PALMETTO GBA®

A CELERIAN GROUP COMPANY

A CMS Medicare Administrative Contractor

Direct Data Entry (DDE) User's Guide

Section 3: Inquiries

Main Menu Option 01

July 2020

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

Acronym	Description
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
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
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
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.

This publication was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

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 July 2020. Medicare Part A and HHH Bulletins/Advisories are available at www.PalmettoGBA.com/medicare.

SECTION 3 – INQUIRIES

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, the status of claims, check the status of claims, view Additional Development Requests (ADRs) letters, Medicare check history, and home health payment totals. To access the Inquiries Menu, select option 01 from the Main Menu.

The Inquiry Menu (MAP1702) - Information on each of the Inquiry Menu options follows.

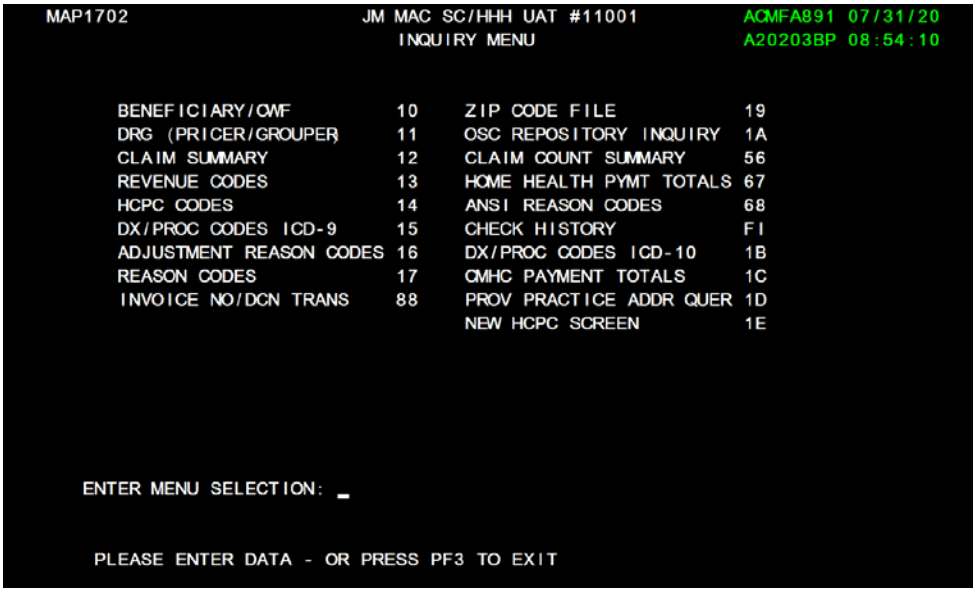

Figure 1 – Inquiry Menu

The screens displayed from each of the options on the inquiry menu screen will display the 'SC' field on the upper left side of the screen. The SC field is defined as the scroll function, which is a two-digit field in which you can enter the number from the inquiry menu screen that you want to access. **Using the scroll function eliminates the need to exit to the menu each time you are ready to proceed to the next inquiry screen.** For example, from any of the Beneficiary/CWF screens, you can enter '10' in the SC field to move to the DRG (Pricer/Grouper) screen instead of hitting the [F3] key to return to the inquiry menu to get to the DRG (Pricer/Grouper) screen.

3.A. Beneficiary/CWF

Select option '10' from the Inquiry Menu to access the Beneficiary/CWF screens. These screens display current Medicare Part A and Part B entitlement and utilization information about a specific beneficiary/patient.

There are several pages (screens) of eligibility information:

- Screen 1 (MAP1751): Patient eligibility information in the FISS
- Screen 2 (MAP1752): Patient eligibility information in the FISS
- Screen 3 (MAP175A): Patient eligibility information in the FISS
- Screen 4 (MAP175J): Patient eligibility information on preventative care in the FISS
- Screen 5 (MAP175M): Patient eligibility information on preventive care in the FISS
- Screen 6 (MAP1755): Patient hospital eligibility information
- Screen 7 (MAP1756): Beneficiary/Patient HMO Enrollment and other eligibility information
- Screen 8 (MAP1757): Beneficiary/Patient Mammography eligibility information

- Screen 9 (MAP1758): Beneficiary/Patient Hospice Benefit periods 1 and 2
- Screen 10 (MAP175C): Beneficiary/Patient Hospice Benefit periods 3 and 4
- Screen 11 (MAP1759) Beneficiary/Patient Medicare Secondary Payer (MSP) information (when applicable)
- Screen 12 (MAP175K): Beneficiary/Patient Smoking and Tobacco Use Cessation Counseling Services
- Screen 13 (MAP175L): Beneficiary/Patient Home Health certification information
- Screen 14 (MAP175N): Beneficiary/Patient Preventive Services HCPC code information
- Screen 15 (MAP175O): Beneficiary/Patient Medicare Choices Model (MCCM) Data
- Screen 16 (MAP175P): Beneficiary/Patient Hospice Election Period

To begin the inquiry process, enter the following information on screen 1 **as it appears on the beneficiary/patient's Medicare card**:

- Medicare Number
- Last name & first initial
- Sex (M or F)
- Date of birth (in MMDDYYYY format)

[TAB] to move between fields on the screen. *Only press* **[ENTER]** *when all fields have been completed.*

3.A.1. Beneficiary/CWF Screens

Screen 1 (MAP1751) – Field descriptions are provided in the table following Figure 2.

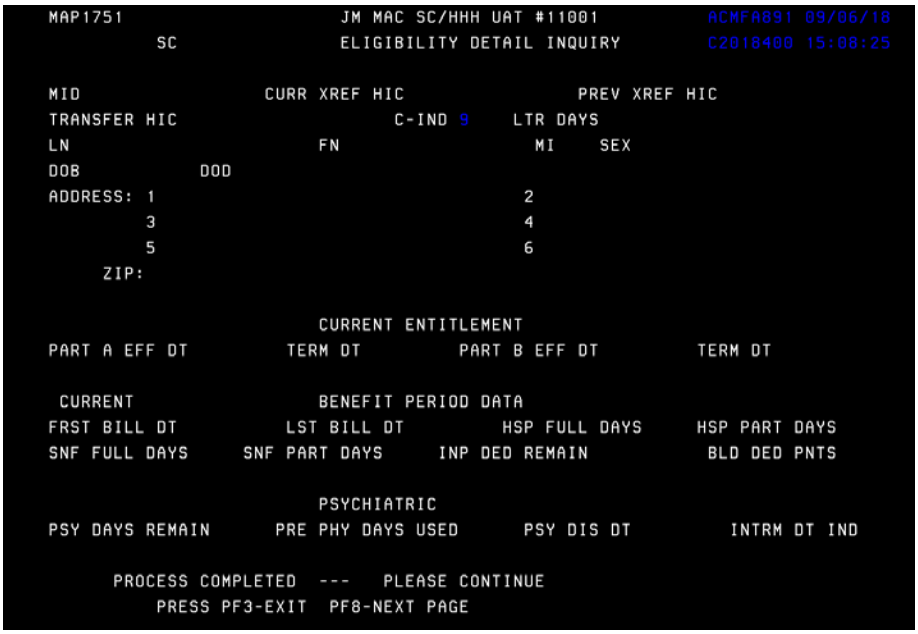

Figure 2 – Beneficiary/CWF Screen 1

Field Name	Description
MID	Type the beneficiary/patient's Medicare number as it appears on the Medicare ID card.
CURR XREF HIC	If the Medicare number has changed for the beneficiary/patient, this field represents the most recent number (the Medicare number as returned by CWF).
PREV XREF HIC	This field is no longer in use.
TRANSFER HIC	This field is no longer in use.
C-IND	Century Indicator – This field represents a one-position code identifying if the beneficiary/patient's date of birth is in the 18th, 19th or 20th century. Valid values are: 8 = 1800s

Field Name	Description
	9 = 1900s 2 = 2000s
LTR DAYS	The lifetime reserve days remaining.
LN	The beneficiary/patient's last name.
FN	The beneficiary/patient's first name.
MI	The beneficiary/patient's middle initial.
SEX	The beneficiary/patient's sex.
DOB	The beneficiary/patient's date of birth in MMDDYYYY format.
DOD	The beneficiary/patient's date of death.
ADDRESS (1 – 6)	The beneficiary/patient's street address, city, and state of residence.
ZIP	The beneficiary/patient's zip code for his/her state of residence.
Current Entitlement	
PART A EFF DT	The date a beneficiary/patient's Medicare Part A benefits become effective.
TERM DT	The date a beneficiary/patient's Medicare Part A benefits were terminated.
PART B EFF DT	The date a beneficiary/patient's Medicare Part B benefits became effective.
TERM DT	The date a beneficiary/patient's Medicare Part B benefits were terminated.
Current Benefit Period Data	
FRST BILL DT	The beginning date of inpatient benefit period.
LST BILL DT	The ending date of inpatient benefit period.
HSP FULL DAYS	The remaining full hospital days.
HSP PART DAYS	The remaining hospital co-insurance days.
SNF FULL DAYS	The full days remaining for a skilled nursing facility.
SNF PART DAYS	The partial days remaining for a skilled nursing facility.
INP DED REMAIN	The Part A inpatient deductible amount the beneficiary/patient must pay.
BLD DED PNTS	The remaining blood deductible pints.
Psychiatric	
PSY DAYS REMAIN	The remaining psychiatric days.
PRE PHY DYS USED	Number of pre-entitlement psychiatric days the beneficiary/patient has used.
PSY DIS DT	Date patient was discharged from a level of care.
INTRM DT IND	Code that indicates an interim date for psychiatric services. Valid values are: Y = Date is through date of interim bill/utilization day N = Discharge date / not a utilization day

Screen 2 (MAP1752) – Field descriptions are provided in the table following Figure 3.

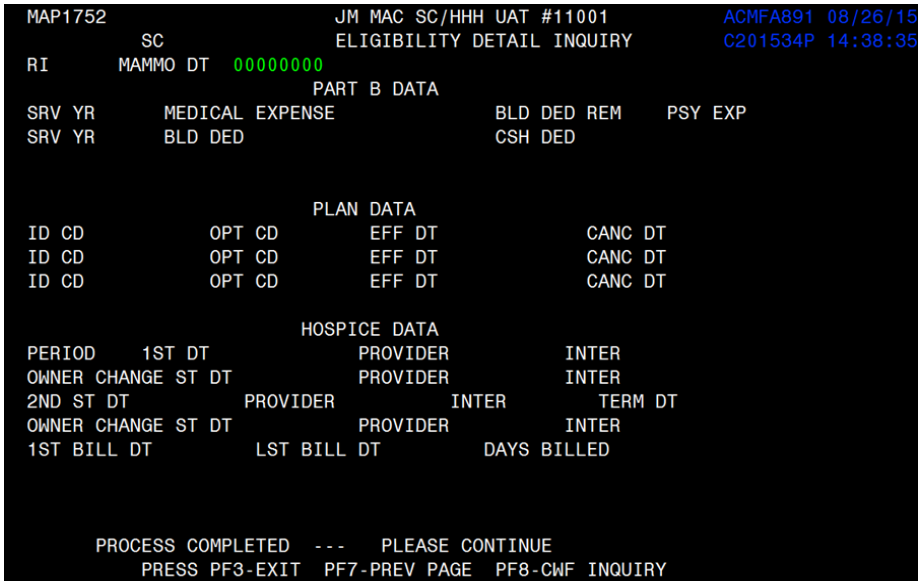

Figure 3 – Beneficiary/CWF Screen 2

Field Name	Description
RI	In DDE/CWF this Reason for Inquiry field is hard-coded with a '1' needed for HIQA Inquiry. Valid values are: 1 = Inquiry 2 = Admission Inquiry
MAMMO DT	Mammography Date.
Part B Data	
SRV YR	The calendar year for current Medicare part B services that are associated with the cash deductible amount entered in the Medical Expense field.
MEDICAL EXPENSE	The cash deductible amount satisfied by the beneficiary/patient for the service year.
BLD DED REM	The remaining of pints of blood to be met.
PSY EXP	The dollar amount associated with psychiatric services.
SRV YR	The calendar year for current Medicare Part B services that are associated with the cash deductible amount entered in the Medical Expense field and with the Blood Deductible field.
BLD DED	This field is no longer applicable.
CSH DED	This field is no longer applicable.
Plan Data	
ID CD	**Plan Identification Code -** This field identifies the Plan Identification code for beneficiaries who are enrolled in a Medicare Advantage (MA) Plan (otherwise known as a Medicare HMO plan). This is a five-position alphanumeric field. This field occurs three times. The structure of the identification number is: Position 1 H Position 2 & 3 State Code Position 4 & 5 Plan number within the state

Field Name	Description
OPT CD	This field identifies whether the current Plan services are restricted or unrestricted. Valid values are: **Unrestricted—Cost-based plans** 1 = Medicare contractor to process all Part A and B provider claims. 2 = Plan to process claims for directly provided service and for services from Providers with effective arrangements. **Restricted—Risk-based Plans** A = Medicare contractor to process all Part A and B provider claims. B = Plan to process claims only for directly provided services. C = Plan to process all claims.
EFF DT	The effective date for the Plan benefits.
CANC DT	The termination date for the Plan benefits.
Hospice Data	
PERIOD	Specific Hospice election period. Valid values are: 1 = The first time a beneficiary/patient uses Hospice benefits. 2 = The second time a beneficiary/patient uses Hospice benefits.
1ST DT	First Hospice Start Date (in MMDDYY format) of the beneficiary/patient's effective period (1-4) with the Hospice Provider.
PROVIDER	Identifies the hospice's six-digit Medicare provider number.
INTER	Identifies the Medicare contractor number for the hospice provider.
OWNER CHANGE ST DT	The Change of Ownership Start Date field will display the start date of a change of ownership within the period for the first provider.
PROVIDER	Identifies the hospice's Medicare provider number.
INTER	The Medicare contractor number for the hospice Provider.
2ND ST DT	A 6-character field that identifies the start date for each 2nd hospice period (1-4).
PROVIDER	Identifies the hospice's Medicare provider number.
INTER	Identifies the Medicare contractor number for the hospice provider.
TERM DT	A 6-digit numeric field that identifies each termination date for hospice services for this hospice Provider (1-4).
OWNER CHANGE ST DT	Displays the start date of a change of ownership within the period for the second provider.
PROVIDER	Identifies the hospice's Medicare provider number.
INTER	Identifies the Medicare contractor number for the hospice provider.
1ST BILL DT	A 6-digit numeric field (in MMDDYY format) that identifies the date of each earliest hospice bill.
LST BILL DT	A 6-digit numeric field (in MMDDYY format) that identifies each most recent hospice date.
DAYS BILLED	A 3-digit numeric field that identifies the cumulative number of days billed to date for the beneficiary/patient under each hospice election.

