



PALMETTO GBA®

A CELERIAN GROUP COMPANY

A CMS Medicare Administrative Contractor

Direct Data Entry (DDE) User's Guide

Section 4: Claims & Attachments

Main Menu Option 02

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ACRONYMS

Acronym	Description
A	
ACS	Automated Correspondence System
ADR	Additional Development Request
ADJ	Adjustment
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center

Acronym	Description
ANSI	American National Standards Institute
B	
C	
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code

Acronym	Description
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMG	Case-mix Group
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CO	Contractual Obligation
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CWF	Common Working File
D	
DCN	Document Control Number
DDE	Direct Data Entry
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSH	Disproportionate Share Hospital
E	
EDI	Electronic Data Interchange
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
F	
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Centers
G	
H	
HCPC	Healthcare Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
HIPPS	Health Insurance Prospective Payment System (the coding system for home health claims)
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRR	Hospital Readmission Reduction
HSA	Health Service Area
HSP	Hospital Specific Payment
HSR	Hospital Specific Rate
I	
ICD	Internal Classification of Diseases
ICN	Internal Control Number
IDE	Investigational Device Exemption
IEQ	Initial Enrollment Questionnaire
IME	Indirect Medical Education

Acronym	Description
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
J	
K	
L	
LGHP	Large Group Health Plan
LOS	Length of Stay
LTR	Lifetime Reserve days
M	
MA	Medicare Advantage Plan
MAC	Medicare Administrative Contractor
MCE	Medicare Code Editor
MID	Beneficiary's Medicare Number (formerly Health Insurance Claim Number)
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N	
NDC	National Drug Code
NIF	Not in File
NPI	National Provider Identifier
O	
OCE	Outpatient Code Editor
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
ORF	Outpatient Rehabilitation Facility
OSC	Occurrence Span Code
OTAF	Obligated To Accept in Full
OT	Occupational Therapy
P	
PC	Professional Component
PHS	Public Health Service
PPS	Prospective Payment System
PR	Patient Responsibility
PRO	Peer Review Organization
PS&R	Provider Statistical and Reimbursement Report
PT	Physical Therapy
Q	
R	
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return To Provider
S	
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income

Acronym	Description
SLP	Speech Language Pathology
SMSA	Standard Metropolitan Statistical Area
T	
TC	Technical Component
TOB	Type of Bill
U	
UB	Uniform Billing
UPC	Universal Product Code
UPIN	Unique Physician Identification Number

Acronym	Description
URC	Utilization Review Committee
V	
W	
X	
X-Ref	Cross-reference
Y	
Y2K	Year 2000
Z	

DIRECT DATA ENTRY (DDE) USER'S GUIDE BREAKDOWN

Refer to the following sections of the DDE User Guide for detailed information about using the DDE screens.

Section	Section Title	Descriptive Language
1	Introduction & Connectivity	This section introduces you to the Direct Data Entry (DDE) system, and provides a list of the most common acronyms as well navigational tips to include function keys, shortcuts, and common claim status and locations. This section also provides screen illustrations with instructions for signing on, the main menu display, signing off, and changing passwords.
2	Checking Beneficiary Eligibility	This section explains how to access beneficiary eligibility information via the Common Working File (CWF) screens, Health Insurance Query Access (HIQA) and Health Insurance Query for HHAs (HIQH), to verify and ensure correct information is submitted on your Medicare claim. Screen examples and field descriptors are also provided.
3	Inquiries (Main Menu Option 01)	This section provides screen illustrations and information about the inquiry options available in DDE, such as viewing inquiry screens to check the validity of diagnosis codes, revenue codes, and HCPCS codes, checking beneficiary/patient eligibility, check the status of claims, view Additional Development Requests (ADRs) letters, Medicare check history, and home health payment totals.
4	Claims & Attachments (Main Menu Option 02)	This section includes instructions, screen illustrations, and field descriptions on how to enter UB-04 claim information, including home health requests for anticipated payment (RAPs), hospice notice of elections (NOEs), and roster bill data entry.
5	Claims Correction (Main Menu Option 03)	This section provides instructions, screen illustrations, and field descriptions on how to correct claims that are in the Return to Provider (RTP) file, adjust or cancel finalized claims.
6	Online Reports (Main Menu Option 04)	This section provides information on certain provider-specific reports that are available through the DDE system.

This publication was current at the time it was published. Medicare policy may change so links to the source documents have been provided within the document for your reference.

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Any changes or new information superseding the information in this guide are provided in the Medicare Part A and Home Health and Hospice (HHH) Bulletins/Advisories with publication dates after September 2018. Medicare Part A and HHH Bulletins/Advisories are available at www.PalmettoGBA.com/medicare.

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SECTION 4 – CLAIMS & ATTACHMENTS

This section provides information on how to enter:

- UB-04s into the DDE format
- Electronic Roster Bills
- Hospice Election Statements

The Claims and Attachments Entry Menu (Main Menu option 02) may be used for online entry of beneficiary/patient billing information from the UB-04. Options are available to allow entry of various attachments. The UB-04 Claim Entry consists of six (6) separate screens/pages:

- **Page 01** **Beneficiary**/patient information (corresponds to form locators 1-41)
- **Page 02** Revenue/HCPCS codes and charges (corresponds to form locators 42-49)
- **Page 03** Payer information, diagnoses/procedure codes (corresponds to form locators 50-57 and 67-83)
- **Page 04** Remarks and attachments (corresponds to form locators 80)
- **Page 05** Other payer and MSP information (corresponds to form locators 58-66)
- **Page 06** MSP information, crossover and detail claim inquiry (**does not** correspond to any form locator)

4.A. General Information

- The online system defaults to the 111 type of bill for inpatient claims (option 20), 131 for outpatient claims (option 22), and 211 for SNF claims (option 24), 322 for Home Health claims (option 26), and 811 for Hospice claims (option 28). If you are entering a different type of bill, then type over the default with the correct type of bill.
- On the bottom of each screen is a list of the PF function keys and the functions they perform.
- Field names within DDE will not always follow the same order as found on the UB-04 claim form. In order to help alleviate confusion, the 'UB-04 X-REF' field on each page directs you to the field that correlates to the UB-04 form.
- For valid values associated with the claim entry field, please refer to your current Uniform Billing manual. The 'UB-04 X-REF' field will direct you to the field that correlates to the UB-04 form noted in the manual.

4.B. Transmitting Data

- When claim entry is completed, press **[F9]** to store the claim and transmit the data.
- If any information is missing or entered incorrectly, the DDE system will display reason codes on the bottom left side of the claim screen to alert you of any errors that need to be corrected. The claim will not transmit until it is free of front-end edit errors. A blank claim entry screen will display if the claim is successfully transmitted.
- Correcting errors:
- Press **[F1]** to see an explanation of the reason code. After reviewing the explanation, press **[F3]** to return to your claim and make the necessary correction(s). If more than one reason code appears, continue this process until all reason codes are eliminated and the claim is successfully captured by the system.
- If more than one reason code is present, pressing **[F1]** will always bring up the explanation of the first reason code unless the cursor is positioned over one of the other reason codes. Working through the reason codes in the order they are listed is the most efficient method. Eliminating the reason codes at the beginning of the list may result in the reason codes at the end of the list being corrected as well.

Note: The system will automatically enter your provider number into the OSCAR field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information. **[TAB]** to the OSCAR field and type in the provider number.

Claim and Attachments Entry Menu (MAP1703)

```

MAP1703                JM MAC SC/HHH UAT #11001          ACMFA891 08/26/15
                        CLAIM AND ATTACHMENTS ENTRY MENU  C201534P 17:30:37

                        CLAIMS ENTRY

                        INPATIENT                20
                        OUTPATIENT              22
                        SNF                     24
                        HOME HEALTH            26
                        HOSPICE                 28
                        NOE/NOA                49
                        ROSTER BILL ENTRY      87

                        ATTACHMENT ENTRY

                        HOME HEALTH            41
                        DME HISTORY            54
                        ESRD CMS-382 FORM      57

ENTER MENU SELECTION:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

TI > NUM 0 20,28 B

```

Figure 1 – Claim and Attachments Entry Menu

4.C. Electronic UB-04 Claim Entry

When entering UB-04s, select the option from the Claim and Attachments Entry Menu that best describes your Medicare line of business:

- Inpatient 20
- Outpatient 22
- SNF 24
- Home Health 26
- Hospice 28
- Hospice Elections 49

4.C.1. UB-04 Claim Entry – Page 1

After you select an option, page one of the UB-04 Claim Entry screen (Figure 2) will display. The screen will include the OSCAR (Provider Number), Type of Bill, and default Status/Location (S B0100). You must enter the beneficiary/patient information (name, address, date of birth, etc.) and any other information needed to process the claim.

INST Claim Entry – Page 1 (MAP1711) – Field descriptions are provided in the table following Figure 2.

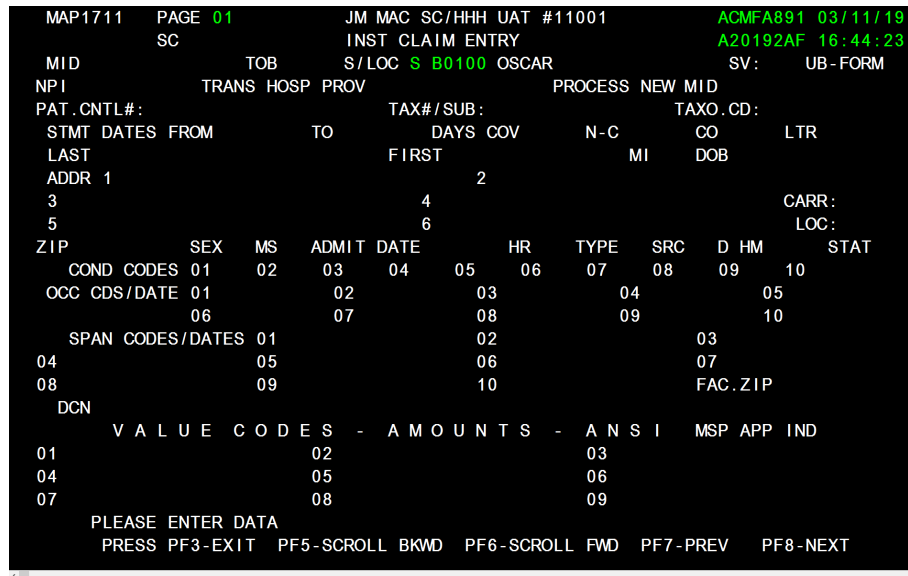


Figure 2 – UB-04 Claim Entry Screen, Page 1

*NOTE: The ‘SC’ field will display at the top of each claim page. This field can be used to navigate to any of the claim inquiry screens if desired during the claim entry process. (Ex: Enter ‘17’ to navigate directly to the reason code inquiry screen). To navigate back to the claim page, press [F3].

Field Name	UB-04 X-Ref.	Description
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
OSCAR	57	Displays the identification number of the institution that rendered services to the beneficiary/patient. The system will automatically pre-fill the Medicare Oscar number when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, CORF, ORF) the Medicare Oscar number must be changed to reflect the provider you wish to submit claims for. If the Medicare Oscar number is not changed for your sub-units, the claims will be processed under the incorrect Oscar number.
SV		Suppress View: This field allows a claim to be suppressed.
UB-FORM		Identifies the type of claim to be processed. All claims must be entered on the same form type. Valid values are: '9' = UB-92 'A' = UB-04
NPI	56	This field identifies the National Provider Identifier number.
TRANS HOSP PROV		Transferring Hospice Provider: Displays the identification number of the institution that rendered services to the beneficiary/patient. System-generated for external operators that are directly associated with one provider. This number is assigned by CMS. This is a 13-digit

Field Name	UB-04 X-Ref.	Description
PROCESS NEW MID	60	Identifies when the incorrect beneficiary/patient Medicare number is present, and then the correct Medicare number can be keyed. Not applicable on new claim entries. Valid values include: <ul style="list-style-type: none"> Y = Incorrect Medicare Number is present E = The new Medicare number is in a cross-reference loop or the new Medicare number entered is cross-referenced on the beneficiary/patient file and this cross-referenced Medicare Number is also cross-referenced. The chain continues for 25 Medicare numbers. S = The cross-referenced Medicare number on the beneficiary/patient file is the same as the original Medicare number on the claim.
PAT. CNTL#	3a	Patient Control Number: The patient's unique number assigned by the provider to facilitate retrieval of individual patient records and posting of the payment.
TAX #/SUB	5	This field identifies the number assigned to the provider by the Federal Government for tax reporting purposes.
TAXO.CD		This field identifies a collection of unique alphanumeric codes known as the provider taxonomy code. The code set is structured into three distinct levels including provider type, classification, and area of specialization.
STMT DATES FROM and TO	6	The statement covers (from and to) dates of the period covered by this bill (in MMDDYY format).
DAYS COV		Indicates the total number of covered days. This field is skipped on Home Health and Hospice claims. <ul style="list-style-type: none"> • Enter the total number of covered days during the billing period (within the 'From' and 'Through' dates in UB-04 X-REF 6 - Statement Covers Period), which are applicable to the cost report, including lifetime reserve days elected (for which hospital requested Medicare payment). • The numeric entry reported in this UB-04 X-REF should be the same total as the total number of covered accommodation units reported in UB-04 X-REF 46. • Exclude any days classified as non-covered (see UB-04 X-REF 8 - Non-covered Days) and leave of absence days. • Exclude the day of discharge or death (unless the patient is admitted and discharged the same day). Do not deduct days for payment made by another primary payer.
N-C		Indicates the total number of non-covered days. Enter the total number of non-covered days in the billing period. <ul style="list-style-type: none"> • Enter the total number of covered days during the billing period (within the 'From' and 'Through' dates in UB-04 X-REF 6 - Statement Covers Period). These days are not covered Medicare payment days on the cost report and the beneficiary/patient will not be charged utilization for Medicare Part A Services. • The reason for non-coverage should be explained by occurrence codes (UB-04 X-REFs 31 - 34), and/or occurrence span code (UB-04 X-REF 35 - 36). Provide a brief explanation of any non-covered days not described via occurrence codes in UB-04 X-REF 80, Remarks. (Show the number of days for each category of non-covered days, e.g., '5 leave days'). • Day of discharge or death is not counted as a non-covered day. Do not deduct days for payment made by another primary payer.
CO		Co-Insurance Days are the inpatient Medicare hospital days occurring after the 60 th day and before the 91 st day. Enter the total number of inpatient or SNF co-insurance days.

