumstances described in the second paragraph of FL58A, B or C, it enters the name of the insurance group or plan.

## FL62A, B, C - Insurance Group Number

*Required.* Where the provider is claiming a payment under the circumstances described in the second paragraph of FL58A, B, or C, it enters the identification number, control number, or code assigned by such health insurance carrier.

## FL63 - Treatment Authorization Code

*Required.* Whenever PRO review is performed for outpatient preadmission, pre-procedure, or inpatient preadmission, the authorization number is required for all approved admissions or services.

## FL64 - Employment Status Code

*Required.* Where the provider is claiming a payment under the circumstances described in the second paragraph of FL58A, B, or C, it enters the code which defines the employment status of the individual identified on the same line in FL58, if the information is readily available.

Code	Employment Status
1	Employed Full-Time
2	Employed Part Time
3	Not Employed, full or part time
4	Self-employed
5	Retired
6	On Active Military Duty
7-8	Reserved for National Assignment
9	Unknown

## FL65 - Employer Name

*Required.* Where the provider is claiming a payment under the circumstances described in the second paragraph of FL58A, B, or C and there is Workers' Compensation, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL58.

## FL66 - Employer Location

*Required.* Where the provider is claiming a payment under the circumstances described in the second paragraph of FL58A, B, or C, and there is Workers' Compensation, it enters the specific location of the employer of the individual identified on the same line FL58. A specific location is the city, plant, etc. in which the employer is located.

## FL67 - Principal Diagnosis Code

CMS only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in the Department of Health and Human Services Publication No. (PHS) 89-1260. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

**Inpatient**

*Required.* The provider reports the principal diagnosis in this field. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital.

**Outpatient**

*Required.* Hospitals report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL67. Hospitals report the diagnosis to their highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (such as cough), for which a definitive diagnosis is not made, the symptom is reported (786.2). If during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (such as acute bronchitis); the definitive diagnosis is reported (466.0).

If a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for “Persons without reported diagnosis encountered during examination and investigation of individuals and populations” (V70-V82). Examples include:

- Routine general medical examination (V70.0)
- General medical examination without any working diagnosis or complaint; patient unsure if the examination is a routine checkup (V79.9)
- Examination of ears and hearing (V72.1)

**FL68-FL75 - Other Diagnoses Codes****Inpatient**

*Required.* The provider reports the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or length of stay. The principal diagnosis entered in FL67 should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, it should be eliminated by the GROUPER.

**Outpatient**

*Required.* Hospitals report the full ICD-9-CM codes in FL68-FL75 for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL67. For instance, if the patient is referred to the hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported here.

**FL76 - Admitting Diagnosis/Patient's Reason for Visit**

*Required.* For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. FL76 is a dual use field. Patient's reason for visit is not required by Medicare but may be used by providers for non scheduled visits for outpatient bills.

**FL77 - E-Code**

Not Required.

**FL78 - (Untitled)**

Not Required. This is one of the four fields which have not been assigned for national use.

**FL79 - Procedure Coding Method**

Not Required

**FL80 - Principal Procedure Code and Date**

*Required – Inpatient Only.* The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (FL67). For this item, surgery includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation.

The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all four digit codes where applicable. The date applicable to the principal procedure is shown numerically as MMDDYY in the “date” portion.

## **FL81 - Other Procedure Codes and Dates**

*Required - Inpatient Only.* The full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL80). The date of each procedure is shown in the date portion of Item 81, as applicable, numerically as MMDDYY.

## **FL82 - Attending/Referring Physician ID**

*Required.* Providers must enter the unique physician identification number (UPIN) and name of the attending/referring physician on inpatient bills or the physician that requested outpatient services. Paper bill specifications are listed below.

### **Inpatient Part A**

*Required.* Hospitals and SNFs must enter the UPIN and name of the attending/referring physician. For hospital services, the Uniform Hospital Discharge Data Set definition for attending physicians is used. This is the clinician primarily responsible for the care of the patient from the beginning of the hospital episode. For SNF services, the attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician’s last name, one space, first name, one space, and middle initial.

### **Home Health and Hospice**

*Required.* HHAs and hospices must enter the UPIN of the physician that signs the home health or hospice plan of care. Enter the UPIN in the first six positions followed by two spaces, the physician’s last name, one space, first name, one space, and middle initial.

## **Outpatient and Other Part B**

*Required.* All providers must enter the UPIN of the physician that requested the surgery, therapy, diagnostic tests or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial. If the patient is self-referred (e.g., emergency room or clinic visit), SLF000 is entered in the first six positions and no name is shown.

Claims Where Physician Not Assigned a UPIN - Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete.

Accept the SLF entry unless the revenue code or HCPCS code indicates the service can be provided only as a result of physician referral. If more than one referring physician is involved, the provider enters the UPIN of the physician requesting the service with the highest charge. If referrals originate from physician-directed facilities (e.g., rural health clinics) enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

## **FL83 - Other Physician ID**

### **Inpatient Part A Hospital**

*Required if procedure is performed.* Hospitals must enter the UPIN and name of the physician who performed the principal procedure. If there is no principal procedure, the hospital enters the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, the hospital leaves this item blank.

### **Outpatient Hospital**

*Required* where the HCPCS code reported is subject to the Ambulatory Surgical Center payment limitation or a reported HCPCS code is on the list of codes the PRO furnishes that require approval.

### **Other Bills**

Not Required.

**FL84 - Remarks**

*Required.* For DME billings by HHAs, the renal rate, cost and anticipated months of usage are shown so that you may determine whether to approve the rental or purchase of equipment. In addition, special annotations may be entered where Medicare is not the primary payer because Workers' Compensation, an automobile medical or no-fault insurer, any liability insurer or an EGHP/LGHP is primary to Medicare.

This space is also available to report overflow from other items.

**FL85 - Provider Representative Signature**

Not Required. No signature is required for a general care hospital unless a certification is required. A provider representative's signature or facsimile is required on the bill of a psychiatric or tuberculosis hospital.

**FL86 - Date**

Not Required. This is the date of the provider representative's signature.