Screen 3 (MAP175A) –description of this screen is provided following Figure 4.

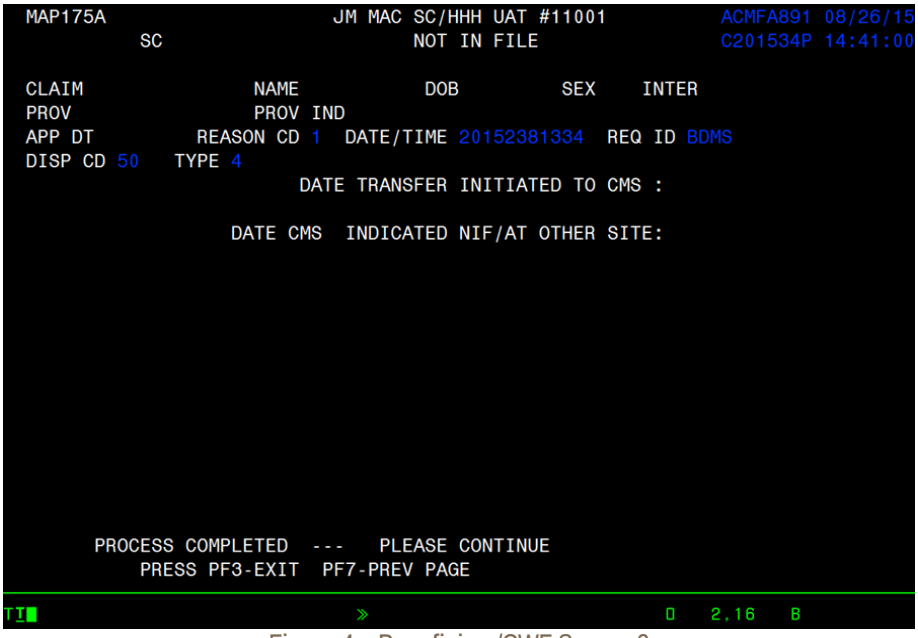

Figure 4 – Beneficiary/CWF Screen 3

Field Name	Description
CLAIM	The beneficiary/patient's Medicare Number as shown on the Medicare card.
NAME	Beneficiary/patient's first initial and last name.
DOB	Beneficiary/patient's date of birth.
SEX	Beneficiary/patient's Sex. Valid values are: 'F' – Female 'M' – Male
INTER	The provider's Medicare Contractor number.
PROV	The Provider's Medicare billing number. This is a six-digit number.
PROV IND	This field identifies the provider number indicator. Valid values are: ' ' – The provider number is a Legacy or OSCAR number 'N' – The provider number is an NPI number
APP DT	This field is used for spell determination, such as the admission date and current date. MMDDYY format.
REASON CD	This field identifies the reason for the inquiry. Valid values are: '1' – Status inquiry '2' – Inquiry related to an admission
DATE/TIME	This field identifies the date and time the request was made. Julian date format.
REQ ID	**Requester ID** - This field identifies the individual who submitted the inquiry.
DISP CD	**CWF Disposition Code** – This field identifies a code assigned when the request is processed through the CWF host site.
TYPE	This field identifies the type of reply from CWF. Valid value is '4' – Not in File.
DATE TRANSFER INITIATED TO CMS	This field identifies the first date the transfer was initiated to CMS.
DATE CMS INDICATED NIF/AT OTHER SITE	This field identifies the date CMS indicated the beneficiary/patient Medicare number was not in file at another site. MMDDYY format.

Screen 4 (MAP175J) – Field descriptions are provided in the table following Figure 5.

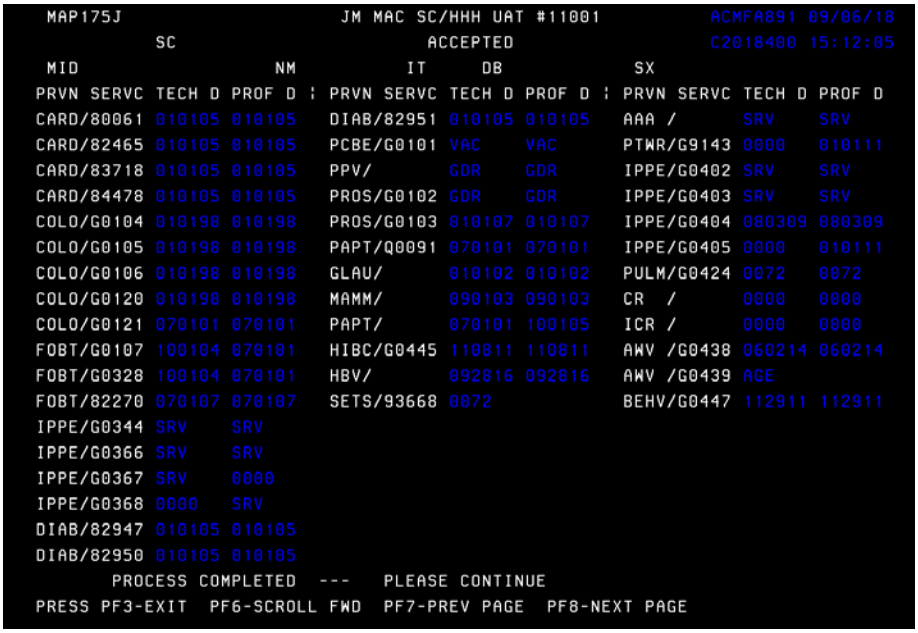

Figure 5 – Beneficiary/CWF Screen 4

Field Name	Description
MID	The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
NM	The beneficiary/patient's last name.
IT	The initial of the beneficiary/patient's first name.
DB	The beneficiary/patient's date of birth (in MMDDYY format).
SX	The beneficiary/patient's sex. Valid values are: F = Female M = Male
PRVN SRVC	This field identifies the preventative service category.
TECH D	**Technical Date** - This field identifies the date the beneficiary/patient is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary/patient is not eligible. Valid values are: ▪ PTB =Beneficiary/patient is not entitled to Part B ▪ RCVD = Beneficiary/patient already received service ▪ DOD = Beneficiary/patient not eligible due to date of death ▪ GDR = Beneficiary/patient not eligible due to gender ▪ AGE = Beneficiary/patient not eligible due to age ▪ SRV = Beneficiary/patient not eligible for the service ▪ VAC = Beneficiary/patient already vaccinated ▪ Service not applicable

Field Name	Description
PROF D	**Professional Date** - This date identifies the date the beneficiary/patient is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary/patient is not eligible. Valid values are: ▪ PTB = Beneficiary/patient is not entitled to Part B ▪ RCVD = Beneficiary/patient already received service ▪ DOD = Beneficiary/patient not eligible due to date of death ▪ GDR = Beneficiary/patient not eligible due to gender ▪ AGE = Beneficiary/patient not eligible due to age ▪ SRV = Beneficiary/patient not eligible for the service ▪ VAC = Beneficiary/patient already vaccinated ▪ Service not applicable

Screen 5 (MAP175M) – Field descriptions are provided in the table following Figure 6.

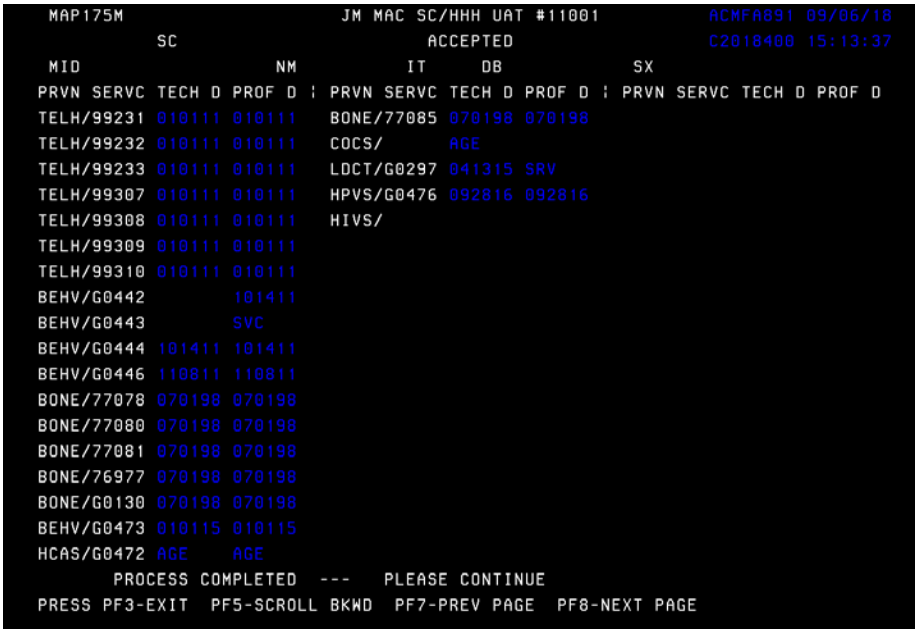

Figure 6 – Beneficiary/CWF Screen 5

Field Name	Description
MID	The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
NM	The beneficiary/patient's last name.
IT	The initial of the beneficiary/patient's first name.
DB	The beneficiary/patient's date of birth (in MMDDYY format).
SX	The beneficiary/patient's sex. Valid values are: F = Female M = Male
PRVN SRVC	This field identifies the preventative service category and HCPCS code.

Field Name	Description
TECH D	**Technical Date** - This field identifies the date the beneficiary/patient is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary/patient is not eligible. Valid values are: ▪ PTB =Beneficiary/patient is not entitled to Part B ▪ RCVD = Beneficiary/patient already received service ▪ DOD = Beneficiary/patient not eligible due to date of death ▪ GDR = Beneficiary/patient not eligible due to gender ▪ AGE = Beneficiary/patient not eligible due to age ▪ SRV = Beneficiary/patient not eligible for the service ▪ VAC = Beneficiary/patient already vaccinated ▪ Service not applicable
PROF D	**Professional Date** - This date identifies the date the beneficiary/patient is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary/patient is not eligible. Valid values are: ▪ PTB =Beneficiary/patient is not entitled to Part B ▪ RCVD = Beneficiary/patient already received service ▪ DOD = Beneficiary/patient not eligible due to date of death ▪ GDR = Beneficiary/patient not eligible due to gender ▪ AGE = Beneficiary/patient not eligible due to age ▪ SRV = Beneficiary/patient not eligible for the service ▪ VAC = Beneficiary/patient already vaccinated ▪ Service not applicable

Screen 6 (MAP1755) – Field descriptions are provided in the table following Figure 7.

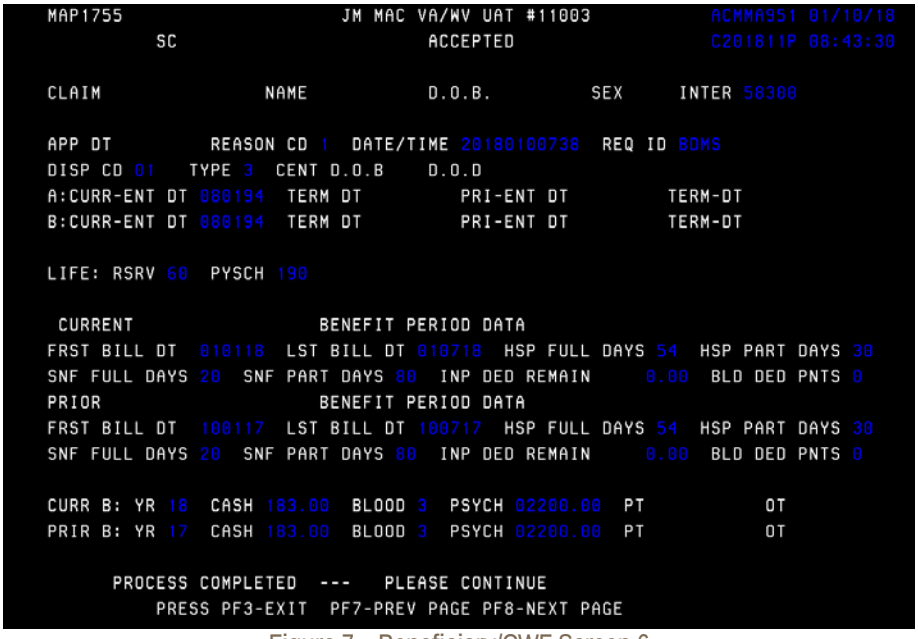

Figure 7 – Beneficiary/CWF Screen 6

Field Name	Description
CLAIM	The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
NAME	The beneficiary/patient's first initial and last name.
D.O.B	The beneficiary/patient's date of birth (in MMDDYY format).

Field Name	Description
SEX	Valid values are: F = Female M = Male U = Unknown
INTER	The Medicare contractor number for the Provider.
APP DT	The date the beneficiary/patient was admitted to the hospital (Application date).
REASON CD	Reason Code – Indicates the reason for the injury. Valid values are: 1 = Status inquiry 2 = Inquiry relating to an admission
DATE/TIME	The date and time in Julian YYDDDHHMMSS format.
REQ ID	Requested ID – Identifies person submitting inquiry.
DISP CD	The CWF disposition code assigned to a claim when it is processed through a CWF host site. Valid values include: 01 = Part A inquiry approved; beneficiary/patient has never used Part A services (Type 3 reply). 02 = Part A inquiry approved; beneficiary/patient has had some prior utilization. 03 = Part A inquiry rejected. 04 = Qualified approval; may require further investigation. 05 = Qualified approval; according to CMS's records, this inquiry begins a new benefit period.
TYPE	Identifies the type of CWF reply. Valid value: 3 = Accept
CENT D.O.B	Century of the beneficiary/patient's date of birth. Valid values are: 8 = 18th Century 9 = 19th Century
D.O.D	Identifies the date of death of the beneficiary/patient.
Part A	
CURR-ENT DT	Current Part A benefits entitlement date (in MMDDYY format).
TERM DT	Termination date for Part A benefits (in MMDDYY format).
PRI-ENT DT	Prior entitlement date for Part A benefits (in MMDDYY format).
TERM DT	Prior termination date for Part A benefits (in MMDDYY format).
Part B	
CURR-ENT	Current Part B benefits entitlement date (in MMDDYY format).
TERM DT	Termination date for Part B benefits (in MMDDYY format).
PRI-ENT DT	Prior entitlement date for Part B benefits (in MMDDYY format).
TERM DT	Prior termination date for Part B benefits (in MMDDYY format).
LIFE: RSRV	Number of lifetime reserve days remaining (00-60).
PSYCH	Number of lifetime psychiatric days available (000-190).
Current Benefit Period Data	
FRST BILL DT	The date of the earliest billing action in the current benefit period (in MMDDYY format).
LST BILL DT	The date of the latest billing action in the current benefit period (in MMDDYY format).
HSP FULL DAYS	The number of regular hospital full days the beneficiary/patient has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary/patient has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary/patient has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary/patient has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary/patient for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary/patient for the benefit period.