Field Name	UB-04 X-Ref.	Description
LTR		Lifetime Reserve Days – This field is only used for hospital inpatient stays. Enter the total number of inpatient lifetime reserve days the patient elected to use during this billing period.
LAST	8a	Patient's last name.
FIRST	8a	Beneficiary/patient's first name.
MI	8a	Beneficiary/patient's middle initial.
DOB	10	The beneficiary/patient's date of birth (in MMDDYYYY format).
ADDR 1 – 6	9a – e	Beneficiary/patient's street address. Must input in fields 1 and 2. State is a 2-character field.
CARR		This field identifies the value codes carrier number. The carrier number is the identification number of the Medicare carrier as designated by the CMS. This field is a five-digit alphanumeric field. NOTE: The carrier and locality information is associated with the nine-digit service facility zip code on the claim record in an available space on MAP1711.
LOC		This field identifies the value codes locality code. The locality code is a specific location of a provider of services in a given state falling under the realm of a particular carrier's jurisdiction. It is a two-digit alphanumeric field. NOTE: The carrier and locality information is associated with the nine-digit service facility zip code on the claim record in an available space on MAP1711.
ZIP	9d	Beneficiary/patient's valid zip code (minimum of 5 digits).
SEX	11	The beneficiary/patient's sex. Refer to your UB-04 Manual for valid values.
MS		The beneficiary/patient's marital status. Not required. Refer to your UB-04 Manual for valid values.
ADMIT DATE	12	Enter date beneficiary/patient was admitted.
HR	13	Enter the hour the beneficiary/patient was admitted (for hospitals only).
TYPE	14	The type of admission. Enter the appropriate inpatient code that indicates the priority of the admission. Refer to your UB-04 Manual for valid values.
SRC	15	The source of admission. Enter appropriate code indicating the point of origin of the source of this admission. Refer to your UB-04 Manual for valid values.
D HM	16	Enter the time at which the beneficiary/patient was discharged from inpatient care (in HHMM format).
STAT	17	Indicates the beneficiary/patient's status at the ending service date in the period. Refer to your UB-04 Manual for valid values.
COND CODES (01 – 10)	18 – 28	The condition codes are used to identify conditions relating to this bill that may affect claim processing, up to 30 occurrences. Refer to your UB-04 Manual for valid values.
OCC CDS/ DATE (01 – 10)	31 – 34	The Occurrence Codes and Dates field consists of a two-digit alphanumeric code and a six-digit date in MMDDYY format. Report all appropriate occurrences, up to 30 occurrences. Refer to your UB-04 Manual for valid values.
SPANCODES/ DATES (01 – 10)	35 – 36	Enter the appropriate Occurrence Span code and Date associated beginning (From) and ending (Thru) dates defining a specific event relating to this billing period. Refer to your UB-04 Manual for valid values.
FAC.ZIP		This field identifies the provider's facility ZIP code. The entire nine-digit ZIP code must be entered and should match the facility's master address in the provider enrollment record (usually the facility's physical location).
DCN		The Document Control Number is not required when entering a new bill. Applicable only on adjustments, void/cancel TOB nn7 and nn8.
VALUE CODES- AMOUNTS-	39 – 41	The Value Codes and related dollar amount(s) identify monetary data necessary for the processing of a claim.

Field Name	UB-04 X-Ref.	Description
ANSI (01 – 09)	(a – d)	ANSI is a 5-digit field made up of 2-digit Group Codes and 3-digit Reason (Adjustment) Code. This field is system-filled and will be used for sending ANSI information for the value codes to the Financial System for reporting on the remittance advice. Refer to your UB-04 Manual for valid values.
MSP APP IND		This field identifies to the MSP PAY module whether the system apportions the primary payer's amount and the OTAF amounts (if present). Valid values are: ‘ ’ = Apportion ‘N’ = Do not apportion This field is not required on claim entry.

4.C.2. UB-04 Claim Entry – Page 2

Enter the following information on page two of the UB-04 Claim Entry screen:

- Revenue codes (the system will automatically submit the claim with the revenue codes in ascending order).
- Dollar amounts without decimal points (e.g., for \$45.50, type ‘4550’).
- Revenue code 001 should be used in the final revenue code entry and correspond with the totals for Total Charges, Non-covered Charges, Total Units, and Covered Units.
- To delete a revenue code line, type four zeros over the revenue code and press **[ENTER]**, or type ‘D’ in first position of field, hit the **[HOME]** key and then press **[ENTER]**.
- To insert a revenue code line, type it at the bottom of the list and press **[ENTER]**; DDE will automatically re-sort the lines. Be sure to adjust the totals on the 001 revenue code line if already entered.
- **[F2]** – a ‘jump key’ when placed on a revenue code on MAP171D allows you to scroll to the same revenue code line on MAP171D

A total of 13 revenue code lines are available per screen. To enter additional revenue lines, press **[F6]** to page forward and **[F5]** to page back. If you delete or insert a revenue code line, the system will re-sort the lines. There are a total of 450 revenue code lines. Thus, only 449 revenue code lines can be entered on a single claim plus the 001 revenue code line.

INST Claim Entry Screen – Page 2 (MAP1712) – Field descriptions are in the table following Figure 3.

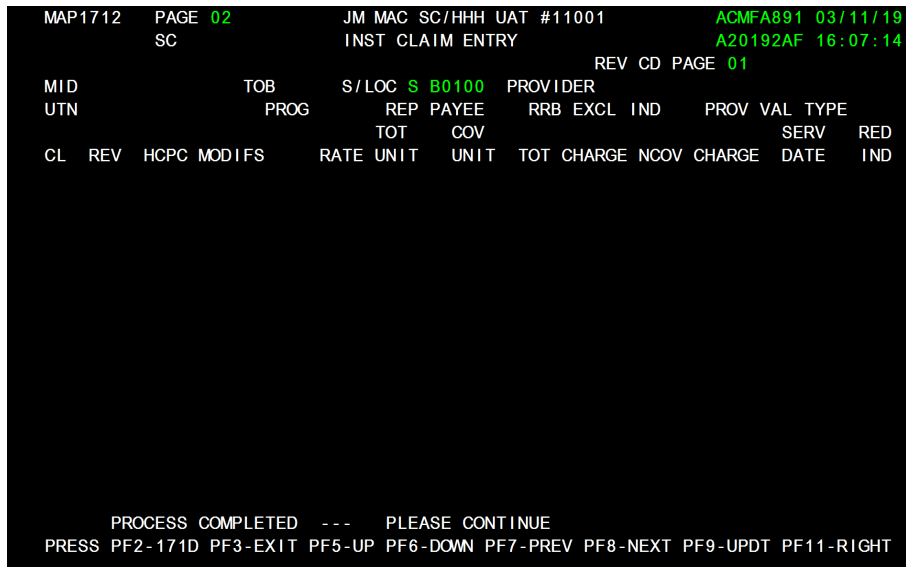


Figure 3 – UB-04 Claim Entry Revenue Screen

Field Name	UB-04 X-Ref.	Description
REV CD PAGE 01		This field identifies the page number for the revenue code lines. A total of 13 revenue code lines can be entered on each page. [F6] to move to the next revenue code line page. The page number will change as you move through the revenue code pages.
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system. The default S/LOC is S B0100.
PROVIDER	57	This field displays the provider identification number.
UTN		Unique Tracking Number (UTN): This is a 14-digit field that identifies the UTN submitted on the claim in the Medicare Treatment Authorization field. The UTN is submitted on claims that require a review of medical documentation before the claim is submitted to Medicare. See figure 11 regarding the Treatment Authorization field.
PROG		Program Indicator: This field identifies the Program ID matching to the item/services submitted on the claim for which documentation was reviewed before the claim is submitted to Medicare. This is a four-digit alpha-numeric field. The valid format is ANNN or HNNN.
REP PAYEE		This field identifies a Medicare Beneficiary with a Rep Payee. This is a one-position alphanumeric field. The valid values are: <ul style="list-style-type: none"> R - Bypass Rep Payee Blank - Rep Payee processing does not apply
RRB EXCL IND		This field identifies the Railroad Board (RRB) Beneficiary Indicator. This is a one-position alphanumeric field. The valid values are: <ul style="list-style-type: none"> Y – Exclude RRB Beneficiary from Prior Authorization services Blank – Beneficiary services are subject to Prior Authorization

Field Name	UB-04 X-Ref.	Description
PROV VAL TYPE		<p>This field identifies the Designated Provider Validation Type. This is a 2-position alphanumeric field. The valid values are:</p> <ul style="list-style-type: none"> AP - Attending Physician CP - Ordering/Referring Physician FA - Facility OP - Operating Physician RP - Rendering Physician <p>Blank - Designated Provider processing does not apply</p>
CL		<p>Identifies the claim line number of the Revenue Code. There are 13 revenue code lines per page with a total of 450 revenue code lines possible per claim (this includes the 001 revenue code line). The system will input the revenue code line number when [F9] is pressed. It will be present for update and inquiry.</p>
REV	42	<p>The Revenue Code for a specific accommodation or service that was billed on the claim. Valid values are 0001 through 9999.</p> <ul style="list-style-type: none"> List revenue codes in an ascending sequence and do not repeat revenue codes on the same bill if possible. To limit line item entries on each bill, report each revenue code only once, except when distinct HCPCS code reporting requires repeating a revenue code (e.g., laboratory services, revenue code 300, repeated with different HCPCS codes), an accommodation revenue code that requires repeating with a different rate, or when mandated per CMS regulations. Revenue code 001 (total charges and units) should always be the final revenue code entry. Some codes require CPT/HCPCS codes, units and/or rates.
HCPC	44	<p>Enter the HCPCS code describing the service, if applicable. HCPCS coding must be reported for specific outpatient services including, but not limited to:</p> <ul style="list-style-type: none"> Outpatient clinical diagnostic laboratory services billed to Medicare, enter the HCPCS code describing the lab service; Outpatient hospital bills for Medicare defined surgery procedure; Outpatient hospital bills for outpatient partial hospitalization; Radiology and other diagnostic services; Durable Medicare Equipment (including orthotics and prosthetics); ESRD drugs, supplies, and laboratory services; Inpatient Rehabilitation Facility (IRF) PPS claims, this HCPC field contains the submitted HIPPS/CMG code required for IRF PPS claims Home Health Agency (HHA) claims, this HCPC field contains the submitted HIPPS code with revenue code 0023; and Other Provider services in accordance with CMS billing guidelines.
MODIFS	44	A 2-digit numeric or alphanumeric modifier (up to 2 occurrences).
RATE	44	Enter the rate for the revenue code if required.
TOT UNIT	46	Total Units of Service indicates the total units billed. This reflects the units of service as a quantitative measure of service rendered by revenue category.
COV UNIT	46	Covered Units of Service indicates the total covered units. This reflects the units of service as a quantitative measure of service rendered by revenue category.
TOT CHARGE	47	Report the total charge pertaining to the related revenue code for the current billing period as entered in the statement covers period.

Field Name	UB-04 X-Ref.	Description
NCOV CHARGE	48	Report non-covered charges for the primary payer pertaining to the related revenue code. Submission of bills by providers for all stays, including those for which no payment can be made, is required to enable the Medicare contractor and CMS to maintain utilization records and determine eligibility on subsequent claims. When non-covered charges are present on the bill, remarks are required in UB-04 X-REF 80.
SERV DT	45	The service date is required for every line item where a HCPCS code is required effective April 1, 2000, including claims where the 'from' and 'through' dates are equal. Inpatient Rehabilitation Facility (IRF) PPS claims, this field is not required on the Revenue Code 0024 line. However, if present on the Revenue Code 0024 line, it indicates the date the Provider transmitted the beneficiary/patient assessment. This date, if present, must be equal to or greater than the discharge date (Statement Cover To Date).
RED IND		This field identifies if the payment for the line was paid using the therapy reduced rate. Not required for new claims entry.

4.C.2.a. UB-04 Claim Entry – Page 2: Additional NPI Lines

This screen displays additional NPI lines and National Drug Code (NDC) fields. This screen can be accessed by pressing [F11] from the revenue code line screen MAP1712.

INST Claim Entry Screen – Page 2 Additional NPI Lines (MAP171E) – Field Descriptions are provided in the table following Figure 4.

MID	TOB	S/LOC	PROVIDER	NDC	CD	PAGE	RETURN
LLR NPI	L	S B0100	F		M	01	SC
LLR NPI	L		F		M		SC
LLR NPI	L		F		M		SC
LLR NPI	L		F		M		SC
LLR NPI	L		F		M		SC
LLR NPI	L		F		M		SC
LLR NPI	L		F		M		SC

PROCESS COMPLETED --- PLEASE CONTINUE
 PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DN PF7-PRE PF8-NXT PF9-UPDT PF10-LT PF11-RT

Figure 4 – UB-04 Claim Entry, Page 2, Additional NPI lines

Field Name	UB-04 X-Ref.	Description
NDC CD PAGE 01		There are a total of 33 pages to account for 450 revenue lines. Press [F6] to advance to the next page. The page number will change each time you press [F6].
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.

Field Name	UB-04 X-Ref.	Description
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
CL 1 - 7		This field identifies the claim line number.
NDC FIELD		This field identifies the National Drug Code (NDC).
NDC QUANTITY		This field identifies the NDC quantity.
QUALIFIER		This field identifies the NDC quantity qualifier.
RETURN HIPPS1		This field identifies the HIPPS codes returned from the QIES Response file. This is a five-digit alphanumeric field.
RETURN HIPPS2		This field identifies the HIPPS code returned from the QIES response file. This is a five-digit alphanumeric field.
MOLDX		This field identifies the Molecular Diagnostic Services test ID. This is a five-position alphanumeric field.
LLR NPI		This field identifies the <i>line level</i> rendering physician's NPI number.
L		The last name of the rendering physician.
F		The first name of the rendering physician.
M		The middle initial of the rendering physician.
SC		This field identifies the Critical Access Hospital Physician/Non-Physician specialty code.

4.C.2.b. UB-04 Claim Entry – Page 2: Line Level Reimbursement

This screen displays line item payment information and allows entry of more than two modifiers. Access the MAP171A screen (Figure 5) by pressing [F11] twice on Claim Page 2 MAP1712.

INST Claim Entry Claim – Page 2 Line Level Reimbursement (MAP171A) – Field descriptions are provided in the table following Figure 5.

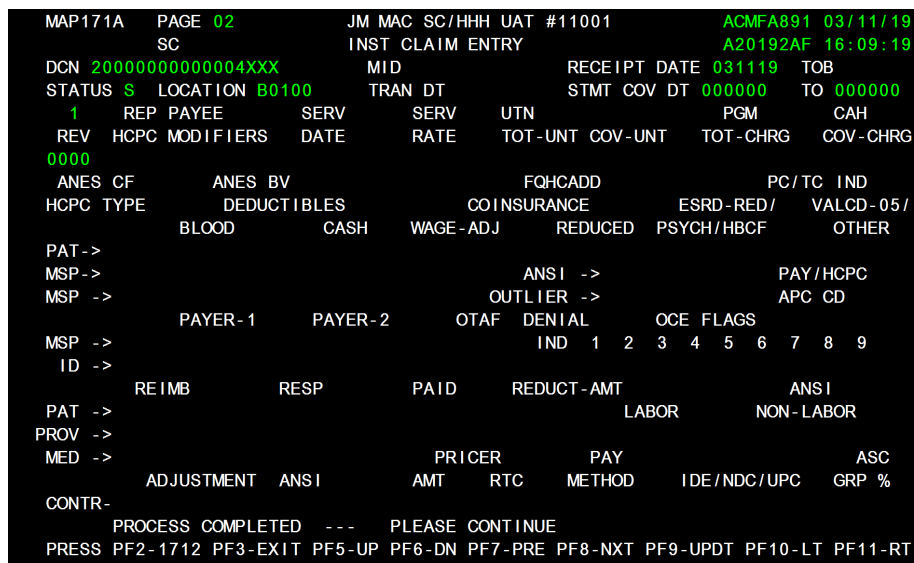


Figure 5 – UB-04 Claim Entry, Page 2, Line Level Reimbursement

Field Name	UB-04 X-Ref.	Description
DCN		The document control number assigned to the claim.
MID	60	The beneficiary/patient's Medicare number as shown on the Medicare card.

Field Name	UB-04 X-Ref.	Description
RECEIPT DATE		The date the claim was received into the Medicare claims processing system. Not required for new claims entry.
TOB	4	This field shows the type of bill being submitted.
STATUS		The current status of the claim. New claim entries will display 'S'.
LOCATION		The current location of the claim in the system. New claim entries will display B0100 until [F9] is pressed.
TRAN DT		This field displays the transaction date. Not displayed on new claim entries.
STMT COV DT/TO	6	The statement cover dates entered on MAP1711.
UTN		Unique Tracking Number (UTN): This is a 14-digit field that identifies the UTN submitted on the claim in the Medicare Treatment Authorization field. The UTN is submitted on claims that require a review of medical documentation before the claim is submitted to Medicare. See figure 11 regarding the Treatment Authorization field.
PROG		Program Indicator: This field identifies the Program ID matching to the item/services submitted on the claim for which documentation was reviewed before the claim is submitted to Medicare. This is a four-digit alpha-numeric field. The valid format is ANNN or HNNN.
CAH		Critical Access Hospital (CAH) Incentive Indicator: This field identifies whether a claim line is eligible for a specific type of bonus. This is a one-position alphanumeric field. Valid values are: 1 = HPSA 2 = PSA 3 = HPSA and PSA 4 = HSIP 5 = HPSA and HSIP 6 = PCIP 7 = HPSA and PCIP ' ' = Not applicable NOTE: The system determines the bonus eligibility status of the line based on the Offsite Zip Code field on MAP1713 in Figure 7.
REV	42	The Revenue Code displays a code for a specific accommodation or service that was billed on the claim. This will be the revenue code selected on MAP1712.
HCPC	44	The Healthcare Common Procedure Code identifies certain medical procedures or equipment for special pricing, assigned by CMS.
MODIFIERS	44	This field will contain five 2-character HCPCS modifiers. The two modifiers entered on MAP1712 will be displayed and the user can enter any remaining modifiers.
SERV DATE	45	The date of service (in MMDDYY format) required for many outpatient bills. It will be the same as the line item selected on MAP1712.
SERV RATE	44	Identifies the per-unit cost for a particular line item. This is the rate that was entered on MAP1712.
TOT-UNT	46	Total Units is a quantitative measure of services rendered by revenue category. The total units displayed on this screen are the same as that entered on MAP1712.
COV-UNT	46	Covered Units is a quantitative measure of services rendered by revenue category. The covered units displayed on this screen are the same as that entered on MAP1712.
TOT-CHRG	47	The total charges displayed on this page are the same as that entered on MAP1712.
COV-CHRG	47	This field identifies the covered charges entered on MAP1712.
ANES CF		This field identifies the anesthesia conversion factor.

Field Name	UB-04 X-Ref.	Description
ANES BV		This field identifies the anesthesia base values.
FQHCADD		Federally Qualified Health Care (FQHC) Add On: This field identifies the line level FQHC additional payment amount for a new beneficiary/patient or initial Medicare visit. This is a 13-digit alphanumeric field in 999999999.99 format.
PC/TC IND		This field identifies the PC/TC Indicator that is added to the CORF services Supplemental Fee Schedule.
HCPC TYPE		This field identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. This is a one-position alphanumeric field. The value values are: M = Originated from MPFS database files ' ' = Did not originate from the MPFS database files NOTE: 'M' indicates the claim is considered an MPFS claim and is edited based on the zip code of the provider master address record. If it's an 'M' and the plus four flag of the 5-digit zip code record is a '1', then the provider master address must contain a valid 4-digit extension. The carrier and locality on the provider master address record and the carrier and locality of the zip code file must match. Otherwise, the claim receives an edit.
DEDUCTIBLES BLOOD		The amount of Medicare Beneficiary/Patient Blood Deductible applied to the line item. Blood deductible will be applied at the line level on revenue codes 380, 381 and 382.
DEDUCTIBLES CASH		The amount of Medicare beneficiary/patient cash deductible applied to the line item. This field is system filled.
COINSURANCE WAGE-ADJ		The amount of Beneficiary/Patient Wage Adjustment Coinsurance applicable to the line based on the particular service rendered. The revenue and HCPCS code submitted define the service. For services subject to outpatient PPS (OPPS) in hospitals (TOB 12X, 13X and 14X) and in community mental health centers (TOB 76X), the applicable coinsurance is wage adjusted. Therefore, this field will have either a zero (for the services without applicable coinsurance) or a regular coinsurance amount (calculated on either charges or a fee schedule), unless the service is subject to OPPS. If the service is subject to OPPS, the national coinsurance amount will be wage adjusted, based on the MSA where the Provider is located or assigned as the result of a reclassification. CMS supplies the national coinsurance amount to the FIs, as well as the MSA by Provider. This field is system filled.
COINSURANCE REDUCED		For all services subject to OPPS (TOB 12X, 13X, 14X, and 76X) the amount of Beneficiary/Patient Reduced Coinsurance applicable to the line for a particular coinsurance amount. Providers are only permitted to reduce the coinsurance amount due from the beneficiary/patient for services paid under OPPS, and the reduced amount cannot be lower than 20% of the payment rate for the line. If the provider does not elect to reduce the coinsurance amount, the field will contain zeros.
ESRD-RED/PSYCH/HBCF		The Beneficiary/Patient End Stage Renal Disease Reduction/Psychiatric Reduction/ Hemophilia Blood Clotting Factor will notate one of three values: <ul style="list-style-type: none"> ▪ ESRD reduction refers to the ESRD network reduction amount and is found on Claim Page 1 in Value Code 71. ▪ Psychiatric reduction applies to line items that have a 'P' pricing indicator. The amount represents the psychiatric coinsurance amount (37.5% of covered charges). ▪ Hemophilia Blood Clotting Factor represents an additional payment to the DRG payment for hemophilia. The additional payment is based on the applicable HCPC. This payment add-on applies to inpatient claims.

Field Name	UB-04 X-Ref.	Description
VALCD-05/ OTHER		If Value Code 05 is present on the claim, this field will contain the portion of the value code 05 amount that is applicable to this line item. The value code 05 amount is first applied to revenue codes 96n, 97n and 98n, and then applied to revenue code lines in numeric order that are subject to deductible and/or coinsurance.
PAT		This field identifies the amount of the beneficiary/patient's blood and cash deductibles and the coinsurance amounts.
MSP		This field identifies the Medicare Secondary Payer deductible (blood and cash) and coinsurance (wage adjusted and reduced) amounts calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. Not displayed on new claims.
MSP		This field identifies additional Medicare Secondary Payer deductible (blood and cash) and coinsurance (wage adjusted and reduced) amounts calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. Not displayed on new claims.
ANSI		This 2-character Group Code and 3-character Reason (Adjustment) Code is used to send ANSI information to the Financial System for reporting on the remittance advice for the ESRD Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor.
PAY/HCPC APC CD		<p>HCPC Ambulatory Payment Classification Code – Identifies the APC (Ambulatory Payment Classification Code) group number by line item. Payment for services under the OPSS is calculated based on grouping outpatient services into APC groups. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. Both APC codes appear on the claims file, but only one appears on the screen. If their values are different, this indicates a partial hospitalization item. In this case the payment APC code is displayed. When the item is not a partial hospitalization, the HCPC APC code is displayed. This data is read from the claims file. If an APC is not found, the value will default to '00000'.</p> <p>Claim page 31 displays the HIPPS code if different from what is billed. If medical changes the code, the new HIPPS code is displayed in the PAY/HCPC APC CD field and a value of 'M' is in the OCE flag 1 field. When a value of 'M' is in the OCE flag 1 field, the MR IND field is automatically populated with a 'Y'. If Pricer changes the code, the new HHRG is displayed in the PAY/HCPC APC CD field and a value of 'P' is in the OCE flag 1 field. If the HIPPS code was not changed, fields PAY/HCPC APC CD and OCE flag 1 are blank.</p> <p>For Home Health PPS claims, claim page 31 displays the HIPPS code if different from what is billed.</p> <p>If the Inpatient Rehabilitation Facility (IRF) PPS Pricer returns a HIPPS/CMG code different from what was billed, the new HIPPS/CMG code is displayed on the revenue code 0024 line in the PAY/HCPC/APC CD field and a value of 'I' is displayed in the OCE FLAG 1 field. If the IRF PPS Pricer does not change the HIPPS/CMG code, these fields are blank.</p>
OUTLIER		This field identifies the outlier amount paid, if applicable.
PAYER-1		The amount entered by the user (if available) or apportioned by MSPPAY as payment from the primary (Medicare Secondary Payer 1) payer. The MSPPAY module based on amount in the value code for the primary payer apportions this amount. Not displayed on new claims.
PAYER-2		The amount entered by the user (if available) or apportioned by MSPPAY as payment from the secondary (Medicare Secondary Payer 2) payer. The MSPPAY module based on amount in the value code for the secondary payer apportions this amount. Not displayed on new claims.

Field Name	UB-04 X-Ref.	Description
OTAF		The Obligated to Accept in Full field contains the line item apportioned amount entered by the user (if available) or apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full. This field will be populated when value code 44 is present. Not displayed on new claims.
DENIAL IND		The Medicare Secondary Payer Denial Indicator field provides the user an opportunity to tell the MSPPAY module that an insurer primary to Medicare has denied this line item. Not displayed on new claims. . Valid values are: ' ' = Blank D = Denied
OCE FLAGS		The Outpatient Code Editor flags identify eight fields that are returned by the OCE module via the APC return buffer. OCE flags are: Flag 1 = Service Flag 2 = Payment Flag 3 = Discounting Factor Flag 4 = Line Item Denial or Rejection Flag 5 = Packing Flag 6 = Payment Adjustment Flag 7 = Type of Bill Inclusion Flag 8 = Line Item Action
MSP		This field identifies the MSP Payer 1 and Payer 2 amounts entered based on the value codes entered. Not required on new claims entry. Not displayed on new claims.
ID		This Medicare Secondary Payer Payer-1 ID code identifies the specific payer. If Medicare is primary, this field will be blank or populated with a 'Z' for Medicare. Valid values are: 1 = Medicaid 2 = Blue Cross 3 = Other 4 = None A = Working Aged B = End Stage Renal Disease (ESRD) Beneficiary/patient in 12-month coordination period with an employer group health plan C = Conditional Payment D = Auto No-Fault E = Workers' Compensation F = Public Health Service or other Federal Agency G = Disabled H = Black Lung I = Veterans Administration L = Liability
REIMB		The Beneficiary/Patient Reimbursement amount is determined by the system to be paid to the beneficiary/patient on the basis of the amount entered by the Provider on claim page 3, in the 'Due from Pat' field. This amount is the calculated line item amount.
RESP		Patient Responsibility identifies the amount for which the individual receiving services is responsible. The amount is calculated as follows <ul style="list-style-type: none"> • If the Payer-1 indicator is 'C' or 'Z', then the amount will equal Cash Deductible + Coinsurance + Blood Deductible. • If the Payer-1 indicator is not 'C' or 'Z', then the amount will equal MSP Blood + MSP Cash Deductible + MSP Coinsurance. Not displayed on new claims.