Field Name	Description
Prior Benefit Period Data	
FRST BILL DT	The date of the earliest billing action in the current benefit period.
LST BILL DT	The date of the latest billing action in the current benefit period.
HSP FULL DAYS	The number of regular hospital full days the beneficiary/patient has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary/patient has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary/patient has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary/patient has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary/patient for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary/ patient for the benefit period.
Current B	
YR	The most recent Medicare Part B year (in YY format).
CASH	The remaining Part B cash deductible.
BLOOD	The remaining Part B blood deductible pints.
PSYCH	The remaining psychiatric limit.
PT	The physical therapy dollars remaining.
OT	The occupational therapy dollars remaining.
Prior B	
YR	The prior Medicare Part B year (in YY format).
CASH	The Part B cash deductible remaining to be met in the prior year.
BLOOD	The Part B blood deductible pints remaining to be met in the prior year.
PSYCH	The remaining psychiatric limit in the prior year.
PT	Physical therapy dollars remaining in the prior year.
OT	Occupational therapy dollars remaining in the prior year.

Screen 7 (MAP1756) – Field descriptions are provided in the table following Figure 8.

```
MAP1756                  JM MAC VA/WV UAT #11003          ACMMA951 08/26/15
          SC                      ACCEPTED                C201534P 14:50:24

DATA IND 0000000000  NAME                              ZIP

PLAN: ENR CD
CURR PLAN:                      CUR ID        OPT 0  ENR         TERM
PRIR PLAN:                      PRI ID        OPT 0  ENR         TERM

OTHER ENTITLEMENTS OCCURRENCE CD/DATE 0          / 0

ESRD CD/DATE             /

CAT DATA: PSYCH 190  DISCHG          IND 0  DAYS USED      BLOOD

YR 89  APP           MET 00560.00  BLD 3  CO 08  FL 142  FRM         TO
IND      INT        ADM         FRM         TO           APP
ADJ IND    CALC DED           CMS  DT
YR 89  APP           MET 00560.00  BLD 3  CO 08  FL 142  FRM         TO
IND      INT        ADM         FRM         TO           APP
ADJ IND    CALC DED           CMS  DT

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 8 – Beneficiary/CWF Screen 7

Field Name	Description	
DATA IND	Data Indicators – 10-Digit Numeric Field. Valid values are:	
	Pos. 1 – Part B Buy-In	0 = Does not apply 1 = State buy-in involved
	Pos. 2 – Alien indicator	0 = Does not apply 1 = Alien non-payment provision may apply
	Pos. 3 – Psych Pre-Entitlement	0 = Does not apply 1 = Psychiatric pre-entitlement reduction applied
	Pos. 4 – Reason for Entitlement	0 = Normal Entitlement 1 = Disability (DIB) 2 = End Stage Renal Disease (ESRD) 3 = Has or had ESRD, but has current DIB 4 = Old age but had or has ESRD 8 = Has or had ESRD and is covered under premium Part A 9 = Covered under premium Part A
	Pos. 5 – Part A Buy-In	0 = No Part A Buy-In 1 = Part A Buy-In
	Pos. 6 – Rep Payee Indicator	0 = Does not apply 1 = Selected for GEP Contract 2 = Has Rep Payee 3 = Both Conditions Apply
	Pos. 7-10 – Not used at this time	Pre-filled with zeros.
NAME	Displays last name, first name, and middle initial of the beneficiary/patient.	
ZIP	Zip Code of the residence of the beneficiary/patient.	
PLAN: ENR CD	Number of periods of Plan enrollment code. Valid values include: 0 = Zero periods of enrollment 1 = One period of enrollment 2 = Two periods of enrollment 3 = More than two periods of enrollment	
Current Plan		
CUR ID	Current Plan ID code assigned by CMS. Position – Description 1 – H or 1-9 2 & 3 – State code 4 & 5 – Plan number within the state	
OPT	Plan Option Code. Valid values are: **Restricted**— A = Medicare contractor to process all claims. B = Plan to process claims for directly provided services. C = Plan to process all claims. **Unrestricted**— 1 = Medicare contractor to process all Part A and Part B provider claims 2 = Plan to process claims for directly provided services from providers with effective arrangements	
ENR	The enrollment date of the Plan benefits (in MMDDYY format).	
TERM DT	The termination date of the Plan benefits (in MMDDYY format).	
Prior Plan		
PRI ID	Prior Health ID code assigned by CMS: Position – Description 1 – H or 1-9 2 & 3 – State code 4 & 5 – Plan number within the state	

Field Name	Description
OPT	Plan Option Code: **Restricted**— A = Medicare contractor to process all claims. B = Plan to process claims for directly provided services. C = Plan to process all claims. **Unrestricted**— 1 = Medicare contractor to process all Part A and Part B provider claims 2 = Plan to process claims for directly provided services from providers with effective arrangements
ENR	The enrollment date of the Plan benefits for the prior year (in MMDDYY format).
TERM	Termination date of the Plan benefits for the prior year (in MMDDYY format).
OTHER ENTITLEMENTS OCCURRENCE CD/DATE	The first two occurrence codes and dates indicating another Federal Program or another type of insurance that may be the primary payer. Valid occurrence code values include: A = Working Aged beneficiary/patient or spouse covered by Employer Group Health Plan (EGHP) B = End Stage Renal Disease (ESRD) beneficiary/patient in 30-month coordination period and covered by employer health plan C = Medicare has made a conditional payment pending final resolution D = Automobile no-fault or other liability insurance involvement E = Workers' Compensation F = Veteran's Administration program, public health service or other federal agency program G = Working disabled beneficiary/patient or spouse covered by Employer Group Health Plan H = Black Lung I = Veteran's Administration Program Occurrence Codes — Date Definition 1 or 2: Date is the effective date of applicable program involvement. A - I: Date is the date of previous claim where Medicare was determined to be secondary.
ESRD CD/ DATE	The home dialysis method and effective date in MMDDCCYY format. Valid values are: 1 = Beneficiary/patient elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claim. 2 = Beneficiary/patient elects to deal directly with one supplier for home dialysis supplies and equipment and beneficiary/patient submits claim to Carrier.
Cat Data	
PSYCH	The remaining lifetime psychiatric days.
DISCHG	Last or through discharge date (in MMDDYY format).
IND	Identifies whether the discharge date is an interim date. Valid values are: 0 = Initialized 1 = Interim
DAYS USED	The number of pre-entitlement psychiatric days used by the beneficiary/patient.
BLOOD	The number of blood pints carried over from 1988 to 1989.
Days Information (2 occurrences)	
YR	The catastrophic trailer year.
APP	Identifies whether a December inpatient stay has been applied to the current year deductible.
MET	The remaining inpatient hospital deductible.
BLD	The remaining blood deductible.
CO	The remaining skilled nursing facility coinsurance days.

Field Name	Description	
FL	Number of full SNF days remaining.	
FRM	The 'From Date' of the earliest processed bill.	
TO	The 'Through Date' of the earliest processed bill.	
IND	The yearly data indicators:	
	Pos. 1	0 = Not Used 2 = Clerical Involvement 3 = Religious Non-Medical Healthcare Institution/SNF Usage 4 = Both 1 and 2
	Pos. 2	0 = Not Used 1 = Through Date is Interim
	Pos. 3-4	For Future Use
INT	The fiscal Medicare contractor number for earliest processed hospital bill with a deductible.	
ADM	The 'Admission Date' for the earliest processed hospital bill with a deductible.	
FRM	The 'From Date' for the earliest hospital bill processed with a deductible.	
TO	The 'Through Date' for the earliest hospital bill processed with a deductible.	
APP	Deductible amount applied for the earliest hospital bill processed with a deductible.	
ADJ IND	The type of adjustment made. Valid values are: 0 = No Adjustment 1 = Downward Adjustment 2 = Upward Adjustment	
CALC DED	The amount of deductible calculated.	
CMS DT	The date the claim was processed by CMS.	

Screen 8 (MAP1757) – Field descriptions are provided in the table following Figure 9.

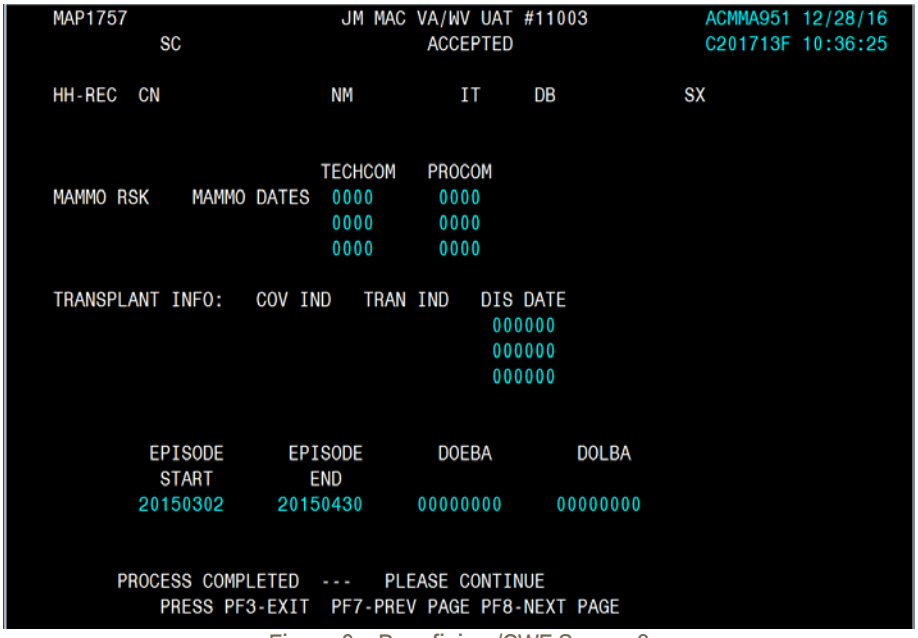

Figure 9 – Beneficiary/CWF Screen 8

Field Name	Description
HH-REC	The requested Home Health record.
CN	The beneficiary/patient's Medicare number as it appears on the Medicare ID card
NM	The last name of the beneficiary/patient.
IT	The first initial of the beneficiary/patient name.
DB	The date of birth of the beneficiary/patient.

Field Name	Description
SX	Sex of the beneficiary/patient. Valid values: F = Female M = Male
MAMMO RSK	The mammography risk indicator. Valid values are: Y = Yes N = No
Mammo Dates	
TECHCOM	**Technical Component Date** – The date the technician interpreted the mammography screening. Up to three dates may be displayed in MMYY format.
PROCOM	**Professional Component Date** – The date the mammography screening required an interpretation by a physician. Up to three dates may be displayed in MMYY format.
Transplant Info	
COV IND	The Transplant Covered Indicator. Valid values are: Y = Covered Transplant N = Non-covered Transplant
TRAN IND	The type of transplant performed. Valid values are: 1 = Allogeneous Bone Marrow 2 = Autologous Bone Marrow H = Heart Transplant K = Kidney Transplant L = Liver Transplant
DIS DATE	The discharge date for the transplant patient. There may be up to three discharge dates displayed.
Home Health Episode Info	
EPISODE START	The start date of an episode.
EPISODE END	The end date of an episode.
DOEBA	The first service date of the HHPPS period.
DOLBA	The last service date of the HHPPS period.

Screen 9 (MAP1758) – Field descriptions are provided in the table following Figure 11.

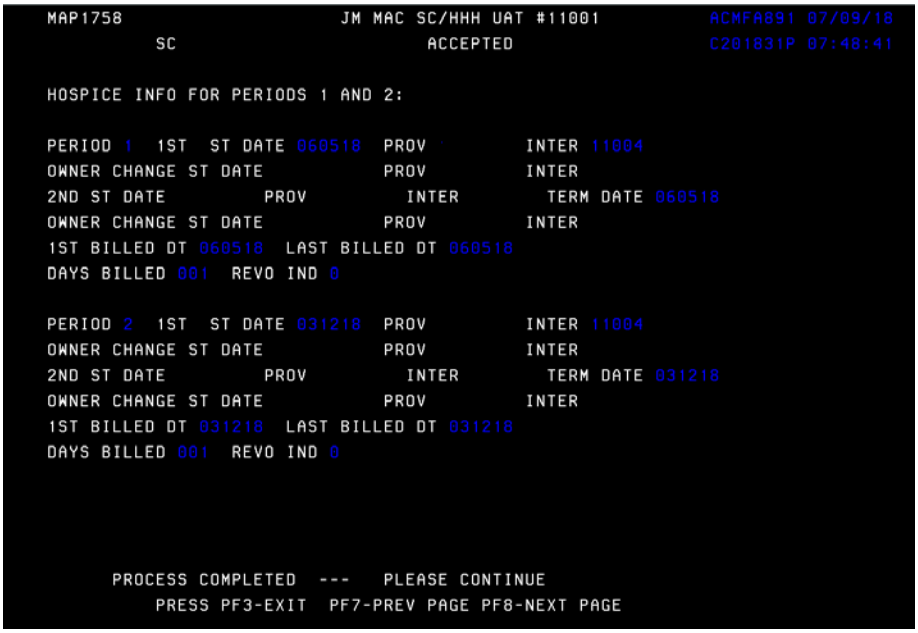

Figure 10 – Beneficiary/CWF Screen 9

Screen 10 (MAP175C) – Field descriptions are provided in the table following Figure 11.

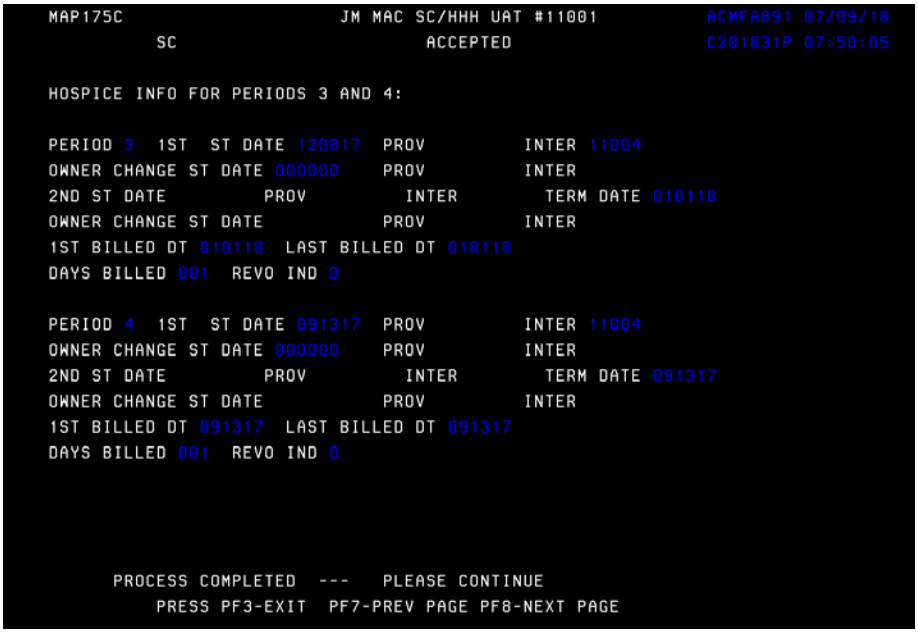

Figure 11 – Beneficiary/CWF Screen 10

Field Name	Description