Field Name	UB-04 X-Ref.	Description
PAID		This is the patient paid amount calculated by the system. This amount is the lower of Patient Reimbursement + Patient Responsibility or the remaining Patient Paid (after the preceding lines have reduced the amount entered on Claim Page 3).
REDUCT - AMT		This field identifies the 10% reduction amount by a processed 121 re-billed demonstration claim that paid 90% of allowable services identified by including Claim Adjustment Reason Codes (CARC) '45' to report the adjustment due to difference in billed charged and allowed amount, and CARC '132' to report adjustments due to a 10% reduction in conjunction with Group Code of 'CO'. This is a ten-position alphanumeric field in 99999999.99- format.
ANSI		This field identifies the group code and the CARC code for the reduction amount above. The group code is a one-digit alphanumeric field.
PAT		The patient's reimbursement, responsibility, paid and reduction amounts.
PROV		The provider's reimbursement, responsibility, paid and reduction amounts.
MED		The Medicare reimbursement amount
LABOR		Identifies the labor amount of the payment as calculated by the pricer.
NON-LABOR		Identifies the non-labor amount of the payment as calculated by the pricer.
MED		This is the total Medicare Reimbursement for the line item. It will be the sum of the Patient Reimbursement and the Provider Reimbursement.
ADJUSTMENT		<p>The following calculation will be performed to obtain the total Contractual Adjustment:</p> <p>(Submitted Charges) – (Deductible) – (Wage Adjusted Coinsurance) – (Blood Deductible) – (Value Code 71) – (Psychiatric Reduction) – (Value Code 05/Other) – (Reimbursement Amount).</p> <p>For MSP claims, the MSP deductible, MSP blood deductible and MSP coinsurance are used in the above calculation in place of the deductible, blood deductible and coinsurance amounts. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.</p>
ANSI		The ANSI Group-ANSI Adjustment Code consists of a 2-character group code and a 3-character reason (adjustment) code. It is used to send ANSI information to the Financial System for reporting on the remittance advice.
PRICER AMT		The Pricer Amount provides the line item reimbursement received from a Pricer.
PRICER RTC		<p>Identifies the Pricer Return Code from OPPS. Valid values include:</p> <p><i>Describes how the bill was priced</i></p> <p>00 = Priced standard DRG payment 01 = Paid as day outlier/send to PRO for post payment review 02 = Paid as cost outlier/send to PRO for post payment review 03 = Paid as per diem/not potentially eligible for cost outlier 04 = Standard DRG, but covered days indicate day outlier but day or cost outlier status was ignored 05 = Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 = Pay per diem days only for transfers without an approved outlier 10 = Bad state code for SNF Rug Demo or Post-Acute Transfer for Inpatient PPS Pricer DRG is 209, 210 or 211 12 = Post-acute transfer with specific DRGs of 14,113,236, 263, 264, 429, 483 14 = Paid normal DRG payment with per diem days = or > average length of stay 16 = Paid as a Cost Outlier with per diem days = or > average length of stay 20 = Bad revenue code for SNF Rug Demo or invalid HIPPS code for</p>

Field Name	UB-04 X-Ref.	Description
		<p>SNF PPS Pricer</p> <p>30 = Bad Metropolitan Statistical Area (MSA) Code</p> <p><u>Describes why the bill was not priced</u></p> <p>50 = No Provider specific information found</p> <p>52 = Invalid MSA in Provider file</p> <p>53 = Waiver State – no calculated by PPS</p> <p>54 = DRG not '001'-'468' or '471'-'910'</p> <p>55 = Discharge date is earlier than Provider's PPS start date</p> <p>56 = Invalid length of stay</p> <p>57 = Review code not '00' – '07'</p> <p>58 = Charges not numeric</p> <p>59 = Possible day outlier candidate</p> <p>60 = Review code '01' and length of stay indicates day outlier. Bill is not eligible as cost outlier</p> <p>61 = Lifetime reserve days not numeric</p> <p>62 = Invalid number of covered days (e.g., more than approved length of stay, non-numeric or lifetime reserve days greater than covered days)</p> <p>63 = Review code of '00' or '03,' and bill is cost outlier candidate</p> <p>64 = Disproportionate share percentage and bed size conflict on Provider specific file</p> <p>98 = Cannot process bill older than 10/01/87</p>
PAY METHOD		<p>Identifies the method of payment (i.e., OPPS, LAB fee schedule, etc.) returned from OCE. Valid values include:</p> <ol style="list-style-type: none"> 1 = Paid standard OPPS amount (service indicators 'S,' 'T,' 'V,' 'X,' or 'P') 2 = Services not paid under OPPS (service indicator 'A,' or no HCPCS code and certain revenue codes) 3 = Not paid (service indicators 'C' or 'E') 4 = Acquisition cost paid (service indicator 'F') 5 = Designated current drug or biological payment adjustment (service indicator 'G') 6 = Designated new device payment adjustment (service indicator 'H') 7 = Designated new drug or new biological payment adjustment (service indicator 'J') 8 = Not used at present 9 = No separate payment included in line items with APCS (service indicator 'N,' or no HCPCS code and certain revenue codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization program services)
IDE/NDC/UPC		<p>This field contains IDE, NDC, or UPC.</p> <p>IDE- Investigational Device Exemption</p> <p>NDC Reserved for future use</p> <p>UPC Reserved for future use</p>
ASC GRP		Identifies the Ambulatory Surgical Center Group code for the indicated revenue code.
ASC %		Identifies the Ambulatory Surgical Center Percentage used by the ASC Pricer in its calculation for the indicated revenue code.
CONTR		This field identifies the contractor amounts.

4.C.2.c. UB-04 Claim Entry – Page 2: Additional Detail

This page is a copy of core claim MAP171D. Providers may only view this page. No additions, modifications or deletions may be made here. This page is accessed by pressing [F2] or [F11 three times] on claim page 2 (MAP1712).

INST Claim Entry Screen – Page 2 Additional Details (MAP171D) Field descriptions for this screen are provided in the table following Figure 6

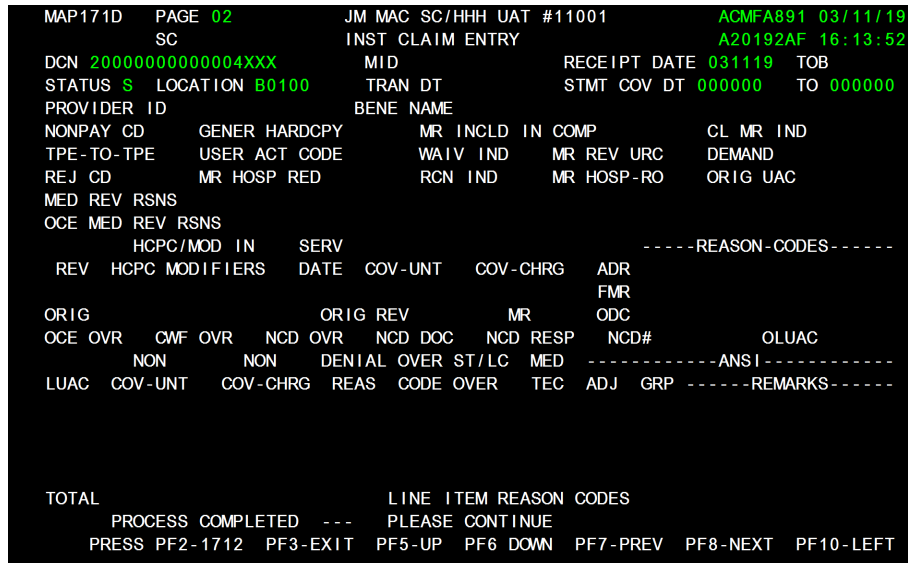


Figure 6 – UB-04 Claim Entry, Page 2, Additional Detail

Field Name	UB-04 X-Ref.	Description
DCN		The document control number assigned to the claim.
MID	60	The beneficiary/patient's Medicare number as shown on the Medicare card.
RECEIPT DATE		The date the claim was received into the Medicare claims processing system. Not required for new claims entry.
TOB	4	This field shows the type of bill being submitted.
STATUS		The current status of the claim. New claim entries will display 'S'.
LOCATION		The current location of the claim in the system. New claim entries will display B0100 until [F9] is pressed.
TRAN DT		This field displays the transaction date. Not displayed on new claim entries.
STMT COV DT/TO	6	The statement cover dates entered on MAP1711.
PROVIDER ID	57	Identifies the identification number of the Provider submitting the claim.
BENE NAME	8a	The name of the beneficiary/patient (20 positions for the last name and 10 positions for the first name).
NON PAY CD		The Non-Pay Code identifies the reason for Medicare's decision not to make payment. Valid values include: B = Benefits exhausted C = Non-Covered Care (discontinued) E = First Claim Development (Contractor 11107) F = Trauma Code Development (Contractor 11108) G = Secondary Claims Investigation (Contractor 11109) H = Self Reports (Contractor 11110) J = 411.25 (Contractor 11111) K = Insurer Voluntary Reporting (Contractor 11106) N = All other reasons for non-payment P = Payment requested

Field Name	UB-04 X-Ref.	Description
		<p>Q = MSP Voluntary Agreements (Contractor 88888) Q = Employer Voluntary Reporting (Contractor 11105) R = Spell of illness benefits refused, certification refused, failure to submit evidence, Provider responsible for not filing timely or Waiver of Liability T = MSP Initial Enrollment Questionnaire (Contractor 99999 or 11101) U = MSP HMO Cell Rate Adjustment (Contractor 55555) U = HMO/Rate Cell (Contractor 11103) V = MSP Litigation Settlement (Contractor 33333) V = Litigation Settlement (Contractor 11104) W = Workers Compensation X = MSP cost avoided Y = IRS/SSA Data Match Project MSP Cost Avoided (Contractor 77777) Y = IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102) Z = System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed. 00 = COB Contractor (Contractor 11100) 12 = Blue Cross – Blue Shield Voluntary Agreements (Contractor 11112) 13 = Office of Personnel Management (OPM) Data Match (Contractor 11113) 14 = Workers' Compensation (WC) Data Match (Contractor 11114)</p>
GENER HARDCPY		<p>Instructs the system to generate a specific type of hard copy document. Valid values include: 2 = Medical ADR 3 = Non-Medical ADR 4 = MSP ADR 5 = MSP Cost Avoidance ADR 7 = ADR to beneficiary/patient 8 = MSN (Line Item) or Partial Benefit Denial Letter 9 = MSN (Claim Level) or Benefit Denial Letter</p>
MR INCLD IN COMP		<p>The Composite Medical Review Included in the Composite Rate field that identifies (for ESRD bills) if the claim has been denied because the service should have been included in the Comp Rate. Valid value is 'Y' (the claim has been denied). Note: ESRD claims are no longer paid based on a composite rate.</p>
CL MR IND		<p>This indicator identifies if all services on the claim received Complex Manual Medical Review. The value entered in this field automatically populates the MR IND field for all revenue code lines on the claim. Valid values are: ' ' = The services did not receive manual medical review (default) Y = Medical records received. This service received complex manual medical review N = Medical records were not received. This service received routine manual medical review</p>

Field Name	UB-04 X-Ref.	Description																																																												
TPE-TO-TPE		<p>Identifies the tape-to-tape flag (if applicable). The flag indicators across the top of the chart instruct the system to either perform or skip each of the four functions listed on the left of the chart below. The first indicator column represents a blank. If this field is blank, all functions are performed (as indicated on this chart).</p> <table border="1"> <thead> <tr> <th>Function</th> <th>' '</th> <th>Q</th> <th>R</th> <th>S</th> <th>T</th> <th>U</th> <th>V</th> <th>W</th> <th>X</th> <th>Y</th> <th>Z</th> </tr> </thead> <tbody> <tr> <td>Transmit to CWF</td> <td>Y</td> <td>N</td> <td>N</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>N</td> <td>N</td> <td>N</td> </tr> <tr> <td>Print on Remittance Advice</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>N</td> <td>N</td> <td>Y</td> <td>N</td> <td>Y</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Include on PS&R</td> <td>Y</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Include on Workload</td> <td>Y</td> <td>Y</td> <td>N</td> <td>Y</td> <td>Y</td> <td>N</td> <td>N</td> <td>Y</td> <td>Y</td> <td>N</td> <td>N</td> </tr> </tbody> </table>	Function	' '	Q	R	S	T	U	V	W	X	Y	Z	Transmit to CWF	Y	N	N	Y	Y	Y	Y	Y	N	N	N	Print on Remittance Advice	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	Include on PS&R	Y	N	N	N	N	N	Y	Y	Y	Y	N	Include on Workload	Y	Y	N	Y	Y	N	N	Y	Y	N	N
Function	' '	Q	R	S	T	U	V	W	X	Y	Z																																																			
Transmit to CWF	Y	N	N	Y	Y	Y	Y	Y	N	N	N																																																			
Print on Remittance Advice	Y	Y	Y	Y	N	N	Y	N	Y	Y	N																																																			
Include on PS&R	Y	N	N	N	N	N	Y	Y	Y	Y	N																																																			
Include on Workload	Y	Y	N	Y	Y	N	N	Y	Y	N	N																																																			
USER ACT CODE		<p>The User Action Code is used for medical review and reconsideration only. The first position is the User Action Code and the second position is the Reconsideration Code. The reconsideration user action code will always be 'R'. When a reconsideration is performed on the claim, the user should enter a 'R' in the second position of the claim user action code, or in the line user action code field. This tells the system that reconsideration has been performed. Valid values include:</p> <p><i>Medical Review</i></p> <p>A = Pay per waiver - full technical. B = Pay per waiver - full medical. C = Provider liability - full medical - subject to waiver provisions. D = Beneficiary/patient liability - full - subject to waiver provisions. E = Pay claim - line full. F = Pay claim - partial - claim must be updated to reflect liability. G = Provider liability - full technical - subject to waiver provisions. H = Full or partial denial with multiple liabilities. Claim must be updated to reflect liability. I = Full Provider liability - medical - not subject to waiver provisions. J = Full Provider liability - technical - not subject to waiver provisions. K = Full Provider liability - not subject to waiver provisions. M = Pay per waiver - line or partial line. N = Provider liability - line or partial line. O = Beneficiary/patient liability - line or partial line. P = Open biopsy changed to closed biopsy. Q = Release with no medical review performed. R = CWF (Common Working File) denied but medical review was performed. Z = Force claim to be re-edited by Medical Policy.</p> <p><i>Special Screening</i></p> <p>5 = Generates systematically from the reason code file to identify claims for which special processing is required. 7 = Force claim to be re-edited by Medical Policy edits in the 5XXXX range but not the 7XXXX range. 8 = A claim was suspended via an OCE MED review reason. 9 = Claim has been identified as 'First Claim Review.'</p>																																																												
WAIV IND		<p>Identifies whether the Provider has their presumptive waiver status. Valid values are:</p> <p>Y = The Provider does have their waiver status N = The Provider does not have their waiver status</p>																																																												
MR REV URC		<p>The Medical Review Utilization Review Committee Reversal field identifies whether an SNF URC Claim has been reversed. This indicator can be used</p>																																																												