HOSPICE INFO FOR PERIODS 1 AND 2	There are four occurrences of Hospice Information on two screens to provide for the four most recent hospice periods.
Period 1 (or 3)	
PERIOD	The Hospice Benefit Period Number. Valid values are: 1 = The most recent period of time a beneficiary/patient uses hospice benefits 3 = The third most recent period of time a beneficiary/patient uses hospice benefits
1ST ST DATE	The start date of beneficiary/patient's effective benefit period with the Hospice Provider (MMDDYY format).
PROV	The hospice's Medicare provider number.
INTER	The hospice's Medicare contractor number.
OWNER CHANGE ST DATE	The start date of a change of ownership for the first Provider, within the benefit period.
PROV	The hospice's Medicare Provider Number.
INTER	The Medicare contractor number.
2ND ST DATE	The start date of the change of provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
TERM DATE	The date the hospice benefit period was terminated.
OWNER CHANGE ST DATE	The start date of a change of ownership within the benefit period for the second Provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
1ST BILLED DT	The date of each earliest hospice bill date (in MMDDYY format).
LAST BILLED DT	The last date of each most recent hospice bill date (in MMDDYY format).
DAYS BILLED	Number of hospice days used for each hospice period.

Field Name	Description
REVO IND	The revocation indicator per hospice period. Valid values are: 0 = Beneficiary/patient has not been discharged or revoked hospice benefits. 1 = Beneficiary/patient has been discharged or revoked hospice benefits. 2 = Beneficiary/patient has been discharged or revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.
Period 2 (or 4)	
PERIOD	The Hospice Benefit Period Number. Valid values are: 2 = The second most recent period of time a beneficiary/patient uses hospice benefits 4 = The fourth most recent period of time a beneficiary/patient uses hospice benefits
1ST START DATE	The start date of beneficiary/patient's effective benefit period with the Hospice Provider (MMDDYY format).
PROV	The hospice's Medicare provider number.
INTER	The hospice's Medicare Contractor number.
OWNER CHANGE ST DATE	The start date of a change of ownership for the first Provider, within the benefit period.
PROV	The number of the Medicare hospice Provider.
INTER	The hospice's Medicare Contractor number.
2ND START DATE	The start date of the change of provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
TERM DATE	The date the hospice benefit period was terminated.
OWNER CHANGE ST DATE	The start date of a change of ownership within the benefit period for the second Provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
1ST BILLED DT	The date of each earliest hospice bill date (in MMDDYY format).
LAST BILLED DT	The last date of each most recent hospice bill date (in MMDDYY format).
DAYS BILLED	Number of hospice days used for each hospice period.
REVO IND	The revocation indicator per hospice period. Valid values are: 0 = Beneficiary/patient has not been discharged or revoked hospice benefits. 1 = Beneficiary/patient has been discharged or revoked hospice benefits. 2 = Beneficiary/patient has been discharged or revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.

Screen 11 (MAP1759) – Field descriptions are provided in the table following Figure 12

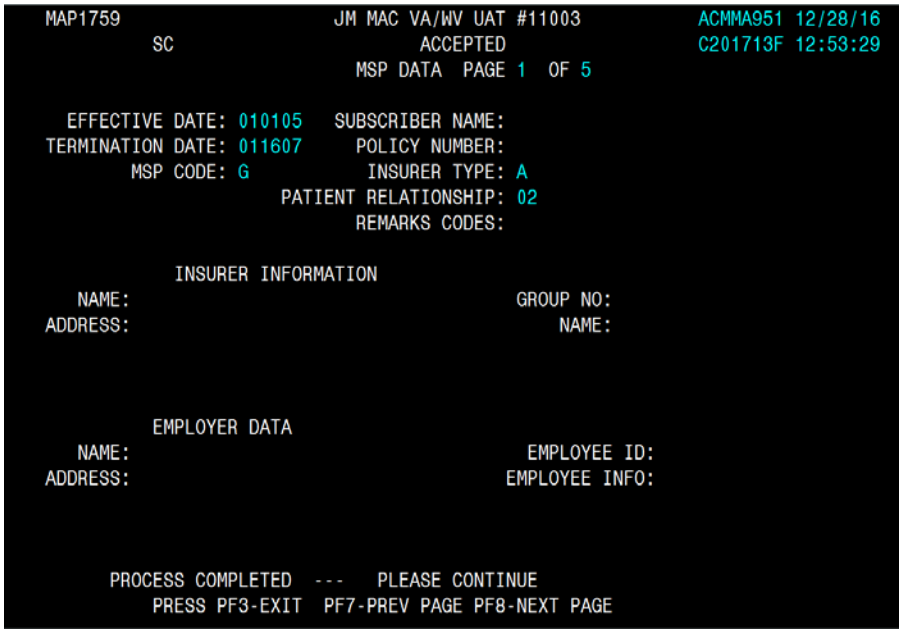

Figure 12 – Beneficiary/CWF Screen 11

Field Name	Description
MSP DATA PAGE 1 of 5 This field identifies the sequence number of the MSP data page being displayed and the total number of pages that can be displayed. The total number of MSP data pages that can be displayed will depend upon the number of valid MSP records in the CWF. If a beneficiary/patient does not have any valid MSP records in the CWF, no MSP data will be displayed.	
EFFECTIVE DATE	This field identifies the effective date of the MSP coverage. This is a six-position alphanumeric field.
TERMINATION Date	This field identifies the termination date of the MSP coverage. This is a six-position alphanumeric field. If this field is blank, the policy is still in effect.
MSP CODE	This field identifies the MSP source code. This is a one-position alphanumeric field. Valid Values are: A = Working aged *(Value Code 12)* B = End Stage Renal Disease (ESRD) Beneficiary in 30 Month Coordination Period with an EGHP (Employer Group Health Plan) *(Value Code 13)* D = Auto No-Fault *(Value Code 14)* E = Worker's Compensation *(Value Code 15)* F = Public Health Service or Other Federal Agency *(Value Code 16)* G = Disabled *(Value Code 43)* H = Black Lung *(Value Code 41)* L = Liability *(Value Code 47)*
SUBSCRIBER NAME	This field identifies the last and first name of the individual subscribing to the MSP coverage. The last name is a 16-position alphanumeric field.
POLICY NUMBER	This field identifies the policy number with the payer listed. This is a 17-position alphanumeric field.
INSURER TYPE	This field identifies the type of insurance (e.g., insurance or indemnity)

Field Name	Description
PATIENT RELATIONSHIP	This field identifies the relationship of the beneficiary/patient to the insured under the policy listed. This is a two-position alphanumeric field. Valid values are: 01 = Self 02 = Spouse 03 = Natural child/insured has financial responsibility 04 = Natural child, insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 – Unknown (relationship to insured is unknown) 10 = Handicapped dependent 11 = Organ donor 12 = Cadaver donor 13 = Grandchild 14 = Niece/nephew 15 = Injured plaintiff 16 = Sponsored dependent 17 = Minor dependent of a minor dependent 18 = Parent 19 = Grandparent 20 = Life Partner (e.g., domestic partner, significant other)
REMARKS Codes	This field identifies information needed by the contractor to assist in additional development. Up to three remarks codes may be displayed.
INSURER INFORMATION	
NAME	This field identifies the name of the insurance company which may be primary over Medicare. This is a 32-position alphanumeric field.
ADDRESS	This field identifies the street, city, state, and ZIP code for the insurer. These are 32 15, 2, and 9 alphanumeric positions.
GROUP NO	This field identifies the group number for the policyholder with this insurer name. This is a 20-position alphanumeric field.
NAME	This field identifies the name of the insurer group. This is a 17-position alphanumeric field.
EMPLOYER DATA	
NAME	This field is not utilized in DDE
ADDRESS	This field is not utilized in DDE
EMPLOYEE ID	This field is not utilized in DDE
EMPLOYEE INFO	This field is not utilized in DDE

Screen 12 (MAP175K) – Field descriptions are provided in the table following Figure 13.

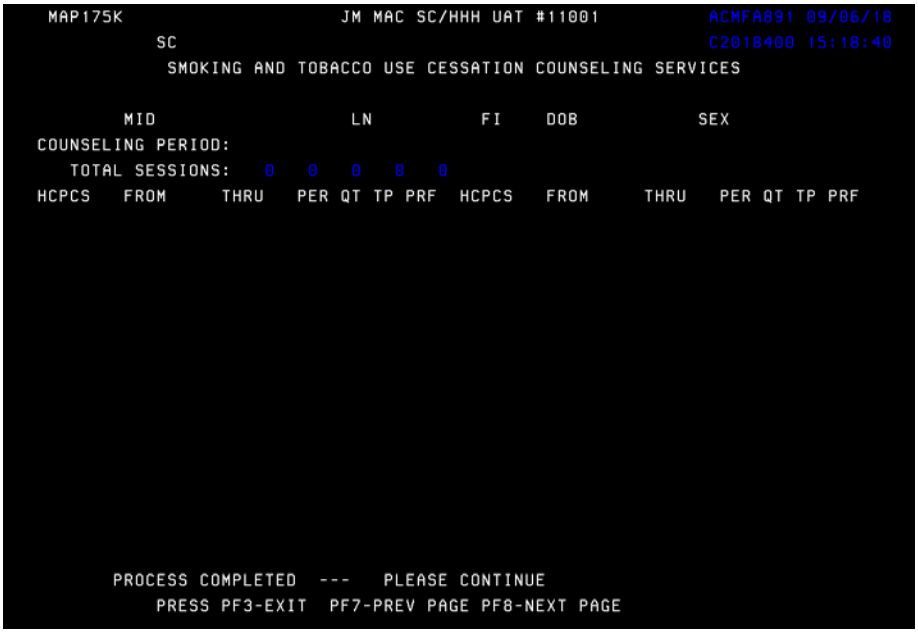

Figure 13 – Beneficiary/CWF Screen 12

Field Name	Description
Smoking and Tobacco Use Cessation Counseling Services	
MID	The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
LN	The beneficiary/patient's last name.
FI	The first initial of the beneficiary/patient's first name.
DOB	The beneficiary/patient's date of birth (in MMDDYY format).
SEX	Valid values are: F = Female M = Male
COUNSELING PERIOD	This field identifies up to five years of counseling data. Valid values are: '1' – One year '2' – Two years '3' – Three years '4' – Four years '5' – Five years
TOTAL SESSIONS	This field identifies the number of sessions billed for the beneficiary/patient. **Note**: If a date range is billed on a detail, and a quantity that matches the range is not identified, CWF posts the session as1 unit. (i.e., 10/25 – 10/27 Unit 1 will post as 1 session.
HCPCS	This field identifies the Healthcare Common Procedure Coding System (HCPCS) code of G0375 or G0376.
FROM	This field displays the 'from' date of the claim in MM/DD/CCYY format.
THRU	This field displays the 'through' date of the claim in MM/DD/CCYY format.
PER	This field identifies up to five year of counseling data. Valid values are: '1' – One year '2' – Two years '3' – Three years '4' – Four years '5' – Five years
QT	**Quantity** - This field identifies the number of services billed for each date.

Field Name	Description
TP	**Claim Type** – This filed identifies the type of claim. Valid values are: 'O' – Outpatient 'B' – Part B
PRF	This field identifies whether the Technical (TECH) or Professional (PROF) component was billed. Valid Values are: T = Technical P = Professional B = Part B Services (on claims with Dates of Service prior to 10/01/2018)

Screen 13 (MAP175L) – Field descriptions are provided in the table following Figure 14.

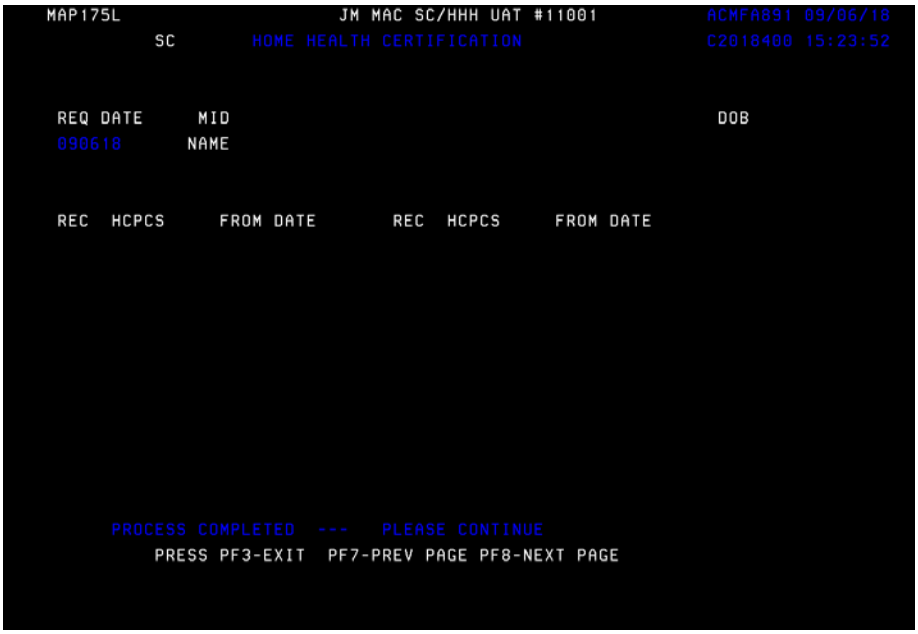

Figure 14 – Beneficiary/CWF Screen 13

Field Name	Description
Home Health Certification	
REQ DATE	Date the request was made through DDE.
MID	The beneficiary/patient's Medicare number as shown on the Medicare card.
DOB	The beneficiary/patient's date of birth (in MMDDYY format).
NAME	The beneficiary/patient's last and first name.
REC	This field identifies the health insurance record number.
HCPCS	This field identifies the HCPCS code billed.
FROM DATE	This field identifies the home health from date in MMDDYY format.

Screen 14 (MAP175N) – Field descriptions are provided in the table following Figure 15.

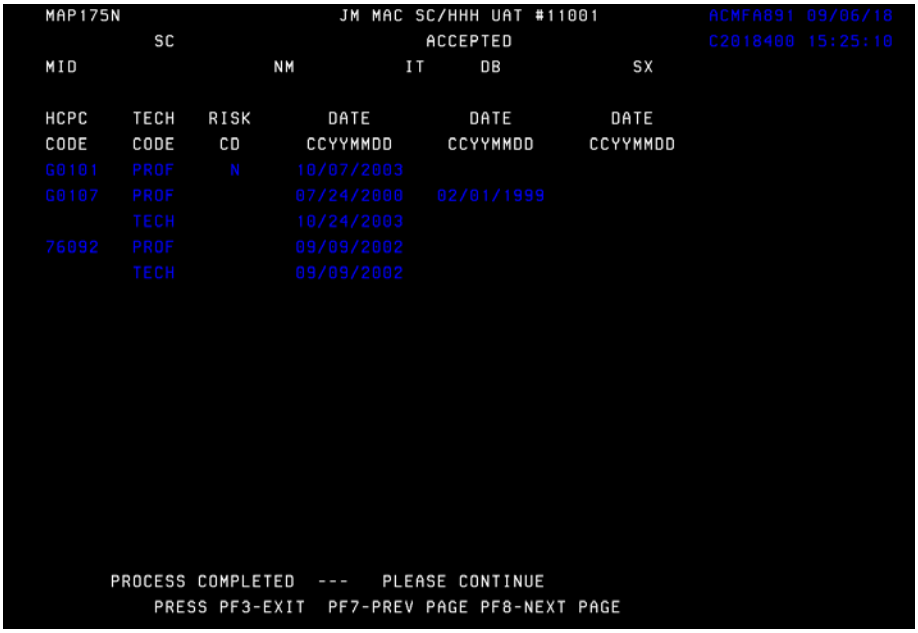

Figure 15 – Beneficiary/CWF Screen 14

Field Name	Description
MID	The beneficiary/patient's Medicare number as it appears on the Medicare ID card
NM	The last name of the beneficiary/patient.
IT	The first initial of the beneficiary/patient name.
DB	The date of birth of the beneficiary/patient.
SX	Sex of the beneficiary/patient. Valid values: F = Female M = Male
HCPC CODE	This field identifies the Healthcare Common Procedure Code (HCPC). This is a five-position alphanumeric field.
TECH CODE	The technical code that corresponds with the HCPC code (e.g., professional). This is a four-position alphanumeric field.
RISK CD	This field identifies the breast cancer risk indicator for the beneficiary. This is a one-position alphanumeric field. The valid values are: Valid values are: Y – High Risk N – Not High Risk
DATE	The first date field identifies the date the HCPC code was returned from CWF. This is a ten-position alphanumeric field in CCYY/MM/DD format.

Screen 15 (MAP175O) – Field descriptions are provided in the table following Figure 16.

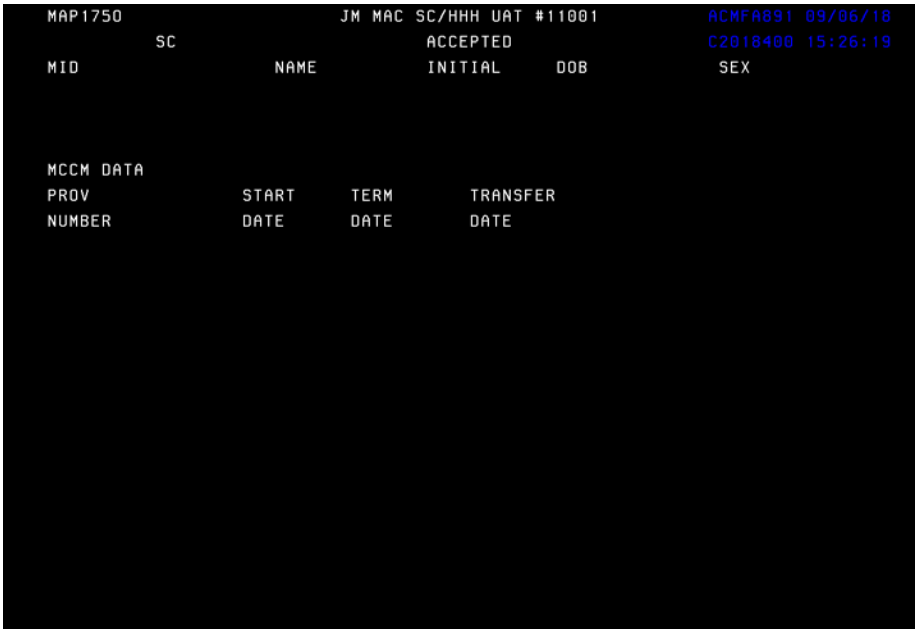

Figure 16 – Beneficiary/CWF Screen 15

Field Name	Description
MID	The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
NAME	The last name of the beneficiary/patient.
INITIAL	The first initial of the beneficiary/patient first name.
DOB	The date of birth of the beneficiary/patient.
SEX	Sex of the beneficiary/patient. Valid values: F = Female M = Male
MCCM Data	The Medicare Choices Model (MCCM) data for hospice providers
PROV NUMBER	This field displays the identification number assigned by Medicare to the Hospice provider. This is a thirteen-position alphanumeric field.
START DATE	This field identifies the beginning date of a beneficiary's election of the MCCM Hospice provider. This is a six-position alphanumeric field in MMDDYY format.
TERM DATE	This field identifies the ending date of a beneficiary's election of the MCCM Hospice provider. This is a six-position alphanumeric field in MMDDYY format.
TRANSFER DATE	This field identifies the date of the MCCM Hospice provider change of ownership. This is a six -position alphanumeric field in MMDDYY format.

Screen 16 (MAP175P) – Field descriptions are provided in the table following Figure 17.

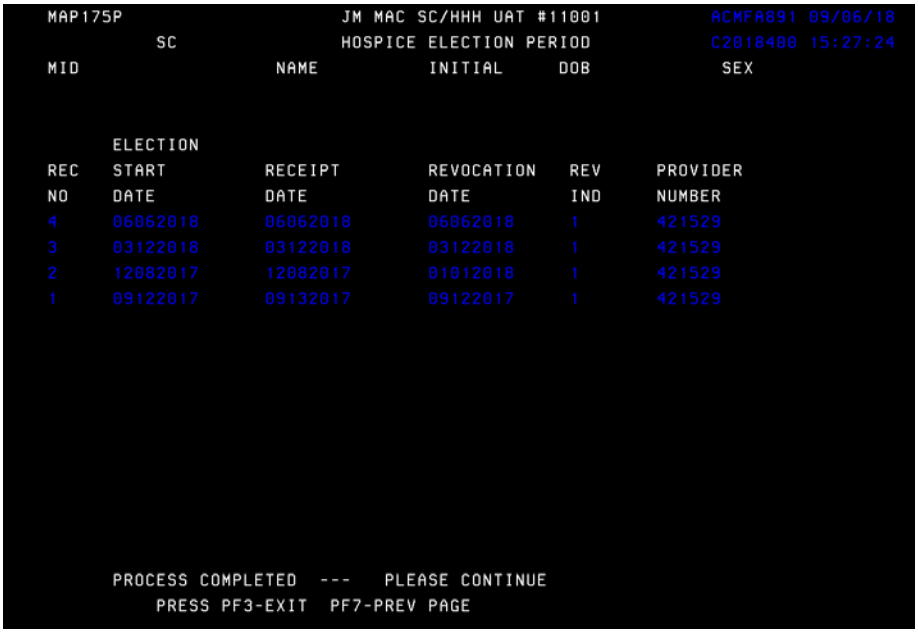

Figure 17 – Beneficiary/CWF Screen 16

Field Name	Description
MID	The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
NAME	The last name of the beneficiary/patient.
INITIAL	The first initial of the beneficiary/patient first name.
DOB	The date of birth of the beneficiary/patient.
SEX	Sex of the beneficiary/patient. Valid values: F = Female M = Male
REC NO	This identifies the number of election periods.
ELECTION START DATE	The date the beneficiary/patient elected the Medicare hospice benefit as reported on the Notice of Election (NOE), Type of Bill (TOB) 8XA.
RECEIPT DATE	The date the NOE was received and accepted in the Medicare system.
REVOCATION DATE	The date the beneficiary/patient was discharged from or revoked the Medicare hospice benefit.
REV IND	**Revocation Indicator** – Indicates if a beneficiary/patient has been discharged or revoked hospice benefits for the election period. Valid values are: 0 = Beneficiary/patient has not been discharged or revoked hospice benefits. 1 = Beneficiary/patient has been discharged or revoked hospice benefits. 2 = Beneficiary/patient has been discharged or revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.
PROVIDER NUMBER	The provider from which the beneficiary/patient has elected for hospice benefit. This is the assigned Medicare provider number.

3.B. DRG (Pricer/Grouper)

Select option '11' from the Inquiry Menu to access the DRG/PPS Inquiry screen (MAP1781 & MAP178B). The DRG/PPS Inquiry screen displays detailed payment information calculated by the Pricer and Grouper software programs. Its purpose is to provide specific DRG assignment and PPS payment calculations. It should be used to research PPS information as it pertains to an inpatient stay.

To start the inquiry process, enter the following information:

- Diagnosis code
- Procedure code
- Sex
- Century indicator
- Discharge status
- Date of Discharge
- Provider number
- Review code
- Total charges
- Date of birth **or** age
- Approved length of stay (LOS)
- Covered days
- Number of lifetime reserve days

[TAB] to move between fields on the screen. *Only press* **[ENTER]** *when all fields have been completed.*

3.B.1. DRG/PPS Inquiry Screen

DRG PPS Screen (MAP1781) – Field Descriptors are in the table that follows Figure 18.

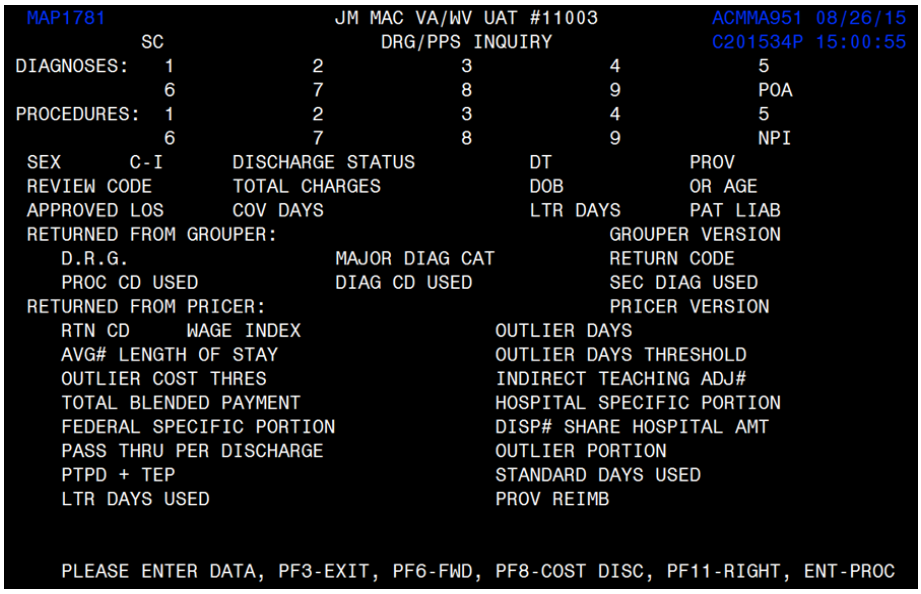

Figure 18 – DRG/PPS Inquiry Screen

Field Name	Description
DIAGNOSES (1 – 9)	Diagnosis Codes – Seven-character alphanumeric fields that identify up to nine codes for coexisting conditions on a particular claim. The *admitting* diagnosis is not entered.
PROCEDURES (1 – 9)	Procedure Codes – Required for inpatient claims. Seven-digit field identifying the principle procedure (first) and up to eight additional procedures.
POA	This field identifies the last character of the Present on Admission (POA) indicator. Valid values are: 'Z' – The end of POA indicators for principal and, if applicable, other diagnoses 'X' – The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' – Not acute care, POA's do not apply
NPI	The provider's National Provider Identifier (NPI) number.
SEX	The Beneficiary/patient's Sex
C-I	Century Indicator – If you enter D.O.B. (date of birth), you must enter the century indicator. Valid values are: 8 =1800-1899 9 =1900-1999 2 = 2000
DISCHARGE STATUS	The Beneficiary/patient's Discharge Status Code. Refer to UB-04 Manual for valid values.
DT	The date the beneficiary/patient was discharged in MMDDYY format.

Field Name	Description
PROV	The provider's Medicare provider number.
REVIEW CODE	Indicates the code used in calculating the standard payment. Valid values are: 00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers 01 = Pay days outlier – Calculates standard payment and the day outlier portion of the payment if the covered days exceed the outlier cutoff for DRG 02 = Pay cost outlier – Calculates the standard payment and the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold; if the length of stay exceeds the outlier cutoff, no payment is made and a return code of '60' is returned 03 = Pay per diem days – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if the covered days equal or exceed the average length of stay the standard payment is calculated – It also calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers 05 = Pay transfer with cost – Pays transfer with cost outlier approved 06 = Pay transfer no cost – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate any cost outlier portion of the payment 07 = Pay without cost – Calculates the standard payment without cost portion 09 =Pay transfer special DRG post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will calculate the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 11 =Pay transfer special DRG no cost post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate the cost outlier portion of the payment
TOTAL CHARGES	The total covered charges submitted on the claim.
DOB	The beneficiary/patient's date of birth (MMDDYYYY format).
OR AGE	The beneficiary/patient's age at the time of discharge. This field may be used instead of the date of birth and century indicator.
APPROVED LOS	The approved length of stay (LOS) is necessary for the Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases, to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay.
COV DAYS	The number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary/patient.
LTR DAYS	The number of lifetime reserve days. This 2-digit field may be left blank.

Field Name	Description
PAT LIAB	The Patient Liability Due identifies the dollar amount owed by the beneficiary/patient to cover any coinsurance days or non-covered days or charges.

After the DRG has been assigned by the system and the PPS payment has been determined, the following information will be displayed on the screen under RETURNED FROM GROUPER or RETURNED FROM PRICER.

Field Name	Description
GROUPER VERSION	The program identification number for the Grouper program used.
D.R.G.	The DRG code assigned by the CMS grouper program using specific data from the claim, such as length of stay, covered days, sex, age, diagnosis and procedure codes, discharge data and total charges.
MAJOR DIAG CAT	Identifies the category in which the DRG resides. Valid values are: 01 = Diseases and Disorders of the Nervous System 02 = Diseases and Disorders of the Eye 03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat 04 = Diseases and Disorders of the Respiratory System 05 = Diseases and Disorders of the Circulatory System 06 = Diseases and Disorders of the Digestive System 07 = Diseases and Disorders of the Hepatobiliary System and Pancreas 08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue 09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast 10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders 11 = Diseases and Disorders of the Kidney and Urinary Tract 12 = Diseases and Disorders of the Male Reproductive System 13 = Diseases and Disorders of the Female Reproductive System 14 = Pregnancy, Childbirth, and the Puerperium 15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period 16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders 17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms 18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites) 19 = Mental Diseases and Disorders 20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders 21 = Injuries, Poisonings, and Toxic Effects of Drugs 22 = Burns 23 = Factors Influencing Health Status and Other Contacts with Health Services 24 = Multiple Significant Trauma 25 = Human Immunodeficiency Viral Infections
RETURN CODE	The Return Code reflects the status of the claim when it has returned from the Grouper Program. This is a one-digit alphanumeric field.
PROC CD USED	Procedure code(s) that identify the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims.
DIAG CD USED	Identifies the primary diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	Diagnosis code used by the Grouper program for calculation.
Returned From Pricer	
PRICER VERSION	The program version number for the Pricer program used.
RTN CD	A Return Code that identifies the status of the claim when it has returned from the Pricer program.

Field Name	Description
WAGE INDEX	Provider's wage index factor for the state where the services were provided to determine reimbursement rates for the services rendered.
OUTLIER DAYS	The number of outlier days that exceed the cutoff point for the applicable DRG.
AVG # LENGTH OF STAY	The predetermined average length of stay for the assigned DRG.
OUTLIER DAYS THRESHOLD	Shows the number of days of utilization permissible for this claim's DRG code. Day outlier payment is made when the length of stay (including days for a beneficiary/patient awaiting SNF placement) exceeds the length of stay for a specific DRG plus the CMS-mandated adjustment calculation.