Field Name	UB-04 X-Ref.	Description
		for a partial or a full reversal. Valid values are: P = Partial reversal F = Full reversal, the system reverses all charges and days
DEMAND		The Medical Review Demand Reversal field identifies that an SNF demand claim has been reversed. Valid values are: P = Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal. F = Full reversal, the system reverses all charges and days.
REJ CD		The Reject Code identifies the reason code for which the claim is being denied.
MR HOSP RED		The Medical Review Hospice Reduced field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. Valid values are: ' ' = Not reduced Y = Reduced
RCN IND		The Reconsideration Indicator is used only for home health claims. Valid values include: A = Finalized count affirmed B = Finalized no adjustment count (pay per waiver) R = Finalized count reversal (adjustment) U = Reconsideration
MR HOSP-RO		The Medical Review Regional Office Referred field identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. Valid values are: ' ' = Not referred Y = Referred
ORIG UAC		Original User Action Code: This field identifies the original user action code. It is populated/updated when the claim level user action code is populated/updated. This is a two-digit alphanumeric field.
MED REV RSNS		The Medical Review Reasons field identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field displays medical review reasons specific to claim level. The system determines this by a 'C' in the claim/line indicator on the reason code file. The medical review reasons must contain a '5' in the first position.
OCE MED REV RSNS		The OCE Medical Review field displays the edit returned from the OPPTS version of OCE. Valid values include: 11 = Non-covered service submitted for review (condition code 20) 12 = Questionable covered service 30 = Insufficient services on day of partialization 31 = Partial hospitalization on same day as electro convulsive therapy or type T procedure 32 = Partial hospitalization claim spans 3 or less days with insufficient services, or electro convulsive therapy or significant procedure on at least one of the days 33 = Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services
UNTITLED		This Claim Line Number field identifies the line number of the revenue code. The line number is located above the revenue code on this map. To move to another revenue code, enter the new line number and press [ENTER].
REV	47	Identifies the Revenue Code for a specific accommodation or service that was billed on the claim. This information was entered on MAP1712. Valid

Field Name	UB-04 X-Ref.	Description
		values are 01 to 9999. To move to the next Revenue Code with a line level reason code, position the cursor in the page number field and press [F2].
HCPC/MOD IN	44	Identifies if the HCPC Code, Modifier or REV Code was changed. Valid values are: <ul style="list-style-type: none"> U = Up coding D = Down coding ' ' = Blank A 'U' or 'D' in this field opens the REV Code and HCPC/Mod fields to accept the changed code. Enter 'U' or 'D', tab down to the REV Code and HCPC/ MOD fields. After the new code is entered, the original Rev Code and HCPC/MOD fields move down to the ORIG REV or ORIG HCPC/MOD field.
HCPC	44	Identifies the HCPC code that further defines the revenue code being submitted. The information on this field was entered on MAP1712.
MODIFIERS	44	Identifies the HCPCS modifier codes for claim processing. This field may contain five-2 position modifiers.
SERV DATE	45	The line item date of service, in MMDDYY format, and is required for many outpatient bills. This information was entered on MAP1712.
COV-UNT	46	The number of covered units associated with the revenue code line item being denied.
COV-CHRG	47	The number of covered charges associated with the revenue code line item being denied.
ADR		Identifies the Additional Development Reason Codes that are present on the screen and allows the user to manually enter up to four occurrences to be used when an ADR letter is to be sent. The system reads the ADR code narrative to print the letter. The letter prints the reason code narrative as they appear on each revenue code line.
FMR		The Focused Medical Review Suspense Codes identify when a claim is edited in the system, based on a parameter in the Medical Policy Parameter file. The system generates the Medical Review code for the corresponding line item on the second page of the Denial/Non-Covered/Charges screen. The system assigns the same Focused Medical Review ID edits on lines that are duplicated for multiple denial reasons. The user may enter or overlay any existing Medical Review suspense codes. Claim level suspense codes should not apply to the line level. The Medical Policy reasons are defined by a '5' or '7' in the first position of the reason code.
ORIG		Identifies the original HCPC billed and modifiers billed, accommodating a 5-digit HCPC and up to 5 2-digit modifiers.
ORIG REV		Identifies the Original Revenue Code billed.
MR		This field indicates if the service received complex manual medical review. The valid values are: <ul style="list-style-type: none"> ' ' The services did not receive manual medical review (default value) 'Y' Medical records received. This service received complex manual medical review 'N' Medical records were not received. This service received routine manual medical review.
ODC		This field identifies original denial reason codes.
OCE OVR		The OCE Override is used to override the way the OCE module controls the line item. Valid values include: <ul style="list-style-type: none"> 0 = OCE line item denial or rejection is not ignored 1 = OCE line item denial or rejection is ignored 2 = External line item denial. Line item is denied even if no OCE edits

Field Name	UB-04 X-Ref.	Description
		3 = External line item rejection. Line item is rejected even if no OCE edits
CWF OVR		The CWF Home Health Override field overrides the way the OCE module controls the line item.
NCD OVR		This Override Indicator identifies whether the line has been reviewed for medical necessity and should bypass the National Coverage Determination (NCD) edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. Valid values are: ' ' = Default value. The NCD edits are not bypassed. A blank in this field is set on all lines for resubmitted RTP'd claim. Y = The line has been reviewed for medical necessity and bypasses the NCD edits. D = The line has no covered charges and bypasses the NCD edits.
NCD DOC		The National Coverage Determination Documentation Indicator identifies whether the documentation was received for the necessary medical service. This indicator will not be reset on resubmitted RTP'd claims. Valid values are: Y = The documentation supporting the medical necessity was received. N = Default Value. The documentation supporting the medical necessity was not received.
NCD RESP		The National Coverage Determination Response Code that is returned from the NCD edits. Valid values include: ' ' = Set to space for all lines on resubmitted RTP'D claims, (default value.) 0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria. The line continues through the system's internal local medical necessity edits. 1 = The line continues through the system's internal local medical necessity edits, because: the HCPCS code was not applicable to the NCD edit table process, the date of service was not within the range of the effective dates for the codes, the override indicator is set to 'Y' or 'D', or the HCPCS code field is blank. 2 = None of the diagnoses supported the medical necessity of the claim (list 3 codes), but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. 3 = The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list 2 codes). The line suspends and indicates that the service is not covered and is to be denied as beneficiary/patient liable due to non-coverage by statute. 4 = None of the diagnosis codes on the claim support the medical necessity for the procedure (list 3 codes) and no additional documentation is provided. This line suspends as not medically necessary and will be denied. 5 = Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the FI will RTP the claim.
NCD #		National Coverage Determination Number: This field identifies the NCD number associated with the beneficiaries claim denial.
OLUAC		Identifies the original line user action code. It is only populated when there is a line user action code and a corresponding denial reason code in the Benefits Savings portion of claim page 32.

Field Name	UB-04 X-Ref.	Description
LUAC		<p>The Line User Action Code identifies the cause of denial for the revenue line and a reconsideration code. The denial code (first position) must be present in the system and pre-defined in order to capture the correct denial reason. The values are equal to the values listed for User Action Codes. The reconsideration code (second position) has a value equal to 'R', indicating to the system that reconsideration has been performed.</p> <p>For the Revenue Code Total Line 0001, the system generates a value in the first two line occurrences of the LUAC field. These values indicate the type of total amount displayed on the total non-covered units and non-covered charges for the revenue code line 0001, only on MAP171D. These values do not apply to this field for any other revenue code line other than 0001. Valid values are:</p> <p style="padding-left: 40px;">1 = LUAC lines present on MAP171D 2 = Non-LUAC lines present on MAP171D</p>
NON COV-UNT		<p>Non-Covered Units identifies the number of days/visits that are being denied. Denied days/visits are required for those revenue codes that require units on Revenue Code file.</p> <p>The first line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines containing a LUAC on MAP171D.</p> <p>The second line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines not containing a LUAC on MAP171D.</p>
NON COV-CHRG	48	<p>Non-Covered Charges identifies the total number of denied/rejected/ non-covered charges for each line item being denied.</p> <p>The first line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines containing a LUAC on MAP171D.</p> <p>The second line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines not containing a LUAC on MAP171D.</p>
DENIAL REAS		<p>The denial reason for the revenue code line. The denial code must be present in the system and pre-defined in order to capture the correct denial reason.</p>
OVER CODE		<p>The override code allows the operator to manually override the system generated ANSI codes taken from the Denial Reason Code file. Valid values are:</p> <p style="padding-left: 40px;">' ' = Default to system generated A = Override system generated ANSI Codes</p>
ST/LC OVER		<p>The Status/Location Override identifies the override of the reason code file status when a line item has been suspended. Valid values are:</p> <p style="padding-left: 40px;">' ' = Process claim with no override code D = Denied, for the reason code on the line R = Rejected, for the reason code on the line</p>
MED TEC		<p>Medical Technical Denial Indicator - This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. Valid values include:</p> <p style="padding-left: 40px;">A = Home Health only - not intermittent care - technical and waiver was applied B = Home Health only - not homebound - technical and waiver was</p>

Field Name	UB-04 X-Ref.	Description
		<p>applied</p> <p>C = Home Health only - lack of physicians orders - technical deletion and waiver was not applied</p> <p>D = Home Health only - Records not submitted after the request - technical deletion and waiver was not applied</p> <p>M = Medical denial and waiver was applied</p> <p>S = Medical denial and waiver was not applied</p> <p>T = Technical denial and waiver was applied</p> <p>U = Technical denial and waiver was not applied</p>
ANSI ADJ		<p>The data for this ANSI Adjustment Reason Code field is from the ANSI file housed as the second page in the Reason Code file.</p> <p>The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the Reason Code file to assign the ANSI code to the denial screen. This code will occur once for each line item.</p>
ANSI GRP		<p>The data for this ANSI Group Code field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.</p>
ANSI REMARKS		<p>The data for this ANSI Remarks Code field is taken from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.</p>
TOTAL		<p>The total of all revenue code non-covered units and charges present on MAP171D.</p>
LINE ITEM REASON CODES		<p>The Line Item Reason Codes assigned out of the system for suspending the line item. There are a maximum of four (4) FISS reason codes that can be assigned to the line level.</p>

4.C.3. UB-04 Claim Entry – Page 3

Enter the following information onto Page 3 of the Claim Entry screen (Figure 7):

- Payer Information
- Diagnoses Codes
- Attending Physician (UPIN, first and last name)

INST Claim Entry Screen – Page 3 (MAP1713) - Field descriptions are provided in the table following Figure 7.