OUTLIER COST THRES	Additional payment amount for claims with extraordinarily high charges. Payment is based on the applicable Federal rate percentage times 75% of the difference between the hospital's cost for the discharge and the threshold established for the DRG.
INDIRECT TEACHING ADJ#	The amount of adjustment calculated by the Pricer for teaching hospitals.
TOTAL BLENDED PAYMENT	The total PPS payment amount consisting of the Federal, hospital, outlier and indirect teaching reductions (such as Gramm Rudman) or additions (such as interest).
HOSPITAL SPECIFIC PORTION	The hospital portion of the total blended payment.
FEDERAL SPECIFIC PORTION	The Federal portion of the total blended payment.
DISP# SHARE HOSPITAL AMT	The percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also SSI.
PASS THRU PER DISCHARGE	Identifies the pass through discharge cost.
OUTLIER PORTION	The dollar amount calculated that reflects the outlier portion of the charges.
PTPD + TEP	The sum of the pass through per discharge cost plus the total blended payment amount.
STANDARD DAYS USED	The number of regular Medicare Part A days covered for this claim.
LTR DAYS USED	The number of lifetime Reserve Days used during this benefit period.
PROV REIM	The actual payment amount to the provider for this claim. This will be the amount on the Remittance Advice/Voucher.

DRG PPS Screen (MAP178B) – Field Descriptors are in the table that follows Figure 19.

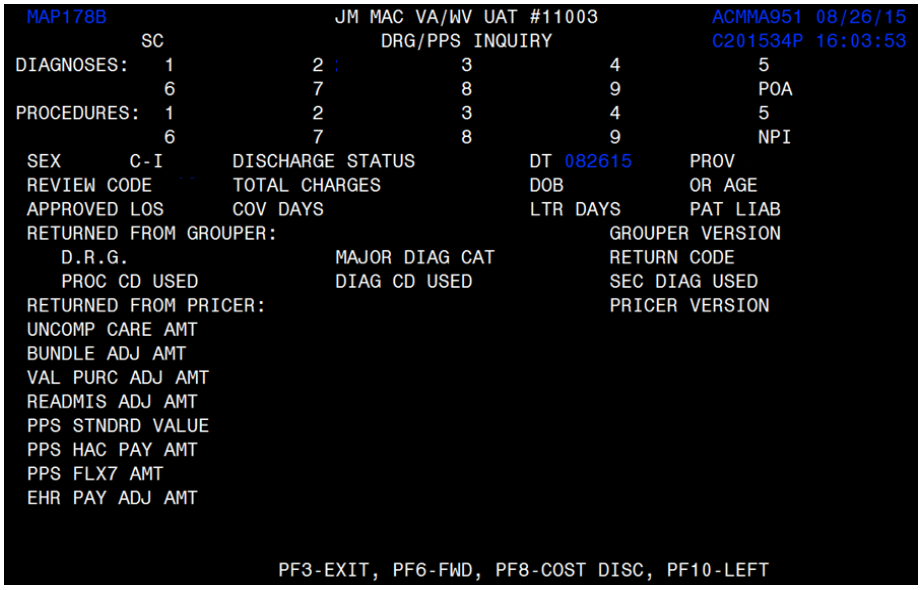

Figure 19 – DRG/PPS Inquiry Screen

The following fields on this screen will remain the same as the data that was entered on MAP1781 in Figure 18.

Field Name	Description
DIAGNOSES (1 – 9)	Diagnosis Codes – Seven-character alphanumeric fields that identify up to nine codes for coexisting conditions on a particular claim. The *admitting* diagnosis is not entered.
PROCEDURES (1 – 9)	Procedure Codes – Required for inpatient claims. Seven-digit field identifying the principle procedure (first) and up to eight additional procedures.
POA	This field identifies the last character of the Present on Admission (POA) indicator. Valid values are: 'Z' – The end of POA indicators for principal and, if applicable, other diagnoses 'X' – The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' – Not acute care, POA's do not apply
NPI	The provider's National Provider Identifier (NPI) number.
SEX	The Beneficiary/patient's Sex
C-I	Century Indicator – If you enter D.O.B. (date of birth), you must enter the century indicator. Valid values are: 8 =1800-1899 9 =1900-1999 2 = 2000
DISCHARGE STATUS	The Beneficiary/Patient's Discharge Status Code. Refer to UB-04 Manual for valid values.
DT	The date the beneficiary/patient was discharged in MMDDYY format.
PROV	The provider's Medicare provider number.
REVIEW CODE	Indicates the code used in calculating the standard payment. Valid values are: 00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers 01 = Pay days outlier – Calculates standard payment and the day outlier portion of the payment if the covered days exceed the outlier cutoff for DRG

Field Name	Description
	02 = Pay cost outlier – Calculates the standard payment and the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold; if the length of stay exceeds the outlier cutoff, no payment is made and a return code of '60' is returned 03 = Pay per diem days – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if the covered days equal or exceed the average length of stay the standard payment is calculated – It also calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers 05 = Pay transfer with cost – Pays transfer with cost outlier approved 06 = Pay transfer no cost – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate any cost outlier portion of the payment 07 = Pay without cost – Calculates the standard payment without cost portion 09 =Pay transfer special DRG post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will calculate the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 11 =Pay transfer special DRG no cost post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate the cost outlier portion of the payment
TOTAL CHARGES	The total covered charges submitted on the claim.
DOB	The beneficiary/patient's date of birth (MMDDYYYY format).
OR AGE	The beneficiary/patient's age at the time of discharge. This field may be used instead of the date of birth and century indicator.
APPROVED LOS	The approved length of stay (LOS) is necessary for the Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases, to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay.
COV DAYS	The number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary/patient.
LTR DAYS	The number of lifetime reserve days. This 2-digit field may be left blank.
PAT LIAB	The Patient Liability Due identifies the dollar amount owed by the beneficiary/patient to cover any coinsurance days or non-covered days or charges.

The information displayed under the RETURNED FROM GROUPER on this screen will be the same as the data returned after the DRG was calculated on MAP1781 in Figure 18.

Field Name	Description
GROUPER VERSION	The program identification number for the Grouper program used.
D.R.G.	The DRG code assigned by the CMS grouper program using specific data from the claim, such as length of stay, covered days, sex, age, diagnosis and procedure codes, discharge data and total charges.
MAJOR DIAG CAT	Identifies the category in which the DRG resides. Valid values are: 01 = Diseases and Disorders of the Nervous System 02 = Diseases and Disorders of the Eye 03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat 04 = Diseases and Disorders of the Respiratory System 05 = Diseases and Disorders of the Circulatory System 06 = Diseases and Disorders of the Digestive System 07 = Diseases and Disorders of the Hepatobiliary System and Pancreas 08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue 09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast 10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders 11 = Diseases and Disorders of the Kidney and Urinary Tract 12 = Diseases and Disorders of the Male Reproductive System 13 = Diseases and Disorders of the Female Reproductive System 14 = Pregnancy, Childbirth, and the Puerperium 15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period 16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders 17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms 18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites) 19 = Mental Diseases and Disorders 20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders 21 = Injuries, Poisonings, and Toxic Effects of Drugs 22 = Burns 23 = Factors Influencing Health Status and Other Contacts with Health Services 24 = Multiple Significant Trauma 25 = Human Immunodeficiency Viral Infections
RETURN CODE	The Return Code reflects the status of the claim when it has returned from the Grouper Program. This is a one-digit alphanumeric field.
PROC CD USED	Procedure code(s) that identifies the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims.
DIAG CD USED	Identifies the primary diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	Diagnosis code used by the Grouper program for calculation.

The Returned from Pricer data displayed on this screen will be as follows:

Field Name	Description
GROUPER VERSION	The program identification number for the Grouper program used.
PRICER VERSION	The program version number for the Pricer program used.
UNCOMP CARE AMT	**Uncompensated Care Payment Amount**: This is the amount published by CMS to the MACs (by provider) entitled to an uncompensated care payment amount add on. The MACs enter the amount for each Federal Fiscal year begin date, 10/01, based on published information. This is an eleven-digit field in 9999999.99 format.

Field Name	Description
BUNDLE ADJ AMT	This field identifies the adjustment amount for hospitals participating in the Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61). This is an eleven-digit field in 9999999.99 format.
VAL PURC ADJ AMT	This field identifies the adjustment amount for hospitals participating in the Value Based Purchase Program. This is an eleven-digit field in 9999999.99 format.
READMIS ADJ AMT	This field identifies the reduction adjustment for those hospitals participating in the Hospital Readmissions Reduction program. This is an eleven-digit field in 9999999.99 format.
PPS STNDRD VALUE	This field identifies the final standardized amount. This value is returned from the IPPS Pricer for claims that meet the criteria identified in specification S0580000. This is an eleven-digit field in 9999999.99- format.
PPS HAC PAY AMT	This field identifies the Hospital Acquired Condition (HAC) payment reduction amount. This is an eleven-digit field in 9999999.99 format.
PPS FLX7 AMT	This field is reserved for future use. This is an eleven-digit field in 9999999.99 format.
EHR PAY ADJ AMT	This field identifies the reduction adjustment amount for hospitals not meaningful users of EHR. This is an eleven-digit field in 9999999.99 format.

DRG Cost Disclosure Inquiry (MAP1782) – Field descriptions are provided in the table following Figure 20.

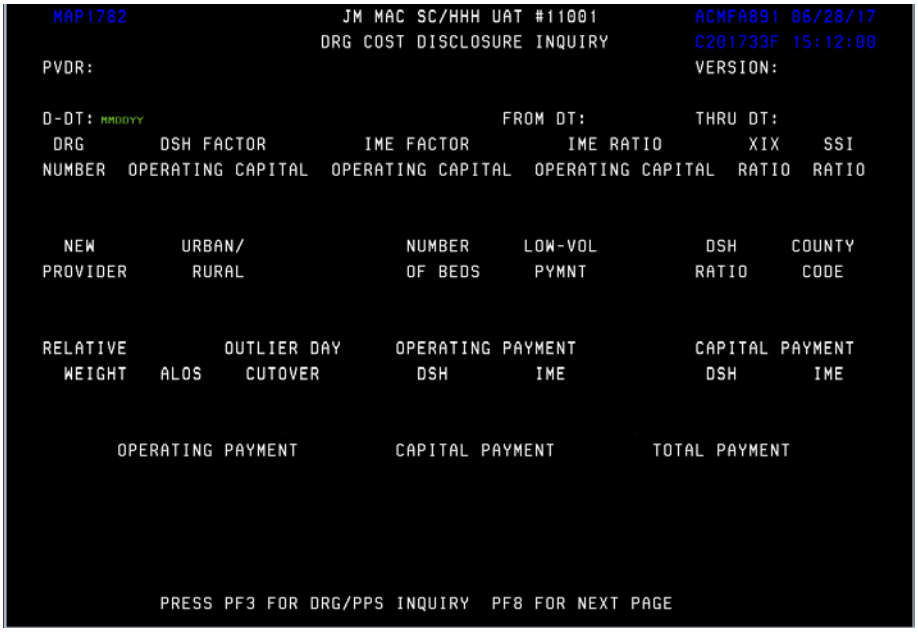

Figure 20 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	Contains the provider name
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The From Date (MMDDYY Format)
THRU DT	The Thru Date (MMDDYY Format)
DRG NUMBER	Pricer version number (five-position alphanumeric field)
DSH FACTOR OPERATING CAPITAL	Operating disproportionate share factor (five-digit field in 9.9999 format)
IME FACTOR OPERATING CAPITAL	Operating indirect medical education factor (five-digit field in 9.9999 format)

Field Name	Description
IME RATIO OPERATING CAPITAL	Operating indirect medical education ratio (five-digit field in 9.9999 format)
XIX RATIO	XIX ratio (five-digit field in 9.9999 format)
SSI RATIO	Supplemental security income ratio, which determines if the hospital qualifies for a disproportionate share adjustment (five-digit field in 9.999 format)
NEW PROVIDER	Displays whether or not the provider is a New Provider.
URBAN/RURAL	The type and location of the hospital and is determined by the DRG pricer (eleven-digit alphanumeric field). Valid values are: Large Urban Other Urban Rural
NUMBER OF BEDS	The number of beds in the facility (six-digit field in 999999 format)
LOW-VOL PYMNT	Amount calculated by the inpatient prospective payment systems (IPPS) Pricer is an estimated interim payment. This estimated interim low-volume payment amount will be adjusted at cost report settlement, if any of the payment amounts upon which the low-volume payment amount is based are recalculated at cost report settlement (for example payments for disproportionate share hospital (DSH), indirect medical education (IME), or federal rate versus hospital-specific rate payments for sole community hospitals/Medicare dependent hospitals).
DSH RATIO	The disproportionate share adjustment percentage (six-digit field in 9.9999 format)
COUNTY CODE	This field displays the County Code (five-digit numeric field).
DISPROPORTIO-NATE SHARE	The disproportionate share amount (five-digit field in 9.9999 format)
RELATIVE WEIGHT	The relative weight amount (six-digit field in 99.9999 format)
ALOS	**Average length of stay** – Identifies the CMS-predetermined LOS based on certain claim data (three-digit field in 99.9 format)
OUTLIER DAY CUTOVER	**Outlier day cutover –** Identifies the outlier day cutover amount (three-digit field in 99.9 format)
OPERATING DSH	**Operating payment disproportionate share –** Identifies the operating payment disproportionate share amount (eight-digit field in $999,999.99 format)
PAYMENT IME	**Operating payment indirect medical education –** Identifies the operating payment indirect medical education amount (eight-digit field in $999,999.99 format)
CAPITAL DSH	**Capital payment disproportionate share** – Identifies the capital payment disproportionate share amount (eight-digit field in $999,999.99 format)
PAYMENT IME	**Capital payment indirect medical education** – Identifies the capital payment indirect medical education amount (eight-digit field in $999,999.99 format)
OPERATING PAYMENT	**Operating payment –** Identifies the total amount for operating payments (eight-digit field in $999,999.99 format)
CAPITAL PAYMENT	**Capital payment** – Identifies the total amount for capital payments (eight-digit field in $999,999.99 format)
TOTAL PAYMENT	**Total Payment –** Identifies the total amount of payments (eight-digit field in $999,999.99 format)

DRG Cost Disclosure Inquiry (MAP1783) – Field descriptions are provided in the table following Figure 21.

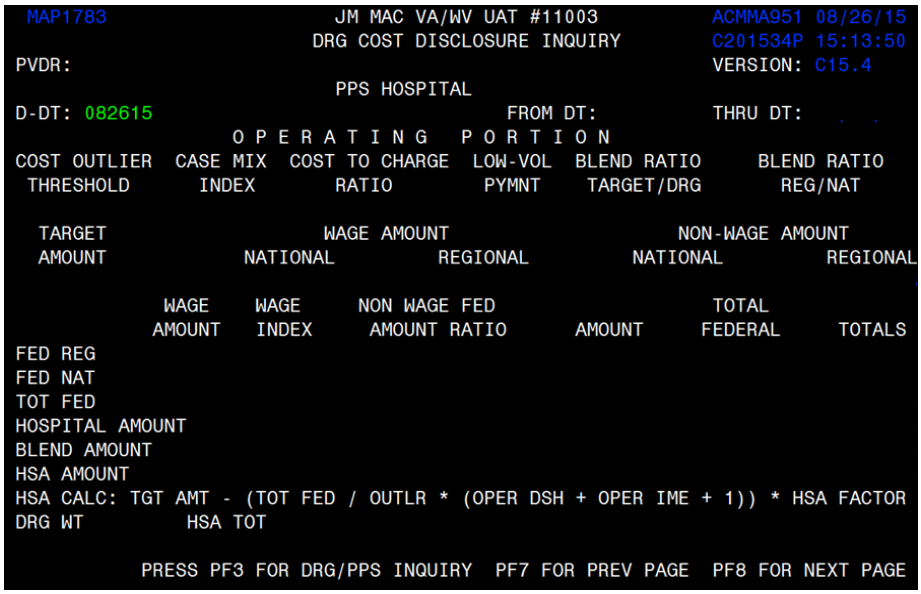

Figure 21 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	This field identifies the program version number for the Pricer program used.
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The beginning date of service (MMDDYY Format)
THRU DT	The ending date of service (MMDDYY Format)
Operating Portion	
COST OUTLIER THRESHOLD	This field identifies the cost outlier threshold amount, which is the standard operating threshold for computing cost outlier payments.
CASE MIX INDES	This field identifies the case mix index from the operating PPS base year.
COST TO CHARGE RATIO	This field identifies the Cost to Charge ratio of operating cost to charges.
LO-VOL PYMNT	This field identifies the low-volume payment amount calculated by the IPPS Pricer.
BLEND REATIO TARGET/DRG	These fields identify the ratio target amount and federal amount used during operating PPS transition periods.
BLEND RATIO REG/NAT	These fields identify the ratio of the regional amount and national amount use during the operating PPS transition periods to determine the operating federal rate.
TARGET AMOUNT	This field identifies the Target amount (the updated hospital specific rate). NOTE: This is used to determine Health Service Area (HSA) add-on amounts for sole community and Medicare dependents hospitals.
WAGE AMOUNT NATIONAL	This field identifies the national wage-related rate. It is used to determine the labor portion of the operating federal rate.
WAGE AMOUNT REGIONAL	This field identifies the regional wage-related amount.
NON-WAGE AMOUNT NATIONAL	This field identifies the national non-wage-related rate. It is used to determine the labor portion of the operating federal rate.
NON-WAGE AMOUNT REGIONAL	This field identifies the regional non-wage-related amount.

Field Name	Description
WAGE AMOUNT	This field identifies the wage-related amount.
WAGE INDEX	This field identifies the wage index as supplied by CMS to be used for the state in which the services were provided to determine reimbursement rates for the services rendered.
NON WAGE FED AMOUNT RATIO	This field identifies the Non-Wage Federal Amount Ratio.
AMOUNT	This field identifies the total amount.
TOTAL FEDERAL	This field identifies the total Federal amount.
TOTALS	This field identifies the total.
FED REG	**Federal Regional** – This field identifies the amount for columns: Wage Amount, Wage Index, Non-Wage Federal Amount Ratio, and Amount.
FED NAT	**Federal National** – This field identifies the amount for columns: Wage Amount, Wage Index, Non-Wage Federal Amount Ratio, and amount.
TOT FED	**Total Federal** – This field identifies amounts for columns Total Federal and Totals. Refer to the note for corresponding formats.
HOSPITAL AMOUNT	This field identifies amounts for columns: Amount and Totals.
BLEND AMOUNT	This field identifies amounts for columns: Wage Index, Non-Wage Federal Amount Ratio, Amount, and Totals.
HSA AMOUNT	This field identifies amounts for columns: Wage Index, Non-Wage Amount, Federal Amount Ratio, Amount, and Totals.
HAS CALC: TGT AMT – (TOT FED / OUTLR * (OPER DSH + OPER IME + 1)) * HAS FACTOR	**Health Service Area (HSA) Calculation** - This field identifies the calculation for HSA.
DRG WT	**Diagnosis Related Group Weight** – This field identifies the payment weight of the DRG.
HAS TOT	**HSA Total** – This field identifies the total of the HSA amount multiplied by the DRG Weight.

DRG Cost Disclosure Inquiry (MAP1784) – Field descriptions are provided in the table following Figure 22.

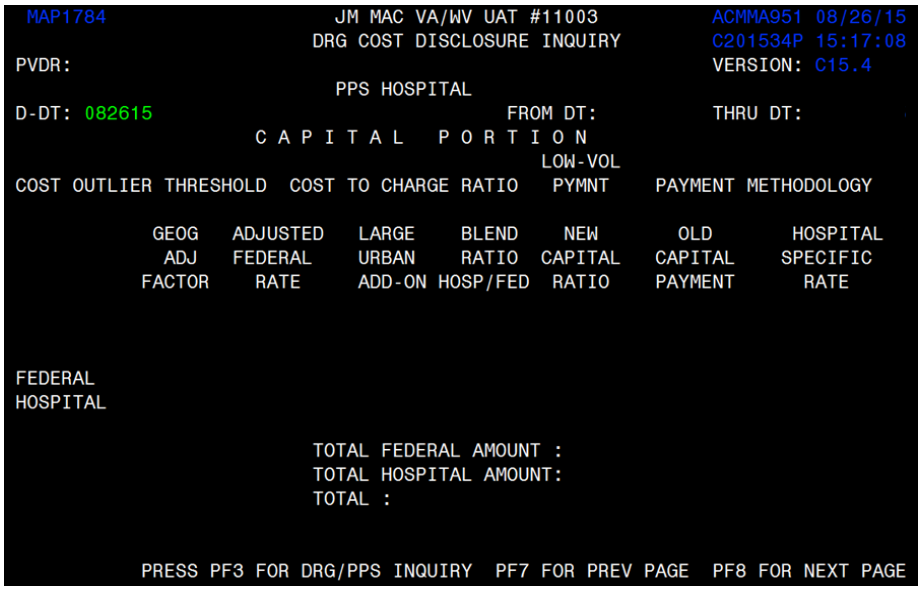

Figure 22 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	This field identifies the program version number for the Pricer program used.
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The beginning date of service (MMDDYY Format)
THRU DT	The ending date of service (MMDDYY Format)
Capital Portion	
COST OUTLIER THRESHOLD	This field identifies the cost outlier threshold amount, which is the standard operating threshold for computing cost outlier payments.
COST TO CHARGE RATIO	This field identifies the Cost to Charge ratio of operating cost to charges.
LOW-VOL PYMT	This field identifies the low-volume payment amount calculated by the IPPS Pricer.
PAYMENT METHOLODOGY	This field identifies the capital PPS payment methodology.
GEOG ADJ FACTOR	**Geographical Adjustment Factor** – This field identifies factor used to adjust the capital federal rate, based on the applicable wage index.
ADJUSTED FEDERAL RATE	This field identifies the base capital rate.
LARGE URBAN ADD-ON	This field identifies the federal rate applicable to those hospitals located in a 'large urban' SMSA.
BLEND RATIO HOSP/FED	These fields identify the ratio of the Hospital Specific Rate (HSR) and the federal rate used to compute capital payments under PPS.
NEW CAPITAL RATIO	This field identifies new capital to total capital and is applicable for hospitals being reimbursed under the hold harmless payment method for capital.
OLD CAPITAL PAYMENT	This field identifies the old capital cost per discharge as provided by the hospital or as provided by the latest filed cost report under capital PPS and is applicable for those hospitals being reimbursed under the hold harmless payment method for capital.
HOSPITAL SPECIFIC RATE	This field identifies the capital base period cost per discharge updated to applicable fiscal year-end.
Federal Hospital	

Field Name	Description
TOTAL FEDERAL AMOUNT	This field identifies the Total Federal amount.
TOTAL HOSPITAL AMOUNT	This field identifies the Total Hospital amount.
TOTAL	This field identifies the total Federal and Hospital amounts.

DRG Cost Disclosure Inquiry (MAP1785) – Field descriptions are provided in the table following Figure 23.

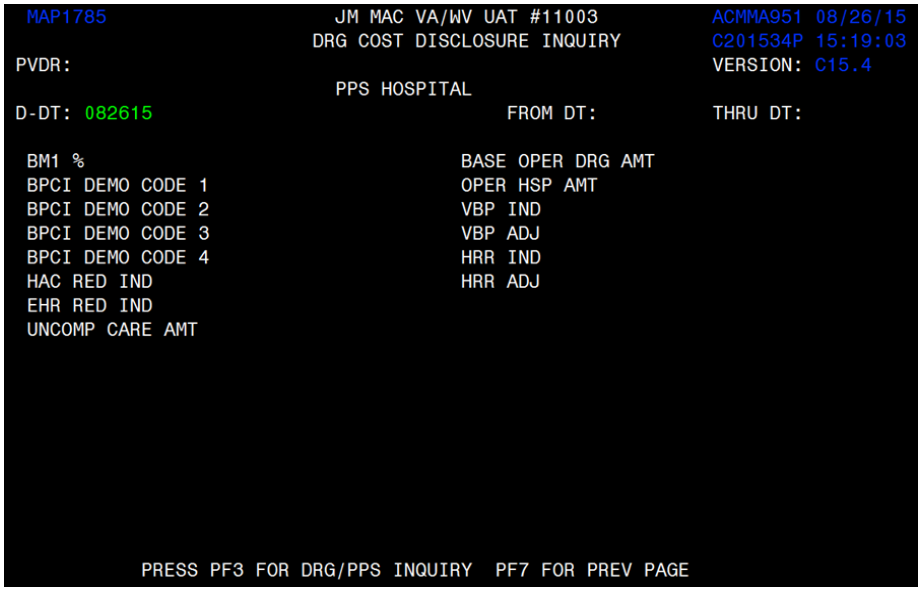

Figure 23 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	This field identifies the program version number for the Pricer program used.
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The beginning date of service (MMDDYY Format)
THRU DT	The ending date of service (MMDDYY Format)
BM1%	This field identifies the Bundle Model 1 Discount Percentage. This is a two-position alphanumeric field in .99 format.
BASE OPER DRG AMT	This field identifies the Base Operating DRG Payment Amount. This is the amount a hospital would normally receive for the discharge of a Medicare beneficiary/patient.
BPCI DEMO Code 1	This field identifies the Bundled Payment for Care Improvement Indicator. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
OPER HSP AMT	**Operating HSP Amount** – This field identifies the Operating HSP (Hospital Specific Payment) DRG amount.
BPCI DEMO CODE 2	This field identifies the Bundled Payment for Care Improvement Indicator 2. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4

Field Name	Description
VBP IND	This field identifies the Value Based Pricing Indicator. This is a one-position alphanumeric field, and the valid values are 'Y' or 'N'.
BPCI DEMO CODE 3	This field identifies the Bundled Payment for Care Improvement Indicator 3. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
VBP ADJ	This field identifies the Value Based Pricing Adjustment.
BPCI DEMO 4	This field identifies the Bundled Payment for Care Improvement Indicator 4. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