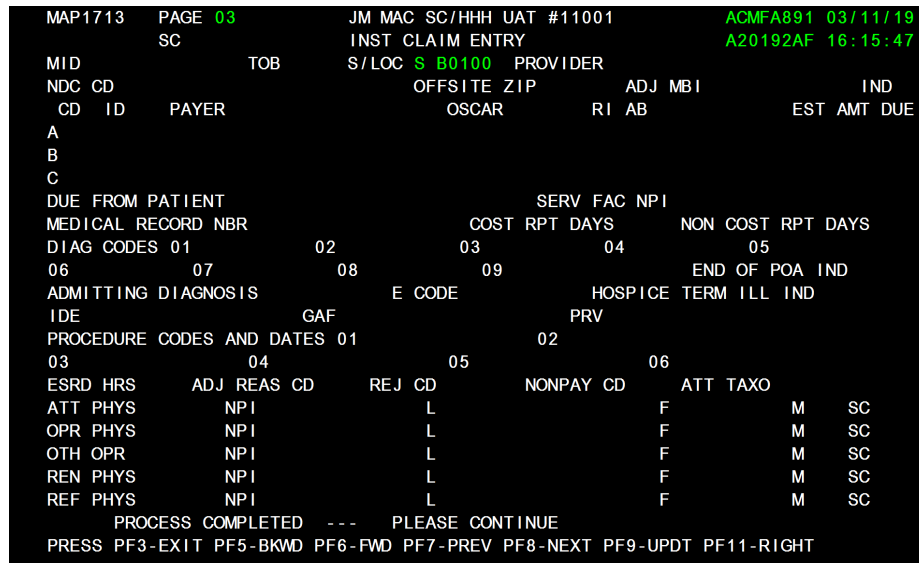


Figure 7 – UB-04 Claim Entry, Page 3

Field Name	UB-04 X-Ref.	Description
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
NDC CD		This field identifies the National Drug Code (NDC).
OFFSITE ZIP		This field identifies offsite Clinic/Outpatient department zip codes. It determines the claim line HPSA/PSA bonus eligibility. NOTE: When a zip code is present, the system uses the zip code for processing, not the zip code for the base provider (CAH). Indicating that one of the off-site clinics/outpatient departments submitted the claim for payment and not the base provider (CAH).
ADJ MBI		This field identifies the Medicare Beneficiary Identifier (MBI) number submitted on the adjustment/cancel claim. This is an 11-position alpha-numeric field.
IND		This field identifies if the adjustment/cancel claim was submitted with a HIC or MBI number. This is a one-position alpha-numeric field. The valid values are: <ul style="list-style-type: none"> ▪ H – The HIC was submitted on the adjustment/cancel claim. ▪ M – The MBI was submitted on the adjustment/cancel claim. ▪ Blank – This field will be blank on adjustment/cancel claims created prior to 7/01/18 and non-adjustment/cancel claims.
CD	50 A, B, C	Use the following list of Primary Payer Codes when submitting electronic claims for payer identification. The following codes are for Medicare requirements only. Other payers require codes not reflected. Not displayed on new claims. Valid values are: <ul style="list-style-type: none"> 1 = Medicaid 2 = Blue Cross

Field Name	UB-04 X-Ref.	Description
		3 = Other 4 = None A = Working-age - Employer Group Health Plan (EGHP) B = End Stage Renal Disease (ESRD) beneficiary/patient in 30-month coordinated period with an Employer Group Health Plan C = Conditional payment D = Automobile no-fault E = Workers' compensation F = Public Health Service (PHS) or other federal agency G = Disabled - Large Group Health Plan (LGHP) H = Black lung (federal black lung program) I = Veteran's administration L = Liability Z = Medicare A
ID		Not required.
PAYER	50 A, B, C	Payer Identification lines: (A) Primary Payer – If Medicare is the primary payer, enter ' Medicare ' on line A. Entering Medicare indicates that the provider developed for other insurance and determined that Medicare is the primary payer. If there are payer(s) of higher priority than Medicare, , enter the appropriate payer information on line(s) A and B.
OSCAR	51 A, B, C	This field will auto-populate with the Oscar Number assigned to the provider.
RI	52 A, B, C	The Release of Information Certification Indicator indicates whether the provider has on file, a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.
AB	53 A, B, C	The Assignment of Benefits Certification Indicator shows whether the provider has a signed form authorizing the third party payer to pay the provider.
EST AMT DUE	55 A, B, C	Not applicable.
DUE FROM PATIENT		The Due From Patient field is for outpatient services only. Enter the amount the provider has received from the patient toward payment.
SERV FAC NPI		Service Facility National Provider Identifier (NPI) . This field is used to enter the facility NPI of where the services were provided when other than the billing provider. This is a ten-digit field.
MEDICAL RECORD NBR	3b	Alphanumeric field used to enter beneficiary/patient's Medical Record Number.
COST RPT DAYS		The Cost Report Days identify the number of days claimable as Medicare beneficiary/patient days for inpatient and SNF types of bills (11X, 41X, 18X, 21X, 28X, and 51X) on the cost report. The system calculates this field and inserts the applicable data.
NON COST RPT DAYS		Identifies the number of Non-Cost Report Days not claimable as Medicare beneficiary/patient days for inpatient and SNF types of bills (11n, 18n, 21n, 28n, 41n, and 51n) on the cost report.
DIAGNOSIS CODE (01 – 09)	67, A - Q	Used to enter the full Diagnosis Codes for the principal diagnosis code and up to eight additional conditions coexisting at the time of admission which developed subsequently, and which had an effect upon the treatment given or the length of stay.

Field Name	UB-04 X-Ref.	Description
END OF POA IND	67	This field identifies the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. The valid values are: 'Z' = The end of POA indicators for principal and, if applicable, other diagnosis 'X' = The end of POA indicators for principal and, if applicable, other diagnosis in special processing situations that may be identified by CMS in the future ' ' = Not acute care, POA's do not apply
ADMITTING DIAGNOSIS	69	In the Admitting Diagnosis field, for inpatients, enter the full code for the principal diagnosis relating to condition established after study to be chiefly responsible for the admission.
E CODE	68	The External Cause of Injury Code field is used for E-codes should be reported in second diagnosis field Form Locator 68.
HOSPICE TERM ILL IND		Not required.
IDE		Identifies the Investigational Device Exemption (IDE) authorization number assigned by the FDA.
GAF		Geographic Adjustment Factors: This field identifies the GAF for state, carrier and locality (at the claim level.) This is a 13-digit alphanumeric field in 999999999.99 format.
PRV		Patient Reason for Visit: This field identifies the ICD-9-CM or ICD-10-CM code describing the beneficiary/patient's stated reason for seeking care at the time of outpatient registration. This is a seven-digit alphanumeric field that displays up to three occurrences.
PROCEDURE CODES AND DATES (01 – 06)	74 a – e	Enter the full code, including all required digits where applicable, for the principal procedure (first code). Enter the date (in MMDDYY format) that the procedure was performed during the billing period (within the 'from' and 'through' dates of services in Form Locator 6).
ESRD HOURS		Enter the number of hours a beneficiary/patient dialyzed on peritoneal dialysis.
ADJUSTMENT REASON CODE		Not required for new claim entry. Adjustment reason codes are applicable only on adjustments TOB XX7 and XX8.
REJ CODE		Not required by provider. For Medicare contractor use only.
NON PAY CODE		Not required by provider. For Medicare contractor use only.
ATT TAXO		This field identifies the taxonomy code for the Attending Physician.
ATT PHYS	76	This field identifies the LICENSED attending physician's identification number or Unique Physician Identification Number (UPIN) Code. This is a six-digit alphanumeric field.
NPI	76	This field identifies the NPI number.
L	76	This field identifies the last name of the attending physician.
F	76	This field identifies the first name of the attending physician.
M	76	This field identifies the middle initial of the attending physician.
SC		This field identifies the attending physician's specialty code. This information will automatically populate when the claim is submitted.

Field Name	UB-04 X-Ref.	Description
OPR PHYS	77	<p>This field identifies the physician who performed the principal procedure.</p> <p><u>Inpatient Part A Hospital</u> – Identifies the physician who performed the principal procedure. If no principal procedure is performed, leave blank.</p> <p><u>Outpatient Hospital</u> – Identifies the physician who performed the principal procedure. If there is no principal procedure, the physician who performed the surgical procedure most closely related to the principal diagnosis is entered. Use the format for inpatient.</p> <p><u>Other bill types</u> - Not required.</p> <p>Please note that if a surgical procedure is performed, and entry is necessary, even if the performing physician is the same as the admitting/attending physician.</p>
NPI	77	This field identifies the N number.
L	77	This field identifies the last name of the operating physician.
F	77	This field identifies the first name of the operating physician.
M	77	This field identifies the middle initial of the operating physician.
SC		This field identifies the operating physician's specialty code. This information will automatically populate when the claim is submitted.
OTH OPR	78 & 79	This field identifies the 'Other Operating' licensed physician.
NPI	78 & 79	This field identifies the NPI number.
L	78 & 79	This field identifies the last name of the other operating physician.
F	78 & 79	This field identifies the first name of the other operating physician.
M	78 & 79	This field identifies the middle initial of the other operating physician.
SC		This field identifies the other operating physician's specialty code. This information will automatically populate when the claim is submitted.
REN PHYS	78 & 79	This field identifies the rendering physician.
NPI	78 & 79	This field identifies the NPI number.
L	78 & 79	This field identifies the last name of the rendering physician.
F	78 & 79	This field identifies the first name of the rendering physician.
M	78 & 79	This field identifies the middle initial of the rendering physician.
SC		This field identifies the rendering physician's specialty code. This information will automatically populate when the claim is submitted.
REF PHYS	78 & 79	This field identifies the Referring Physician. This field will be used by all providers as applicable.
NPI	78 & 79	This field identifies the National Provider Identifier number.
L	78 & 79	This field identifies the last name of the referring physician.
F	78 & 79	This field identifies the first name of the referring physician.
M	78 & 79	This field identifies the middle initial of the referring physician.

Field Name	UB-04 X-Ref.	Description
SC		This field identifies the referring physician's specialty code. This information will automatically populate when the claim is submitted.

4.C.3.a. UB-04 Claim Entry – Page 3: MSP Payment Information

This page is a copy of core claim MAP1713. Providers may access this page to enter the payment information from a primary payer. This page is accessed by pressing [F11] on claim page 3 (MAP1713). Enter the payment information from the first payer source. If more than one insurance is primary to Medicare (making Medicare the tertiary payer), press [F6] to advance to the next page to enter the second payer's information.

INST Claim Entry Screen – Page 3 MSP Payment Information (MAP1719) - Field descriptions are provided in the table following Figures 8 and 9.

```

MAP1719  PAGE 03      JM MAC SC/HHH UAT #11001      ACMFA891 03/11/19
SC                               INST CLAIM ENTRY      A20192AF 16:17:16
MID          TOB          S/LOC S B0100 PROVIDER
                M S P      P A Y M E N T   I N F O R M A T I O N
RI:
PRIMARY PAYER 1  MSP PAYMENT INFORMATION

PAID DATE:          PAID AMOUNT:

GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT
    
```

Figure 8 – UB-04 Claim Entry, Page 3, MSP Payment Information (Payer 1)

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MAP1719  PAGE 03      JM MAC SC/HHH UAT #11001      ACMFA891 03/11/19
SC                               INST CLAIM ENTRY      A20192AF 16:20:38
MID          TOB          S/LOC S B0100 PROVIDER
                M S P      P A Y M E N T   I N F O R M A T I O N
RI:
PRIMARY PAYER 2  MSP PAYMENT INFORMATION

PAID DATE:          PAID AMOUNT:

GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT
    
```

Figure 9 – UB-04 Claim Entry, Page 3, MSP Payment Information (Payer 2)

Field Name	UB-04 X-Ref.	Description
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
RI		This field identifies the Residual-Pay-Indicator at the claim level to allow for secondary payment. This is a one-position alphanumeric field. The system will auto-populate the field with an "X" when Claim Adjustment Reason Codes (CARC) 27, 35, 119, or 149 are present on the claim. Valid Values are: X = Residual – secondary payment Blank = Residual – default X or Blank = Residual - Valid
PRIMARY PAYER MSP PAYMENT INFORMATION		This field displays the primary payer's code identifying the specific payer. This is a one-digit numeric field. (example: 1 = the primary payer)
PRIMARY PAYER 1 AND 2 (if applicable) PAID DATE		This field identifies the date that the provider received payment from Primary Payer 1 and 2 (if applicable). This is a six-position alphanumeric field in MMDDYY format. Press F6 to scroll forward to enter the date for the second primary payer, if applicable. Press F5 to scroll back to the Primary Payer 1 screen.
PRIMARY PAYER 1 and 2 PAID AMOUNT		This field identifies the payment that the provider received from Primary Payer 1 and 2 (if applicable). This is an eleven-position numeric field in 99999999.00 format. Press F6 to scroll forward to enter the payment amount for the second primary payer, if applicable. Press F5 to scroll back to the Primary Payer 1 screen.
PRIMARY PAYER 1 AND 2 GRP CODE		This field identifies the ANSI group codes. This is a two-position alphanumeric field, with UP 20 occurrences. Valid Values are: CO = Contractual Obligation OA = Other Adjustment PI = Payer Initiated Adjustments PR = Patient Responsibility
CARC		This field identifies the ANSI Claim Adjustment Reason Codes (CARCs) for primary payer 1 and primary payer 2. This is a four-position alphanumeric field with up to 20 occurrences. Note: A complete listing of CARCs can be found on the National Uniform Billing Committee (NUBC) website at www.nubc.org or Washington Publishing Company (WPC) website at www.wpc-edi.com .
AMT		This field identifies the dollar amount associated with the group/CARC combination for primary payer 1 and primary payer 2. This field is an eleven-position numeric field in 999999999.99 format with up to 20 occurrences.

4.C.3.b. UB-04 Claim Entry – Page 3: Provider Practice Location Address

This page is a copy of core claim MAP1713. Providers may access this page to enter the service facility address if the SERV FAC NPI field was completed on claim page 3 (MAP1713). This page is accessed by pressing [F11 twice] on claim page 3 (MAP1713). The FISS will auto-populate this field when a Service Facility NPI is submitted on the Electronic Media Claim (EMC).

INST Claim Entry Screen – Page 3 Provider Practice Location Address (MAP171F) - Field descriptions are provided in the table following Figure 10.

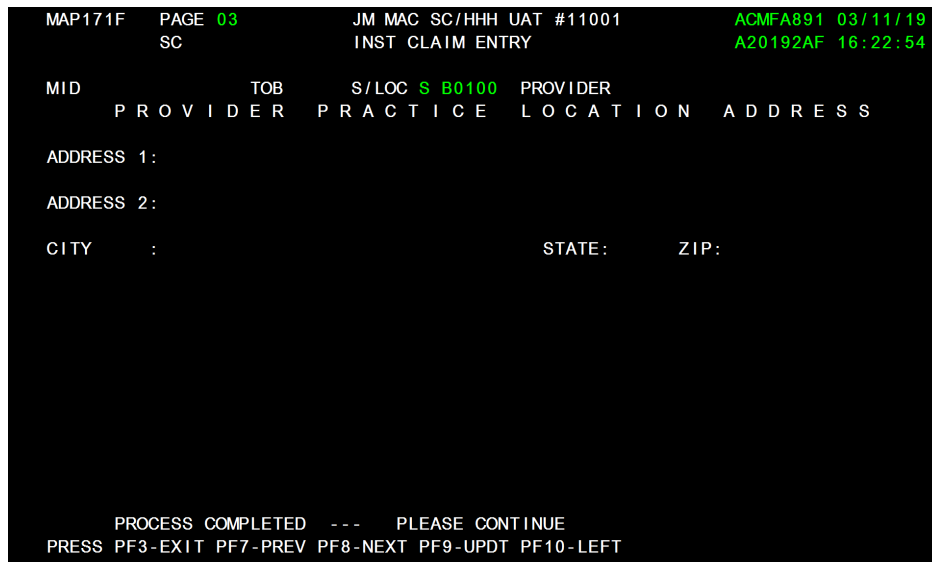


Figure 10 – UB-04 Claim Entry, Page 3, Provider Practice Location Address

Field Name	UB-04 X-Ref.	Description
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
ADDRESS 1		Street address of the Service Facility NPI of where the services were provided when other than the billing provider entered on claim page 3 (MAP1713).
Address 2		Additional address (e.g., Apartment, Suite, etc.) of the Service Facility NPI of where the services were provided when other than the billing provider entered on claim page 3 (MAP1713).
CITY		City of the Service Facility NPI of where the services were provided when other than the billing provider entered on claim page 3 (MAP1713).
State		State of the Service Facility NPI of where the services were provided when other than the billing provider entered on claim page 3 (MAP1713).
ZIP		ZIP code of the Service Facility NPI of where the services were provided when other than the billing provider entered on claim page 3 (MAP1713).

4.C.4. UB-04 Claim Entry – Page 4

The Remarks Page (Figure 11) is used to transmit information submitted on automated claims, and it gives Palmetto GBA staff a mechanism to make comments on claims that need special consideration for adjudication. Providers may utilize Page 4 to:

- Justify claims filed untimely
- Justify adjustments to paid claims (required when using the ‘D9’ Condition Code)
- Justify cancels to paid claims
- Justify other reasons that may delay claim adjudication

INST Claim Entry Screen – Page 4 (MAP1714) – Field descriptions are provided in the table following Figure 11.

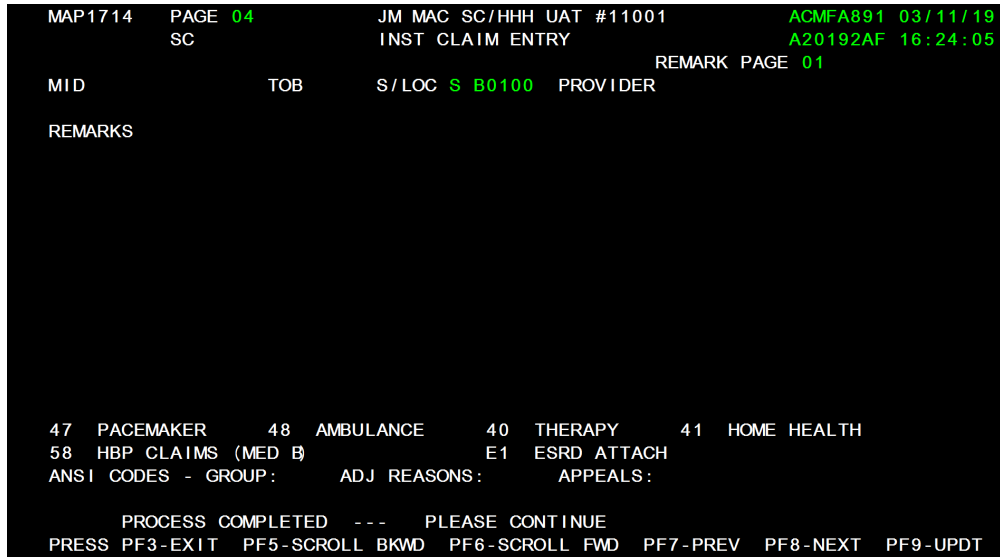


Figure 11 – UB-04 Claim Entry, Page 4

Field Name	UB-04 X-Ref.	Description
REMARK PAGE 01		There are a total 3 pages to enter remarks. Press [F6] to advance to the next page. The page number will change each time you press [F6].
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
REMARKS	80	Maximum of 711 positions/characters can be entered. Enter any remarks needed to provide information not reported elsewhere on the bill, but which may be necessary to ensure proper Medicare payment. This field carries the remarks information as submitted on automated claims, as well as provides internal staff with a mechanism to provide permanent comments regarding special considerations that played a part in adjudicating the claim, e.g., the Medical Review Department may use this area to document their rationale for the final medical determination or to provide additional information to the Waiver Employee to assist that individual with claim finalization. The remarks field is also used for Providers to furnish justification of late filed claims that override the Medicare contractor's existing reason code for timeliness. The following information must be entered on the first line.

Field Name	UB-04 X-Ref.	Description
		Additional information may be entered on the second and subsequent lines of the remarks section for further justification. Select one of the following reasons and enter the information exactly as it appears below: Justify: MSP involvement Justify: SSA involvement Justify: PRO Review involved Justify: Other involvement
[Attachments]		The following provides information on attachments: 47 = Pacemaker – No longer used. 48 = Ambulance – Not used. 40 = Therapy – Not used. 41 = Home Health – Not used. 58 = HBP Claims (Med B) – Not used. E1 = ESRD – Not used.
ANSI CODES GROUP		Identifies the general category of payment adjustment. Used for claims submitted in an ANSI automated format only.
ADJ REASONS		Claim adjustment standard reason code that identifies appeals codes for inpatient or outpatient.
APPEALS		Identifies ANSI appeals codes for inpatient or outpatient.

4.C.5. UB-04 Claim Entry – Page 5

Page five of the UB-04 Claim Entry screen (Figure 12) is used to enter a beneficiary/patient’s payer information.

INST Claim Entry Screen – Page 5 (MAP1715) – Field descriptions are provided in the table following Figure 12.

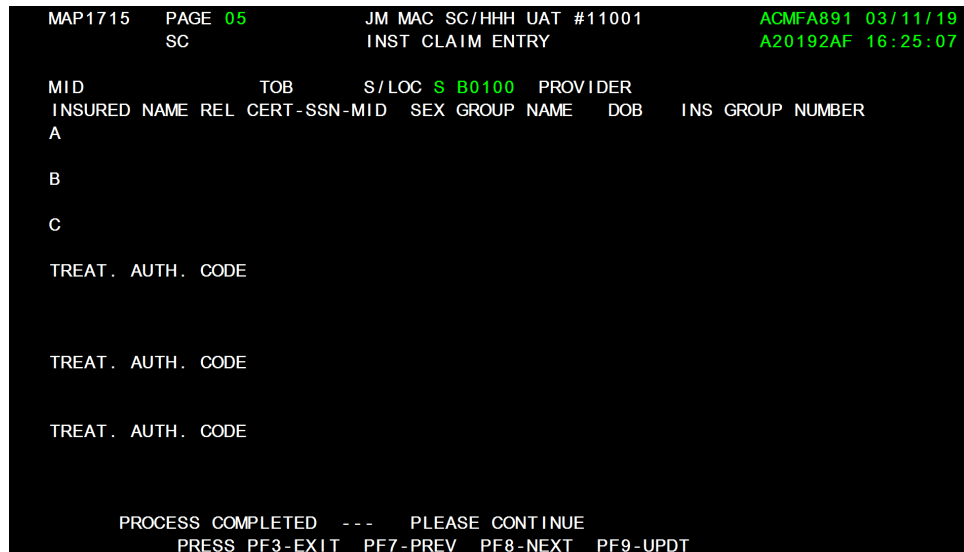


Figure 12 – UB-04 Claim Entry, Page 5

Field Name	UB-04 X-Ref.	Description
MID	60	The beneficiary/patient’s Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system

Field Name	UB-04 X-Ref.	Description
		The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
INSURED NAME (A – C)	58 A, B, C	This field identifies the insured's name and is a maximum of 25 digits; Last Name, First Name. On the same line that corresponds to the line on which Medicare payer information is reported, enter beneficiary/patient's name as reported on his/her Medicare health insurance card. If billing primary insurance, enter the insured's name on line A and B (if Medicare is tertiary). If billing supplemental insurance, enter the name of the insured under line B.
REL (A – C)	59 A, B, C	This field identifies the insured's relationship to the beneficiary/patient. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is reported, enter "18," which is the code that indicates the beneficiary/patient's relationship as "self". When Medicare is not the primary payer, use the two-digit code that identifies the insured's relationship to the beneficiary/patient (e.g. 18 for "self" or "01" for spouse).
CERT.-SSN-HIC-ID (A – C)	60 A, B, C	This field displays the beneficiary/patient's Medicare number, which is entered on the line that corresponds to the line on which Medicare payer information is reported. When reporting payers that are primary or secondary to Medicare, enter the Medicare identification number as displayed in the beneficiary/patient's MSP records on the CWF.
SEX (A – C)		The sex of the beneficiary/patient and insured (when applicable).
GROUP NAME (A – C)	61 A, B, C	Enter the name of the group or plan through which that insurance is provided. Entry required, if applicable.
DOB		The insured's date of birth (in MMDDCCYY format).
INS GROUP NUMBER (A – C)	62 A, B, C	This field identifies the Insurance Group identification number, control number, or code assigned by health insurance companies other than Medicare to identify the group under which the insured individual is covered (if applicable). This field is not required when submitting MSP claims. Information on MSP claims entered in this field must match the information as displayed in the beneficiary/patient's MSP record on the CWF if available.
TREAT. AUTH CODE	63 A, B, C	<p>The HHPPS Treatment Authorization Code for home health claims identifies a matching key to the OASIS (Outcome Assessment Information Set) of the beneficiary/patient. This field is comprised of a 18-digit alphanumeric code that is produced by the Grouper software based on input to the OASIS as follows:</p> <ul style="list-style-type: none"> Positions 1 – 2 = M0030 – Start of care date (2-digit number for the year) Positions 3 – 4 = M0030 – Start of care date (alpha characters derived from MM/DD code; ex: 09/01 = JK) Positions 5 – 6 = M0090 – Date assessment completed (2-digit number for the year) Positions 7 – 8 = M0090 – Date assessment completed (alpha characters derived from the MM/DD; ex: 01/01 = AA) Position 9 = M0100 – Reason for assessment currently being completed (numeric) Position 10 = M0110 – Episode timing (numeric based on the actual episode; ex: episode 1 = '1') Position 11 = Clinical severity points under equation 1 (alpha code) Position 12 = Functional severity points under equation 1 (alpha code) Position 13 = Clinical severity points under equation 2 (alpha code) Position 14 = Functional severity points under equation 2 (alpha code) Position 15 = Clinical severity points under equation 3 (alpha code)

Field Name	UB-04 X-Ref.	Description
		<p>Position 16 = Functional severity points under equation 3 (alpha code) Position 17 = Clinical severity points under equation 4 (alpha code) Position 18 = Functional severity points under equation 4 (alpha code)</p> <p>This field is also used to identify a Centers for Excellence or Provider Partnership Demonstration for NOA Type of Bill '11A' and '11D'. The valid values are:</p> <p>'09' = Discharge from agency '10' = Discharge from agency – no visits completed after start/resumption of care assessment '07' = Centers for Excellence '08' = Providers Partnership Demonstration</p> <p>Enter the treatment authorization code on the line (A, B, or C) that corresponds with the line on which Medicare is reported as the payer.</p> <p>Note: This field is also used to report the Unique Tracking Number (UTN) associated with the Medicare Payer iteration. For bill types other than 32X or 33X, report the UTN in positions 1-14. For 32X bill types, report the 14-position UTN immediately following the 18-position OASIS Treatment Authorization Number. Do not use the space bar when entering the UTN. The system will automatically move to the UTN field. The valid format of the UTN is:</p> <p>Positions 1-2 = MAC Jurisdiction (alpha-numeric) Position 3 = A (Part A program, or H for Home Health/Hospice Program) Positions 4-14 = Numeric</p>

4.C.6. UB-04 Claim Entry – Page 6

The following information can be found on Page 6 of the UB-04 Claim Entry screen (Figure 13):

- Medicare Secondary Payer (MSP) address
- Payment data (coinsurance, deductible, etc.)
- Pricer data (DRG, etc.).

INST Claim Entry Screen – Page 6 (MAP1716) – Field descriptions are provided in the tables following Figure 13.

```

MAP1716 PAGE 06 JM MAC SC/HHH UAT #11001 ACMFA891 03/11/19
SC INST CLAIM ENTRY A20192AF 16:25:59

MID TOB S/LOC S B0100 PROVIDER
MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
CITY ST ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
CITY ST ZIP
PAYMENT DATA --- DEDUCTIBLE COIN CROSSOVER IND
PARTNER ID

PAID DATE PROVIDER PAYMENT PAID BY PATIENT
REIMB RATE RECEIPT DATE 031119 PROVIDER INTEREST
CHECK/EFT NO CHECK/EFT ISSUE DATE PAYMENT CODE
PIP PAY AS CASH PRICER DATA HOSPICE PRIOR DYS
DRG OUTLIER AMT TTL BLNDED PAYMT FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT NET INL
TECH PROV DAYS TECH PROV CHARGES
OTHER INS ID CLINIC CODE
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE
    
```

Figure 13 – UB-04 Claim Entry, Page 6

Field Name	UB-04 X-Ref.	Description
MID	60	The beneficiary/patient's Medicare number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
INSURER'S ADDRESS 1 AND 2	58 A, B, C	Enter the address of the insurance company that corresponds to the line on which payer information is reported on line A, B, and/or C.
CITY 1 AND 2	58 A, B, C	Enter the specific city of the insurance company.
ST 1 AND 2	58 A, B, C	Enter the specific state of the insurance company.
ZIP 1 AND 2	58 A, B, C	Enter the specific zip code of the insurance company.

Payment Data – This information is available for viewing in Detail Claim Inquiry (Option 12) immediately after the claim is updated/entered in DDE.

Field Name	Description
Payment Data	
DEDUCTIBLE	Amount applied to the beneficiary/patient's deductible payment.
COIN	Amount applied to the beneficiary/patient's co-insurance payment.
CROSSOVER IND	The Crossover Indicator identifies the Medicare payer on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. Valid values are: 1 = Primary 2 = Secondary 3 = Tertiary
PARTNER ID	Identifies the Trading Partner number.

Field Name	Description
PAID DATE	This is the actual date that claim was processed for payment consideration.
PROVIDER PAYMENT	This is the actual amount that provider was reimbursed for services.
PAID BY PATIENT	This is the actual amount reimbursed to beneficiary/patient. Not utilized in DDE.
REIMB RATE	Provider's specific reimbursement rate (PPS).
RECEIPT DATE	Date claim was first received in the FISS system.
PROVIDER INTEREST	Interest paid to the provider.
CHECK/EFT NO	Displays the identification number of the check or electronic funds transfers.
CHECK/EFT ISSUE DATE	Displays the date the check was issued or the date the electronic funds transfer occurred.
PAYMENT CODE	Displays the payment method of the check or electronic funds transfer. Valid values are: ACH = Automated Clearing House or Electronic Funds Transfer CHK = Check NON = Non-payment data
PIP PAY AS CASH	This is a one-digit field that identifies if the provider is paid based on the Projected Interim Payment (PIP) method. The field is populated on hospital inpatient claims (TOB 11H) that were adjusted as a result of the Recovery Audit Contractor (RAC). Valid Values are: Y = PIP provider Blank = Non-PIP provider
Pricer Data	
HOSPICE PRIOR DYS	This non-updatable three digit numeric field stores Hospice prior period days, which is updated from the CWF. If the value is not returned from CWF, 00 (zeroes) will be displayed in this field.
DRG	The Diagnostic Related Grouping Code assigned by the pricer's calculation.
OUTLIER AMT	The Outlier Amount qualified for outlier reimbursement.
TTL BLNDED PAYMENT	Not utilized in DDE.
FED SPEC	Not utilized in DDE.
GRAMM RUDMAN ORIG REIM. AMT	The Gramm Rudman Original Reimbursement Amount.
NET INL	Not utilized in DDE.
TECH PROV DAYS	Technical Provider Days: The number of days for which the provider is liable.
TECH PROV CHARGES	Technical Provider Charges: The dollar amount for which the provider is liable.
OTHER INS ID	Not utilized in DDE.
CLINIC CODE	Not utilized in DDE.

4.D. Roster Bill Entry

To access the Roster Bill Entry page, open the Claim and Attachments Entry Menu (select option 02 from the Main Menu) and then select option 87. The DDE Roster Bill page (Figure 14) will display. This page allows providers to enter their pneumococcal pneumonia and flu shots in a roster bill format. After typing roster bill information, press **[F9]** to transmit the claim.

When completing the roster bill, providers should observe the following points

- Only one date of service per roster page
- A maximum of ten beneficiary/patient's per roster page may be reported on a DDE roster page

Vaccine Roster For Mass Immunizers Screen (MAP1681) - Field descriptions are provided in the table following Figure 14.

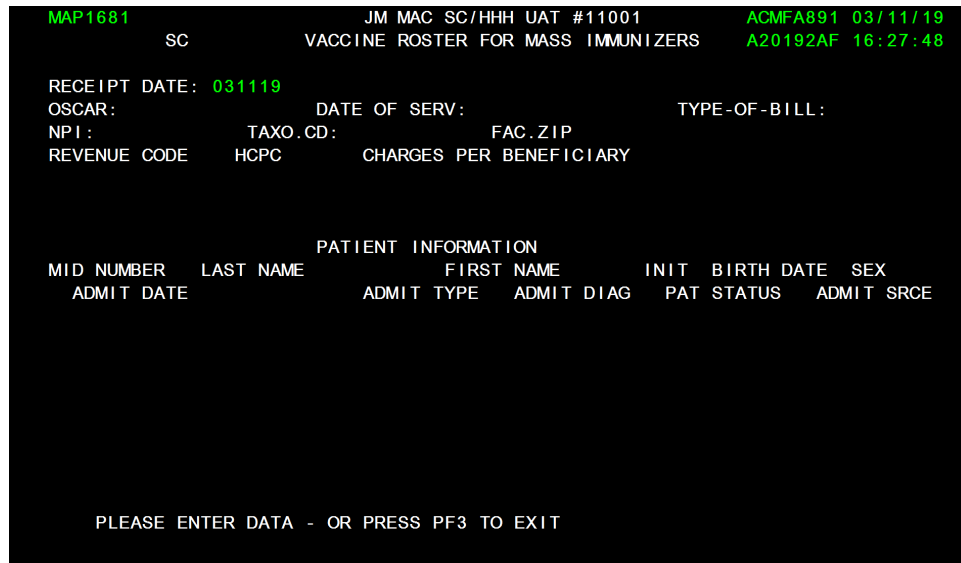


Figure 14 – DDE Roster Bill Page

Field Name	Description
RECEIPT DATE	The system date that the claim was received by the Medicare contractor.
OSCAR	The identification number of the institution that rendered services to the beneficiary/patient. Note: The system will auto-fill the Medicare provider number used when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, Home Health, Inpatient, etc.) the Medicare OSCAR number must be changed to reflect the OSCAR number for which you wish to submit claims. If the Medicare OSCAR number is not changed for your sub-units, the claims will be processed under the incorrect OSCAR number.
DATE OF SERVICE	The date the service was rendered to the beneficiary/patient (in MMDDYYYY format).
TYPE-OF-BILL	Enter the first two digits of the type of bill being submitted as a roster bill. Valid values are: 22 = Skilled Nursing Facility (SNF) Inpatient Part B 23 = SNF Outpatient 34 = Home Health (Part B Only) 72 = Independent or Hospital-Based Renal Dialysis Facility 75 = Comprehensive Outpatient Rehabilitation Facility 85 = Critical Access Hospital The system will autofill the third digit of the bill type when the roster is transmitted.
NPI	This field identifies the National Provider Identifier number.
TAXO.CD	This field identifies a collection of unique alpha numeric codes. The code set is structured into here distinct levels including Provider Type, Classification, and Area of Specialization.
FAC.ZIP	This field identifies the provider or subpart <i>nine</i> -digit ZIP code.
REVENUE CODE	Enter the specific accommodation or service that was billed on the claim. This should be done by line item. Valid values are 0636 <i>or</i> 0770.
HPCPC	HPCPCS applicable to ancillary services being billed.
CHARGES PER BENEFICIARY	Enter the charges per revenue code being charged to the beneficiary/patient.

Field Name	Description
After all the above information is entered, press the 'Enter' key. The cursor will automatically move to the top of the page. Use the 'Tab' key to move to the 'HIC' field and enter the information listed below.	
Patient Information	
MID NUMBER	The Medicare number assigned when a beneficiary/patient becomes eligible for Medicare.
LAST NAME	Enter the last name of the beneficiary/patient as it appears on the beneficiary/patient's Medicare Card or other Medicare notice.
FIRST NAME	Enter the first name of the beneficiary/patient as it appears on the beneficiary/patient's Medicare Card or other Medicare notice.
INIT	Enter the middle initial of the beneficiary/patient (if applicable).
BIRTH DATE	Enter the beneficiary/patient's date of birth (in MMDDYYYY format).
SEX	Enter the sex of the beneficiary/patient. Valid values are: M or F
ADMIT DATE	This field identifies the date of the beneficiary/patient's admission (the system will auto fill this date when the roster is transmitted).
ADMIT TYPE	This field identifies the code indicating the priority of admission. The valid values are: '1' = Emergency '2' = Urgent '3' = Elective '4' = Newborn '5' = Trauma Center
ADMIT DIAG	This field identifies the diagnosis code describing the inpatient condition at the time of the admission (when the roster is transmitted, the system will auto fill the diagnosis code based on the type of vaccine that is being billed).
PAT STATUS	This field identifies the code indicating the beneficiary/patient's status at the ending service date in the period (the system will auto fill the beneficiary/patient status when the roster is transmitted).
ADMIT SRCE	This field identifies the way a beneficiary/patient was referred (the system will auto fill this field when the roster is transmitted).

4.E. ESRD CMS-382 Form

The ESRD attachment form allows ESRD providers to inquire, update, and enter an ESRD method selection data. Select option '57' from the Claim and Attachments Entry Menu. Enter a Medicare number and function. Choose one of the following functions:

- E = Entry
- U = Update
- I = Inquiry

Press **[ENTER]** to access the additional fields for entry. If a beneficiary/patient is currently on file when you enter an 'E' for the method selection form, the system will automatically enter the beneficiary/patient's last name, first name, middle initial, date of birth, and sex based on the information stored on the beneficiary/patient file. In addition, the system should allow access to the provider number, dialysis type, and selection or change fields.

ESRD CMS-382 Inquiry screen (MAP1391) – Field descriptions are provided in the table following Figure 15.

```

MAP1391          JM MAC SC/HHH UAT #11001          ACMFA891 03/11/19
                SC          ESRD CMS-382  INQUIRY          A20192AF 16:29:10
                                                MNT:

MID:              METHOD:      382 EFFECTIVE DATE:      FUNCTION:

LN               FN               MI   DOB           SEX

PROV:            NPI:              TAXO.CD:
                FAC.ZIP:

DIALYSIS TYPE:  NEW SELECTION(=Y) OR CHANGE(=N) :  OPTION YR:

CWF ICN#:                CONTRACTOR:

CWF TRANS DT:    CWF MAINT DT:          TIMES TO CWF:    CWF DISP CD:

REMARK NARRATIVE:  382-EFFECTIVE DATE:      TERM DATE:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
    
```

Figure 15 – ESRD CMS-382 Inquiry Form

Field Name	Description
MID	The beneficiary/patient's Medicare number.
METHOD	The method of home dialysis selected by the beneficiary/patient. Valid values are: 1 = Method I – Beneficiary/patient receives all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claims for their services. 2 = Method II – Beneficiary/patient deals directly with one supplier and is responsible for submitting their own claim
382 EFFECTIVE DATE	Identifies the date the Beneficiary/patient's ESRD Method Selection becomes effective on the (HCFA-382) form.
FUNCTION	Three valid functions include: E = Entry U = Update I = Inquiry
LN	Last name of the beneficiary/patient at the time the method selection occurred.
FN	First name of the beneficiary/patient.
MI	Middle Initial of the beneficiary/patient, if applicable.
DOB	Beneficiary/patient's date of birth.
SEX	Sex of the beneficiary/patient.
PROV	Enter the ESRD Provider number or the facility for which you are entering the ESRD attachment. The Medicare Provider number will system fill with the Provider number you used to log onto the DDE system. Therefore, if you have sub-units (multiple ESRD facilities) you will need to change the Provider number to reflect the ESRD facility for which the attachment information is being entered.
NPI	This field identifies the provider National Provider Identifier number.
TAXO.CD	Taxonomy Code: This field identifies a collection of unique alphanumeric codes. The code set is structured in three distinct levels including provider type, classification, and area of specialization.
FAC.ZIP	This field identifies the provider or subpart nine-digit ZIP code.

Field Name	Description
DIALYSIS TYPE	Valid types of dialysis include: 1 = Hemodialysis 2 = Continuous ambulatory peritoneal dialysis (CAPD) 3 = Continuous cycling peritoneal dialysis (CCPD) 4 = Peritoneal Dialysis
NEW SELECTION OR CHANGE	Indicates an exception to other ESRD data. Valid values are: Y = Selection – Entered on initial selection or for exceptions such as when the option year is equal to the year of the select date N = Change – Entered for a change in selection, e.g., option year is one year greater than the year of select date
OPTION YR	Identifies the year that a beneficiary/patient selection or change is effective. A selection change becomes effective on January 1 of the year following the year the ESRD beneficiary/patient signed the selection form.
CWF ICN#	Common Working File (CWF) Internal Control Number (ICN). FISS inserts this number on the ESRD Remarks screen to ensure the correction is being made to the appropriate ESRD Remark segment.
CONTRACTOR	Identifies the carrier or Medicare contractor responsible for a particular ESRD Maintenance file.
CWF TRANS DT	The date that information was transmitted to the CWF.
CWF MAINT DT	Identifies the date that a CWF response was applied to a particular ESRD record.
TIMES TO CWF	Number of times the record was transmitted to the CWF.
CWF DISP CD	The CWF Disposition Code. Valid values include: 01 = Debit accepted, no automated adjustment 02 = Debit accepted, automated adjustment 03 = Cancel accepted 04 = Outpatient history only accepted 50 = Not in file (NIF) 51 = True NIF on HCFA Batch System 52 = Mater record housed at another CWF site 53 = Record in HCFA alpha match 55 = Name/personal character mismatch 57 = Beneficiary/patient record archived, only skeleton exists 58 = Beneficiary/patient record blocked for cross reference 59 = Beneficiary/patient record frozen for clerical correction 60 = Input/output error on data 61 = Cross-reference database problem AB = Transaction caused CICS abnormal end of job (abend) BT = History claim not present to support spell CI = CICS processing error CR = Crossover reject ER = Consistency edit reject UR = Utilization reject RD = Transaction Error
REMARK NARRATIVE	Valid Remark Narrative types include: M1 = Method I M2 = Method II
382 EFFECTIVE DATE	The method effective date. Valid values are: Y = The 382 effective date is equal to the 382 signature date N = The 382 effective date will be January 1 of the following year
TERM DATE	Projected date of termination of dialysis coverage.