HRR IND	This field identifies the Hospital Readmission Reduction (HRR) Program Indicator. This is a one-position alphanumeric field, and the valid values are '0' through '9'.
HAC RED IND	This field is reserved for future use. This is a one-position alphanumeric field. The valid values for IPPS are: Blank = Hospital Acquired Condition Reduction Program – Non PPS N = Hospital Acquired Condition Reduction Program - PPS
HRR ADJ	**Hospital Readmission (HPR)** Adjustment: This field identifies the HRR adjustment. This is a six-digit field in 9.9999 format.
HER RED IND	**Electronic Health Record Adjustment Reduction Indicator**: This field identifies the HER adjustment reduction indicator for providers that are subject to claim adjustments when the provider does not meet the guidelines for use of EHR technology. This is a one-position alphanumeric field. Valid values are: ▪ Y = Reduction applies ▪ Blank = Reduction does not apply
UNCOMP CARE AMT	**Uncompensated Care Payment Amount**: This is the amount published by CMS to the MACs (by provider) entitled to an uncompensated care payment amount add on. The MACs enter the amount for each Federal Fiscal year begin date, 10/01, based on published information. This is a ten-digit field in 9999999.99 format.

3.C. Claims Summary Inquiry

Select option '12' from the Inquiry Menu to access the Claims Summary Inquiry screen (MAP1741). The Claims Summary Inquiry screen displays specific claim history information for *all* **pending** (RTP claims, MSP claims, Medical Review claims) and **processed** (paid, rejected, denied) claims. The claim status information is available on-line for viewing immediately after the claim is updated/entered on DDE. The entire claim (six pages) can be viewed on-line through the claim inquiry function **but it cannot be updated from this screen.**

Common status and location codes (S/LOC) (see Section 1 for more information) are listed in the following table.

Code	Description
P B9996	Payment Floor.
P B9997	Paid/Processed Claim.
P B7501	Post-Pay Review.
P B7505	Post-Pay Review.
R B9997	Claims Processing Rejection.
D B9997	Medical Review Denial.
T B9900	Daily Return to Provider (RTP) Claim – Not yet accessible.

Code	Description
T B9997	RTP Claim – Claim may be accessed and corrected through the Claim and Attachments Corrections Menu (Main Menu Option 03).
S B0100	Beginning of the FISS batch process.
S B6000	Claims awaiting the creation of an Additional Development Request (ADR) letter. [Do not press [F9] on these claims because the FISS will generate another ADR.]
S B6001	Claims awaiting a provider response to an ADR letter.
S B9000	Claims ready to go to a Common Working File (CWF) Host Site.
S B9099	Claims awaiting a response from a CWF Host Site.
S M0nnn	Suspended claims/adjustments requiring Palmetto GBA staff intervention (the 'n' denotes a variety of FISS location codes).

3.C.1. Performing Claims Inquiries

1. To start the inquiry process, enter the beneficiary/patient's Medicare number, or leave out the beneficiary/patient's Medicare number and enter any of the following fields:
   - Type of bill (TOB)
   - S/LOC
   - Type an '**S**' in the first position of the S/LOC field to view all the suspended claims
   - Type a '**P**' in the first position of the S/LOC field to view all the paid/processed claims
   - Type a '**T**' in the first position of the S/LOC field to view claims returned for correction
   - Type an '**R**' in the first position of the S/LOC field to view all the rejected claims.
   - From Date (optional field – enter a date if you only want to view claims within a certain date range)
   - To Date (optional field – enter a date only if you want to view claims within a certain date range)
   - Type the claim Document Control Number (DCN) for a specific claim you want to view
2. Once the appropriate claim history displays, type an '**S**' in the SEL field in front of the claim you wish to view.
3. Press **[ENTER]** to display the DDE electronic claim. The Claim Summary Inquiry screen (Figure 24) will display.

Claim Summary Inquiry (MAP1741) – Field descriptions are provided in the table following Figure 24.

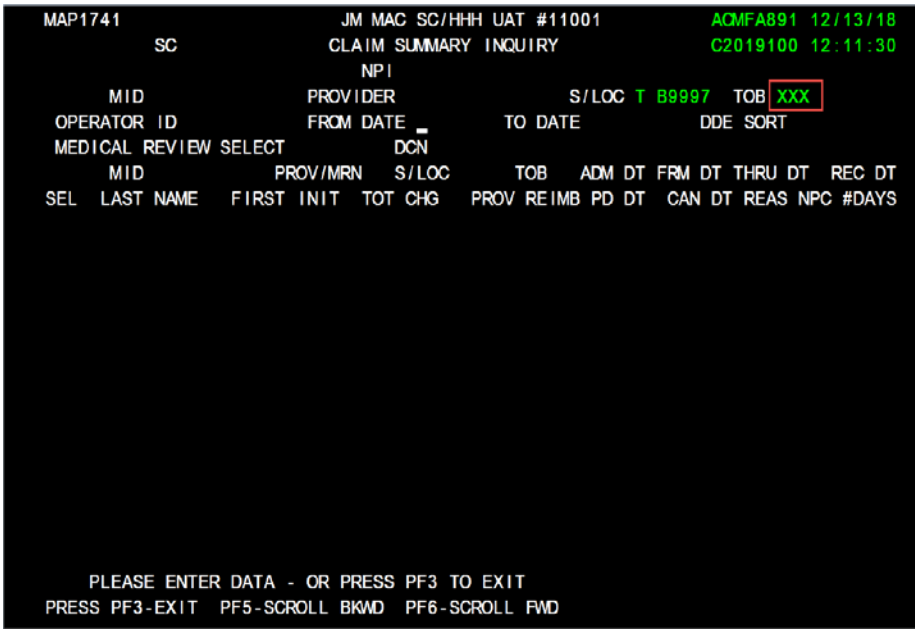

Figure 24 – Claim Summary Inquiry (MAP1741)

Certain information is already completed, including the provider number, the status/location where RTP claims are stored (T B9997), and the first two digits of the type of bill. To narrow the selection, enter any or all of the information in the following table.

Field Name	Description
DDE SORT	Allows multiple sorting of displayed information. Valid values include: ' ' = TOB/DCN (Current default sorting process, S/LOC, Name) M = Medical Record number sort (Ascending order, Medicare Number) N = Name sort (Alpha by last name, first initial, Receipt Date, MR#, Medicare Number) H = Medicare Number sort (Ascending order, Receipt Date, MR#) R = Reason Code sort (Ascending Order, Receipt Date, MR#, Medicare Number) D = Receipt Date sort (Oldest Date displaying first, MR#, Medicare Number)
MEDICAL REVIEW SELECT	Used to narrow the claim selection for inquiry. This will provide the ability to view pending or returned claims by medical review category. Valid values include: ' ' = Selects all claims 1 = Selects all claims 2 = Selects all claims excluding Medical Review 3 = Selects Medical Review only

Note: You may only select one claim at the time.

3.C.2. Viewing an Additional Documentation Request (ADR) Letter

An ADR is an additional documentation request for medical records. Palmetto GBA's medical review department uses ADR's to request medical records from providers during the medical review process. Do the following to view an ADR letter for claims in the ADR status/location:

1. Type '**S B6**' in the S/LOC field.
2. Press **[ENTER]** and all claims in an S B6000 or S B6001 status/location will display.
3. Claims in S B6000 **do not** have an ADR letter attached. Providers should not take any action until or unless the claim moves to status/location S B6001.Type an '**S**' in the SEL field of the desired claim and press **[ENTER]**.

Claim Summary Inquiry screen (MAP1741) – Field descriptions are provided in the table following Figure 25.

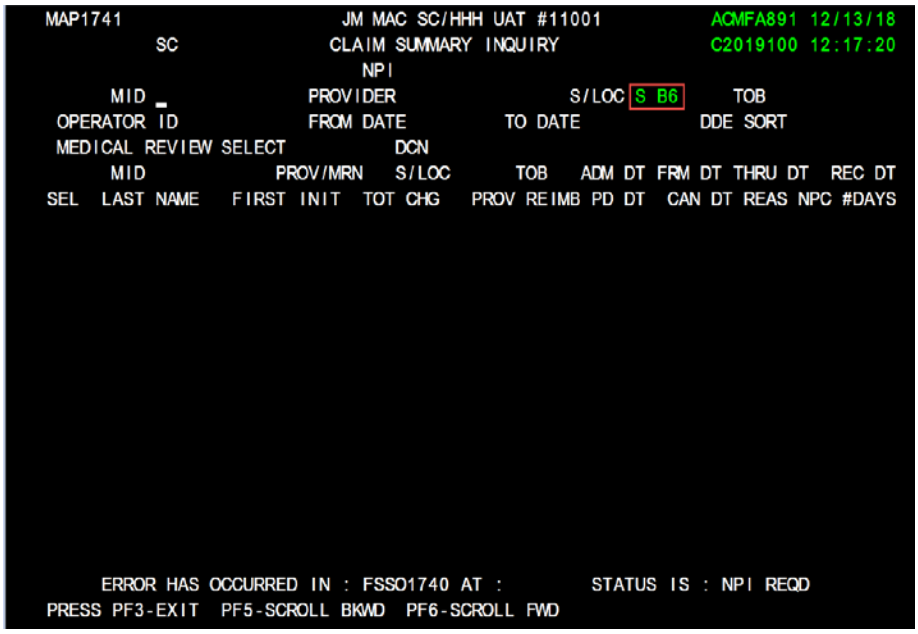

Figure 25 – Claim Summary Inquiry Screen (MAP1741)

Field Name	Description
NPI	This field identifies the National Provider Identifier number.
MID	Type the beneficiary's Medicare number to view a particular beneficiary/patient's claims data.
PROVIDER	Your Medicare ID number will automatically display. **Note:** If your facility has sub-units/aliases (e.g., SNF, ESRD, CORF, ORF) the provider number of the sub-unit must be typed in this field. If the correct provider number associated with the claim you wish to view is not entered, an error message PROCESS COMPLETE --- NO MORE DATA THIS TYPE will be received.
S/LOC	Status and location allows you to type a particular status and location you want to view. See Section 1 for more information regarding status and location codes.
TOB	Type of bill allows you to enter a particular type of bill you want to view. The TOB field consists of 3 digits. The first position indicates the type of facility. The second indicates the type of care. The third position indicates the bill frequency. The first two positions are required for a search.
OPERATOR ID	Operator ID is automatically displayed and indicates the individual who accessed the screen.
FROM DATE	Type the 'From Date' of service you want to view (in MMDDYY format).
TO DATE	Type the 'To Date' of service you want to view (in MMDDYY format).
DDE SORT	This field allows the listed claims to be sorted according to specific criteria. Note: This is only accessible in Claims Correction mode.
MEDICAL REVIEW SELECT	This field is used to narrow the claim selection for inquiry. This provides the ability to view only claims pending or returned for medical review. Note: This field is only accessible in Claims Correction mode.
DCN	Type the Document Control Number (DCN) you want to view
SEL	This field is used to select a claim to view or update. Tab down to the claim and enter an 'S' to view or a 'U' to update. Note: When this screen appears, this field is blank.
First Line Of Data	
MID	Beneficiary/Patient's Medicare number as it was originally typed.

Field Name	Description
PROV/MRN	Medicare provider number/Medical Record Number assigned to the facility by CMS. MRN-USED IN Claims Correction mode.
S/LOC	The status/location code assigned to the claim by the FISS.
TOB	The type of facility, bill classification and frequency of the claim in a particular period of care.
ADM DT	The admission date on the claim.
FRM DT	The 'From Date' on the claim.
THRU DT	The 'Through Date' on the claim.
REC DT	The date the claim was received in the FISS.
Second Line Of Data	
SEL	Type an '**S**' under this field to the left of a specific claim to select that claim. Press [ENTER] to display 'detailed' claim information for the claim you selected. See the Claim Entry section of the *DDE User's Guide* for descriptions of the fields on the entire claim inquiry screen.
LAST NAME	The beneficiary/patient's last name.
FIRST INIT	The beneficiary/patient's first initial.
TOT CHG	The total charges billed on the claim.
PROV REIMB	The provider's reimbursement amount. This field is signed to indicate positive or negative amounts.
PD DT	The date the claim was paid, partially paid, or processed.
CAN DT	The date the claim was canceled.
REAS	Reason code assigned by the FISS (refer to the on-line reason code file).
NPC	Non-payment code used by the system to deny or reject charges. Valid values are: 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 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) T = MSP Initial Enrollment Questionnaire (Contractor 11101) U = MSP HMO Cell Rate Adjustment (Contractor 55555) U = HMO/Rate Cell (Contractor 11103) V = MSP Litigation Settlement (Contractor 33333) 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)

Field Name	Description
#DAYS	Not available in inquiry mode.

4. The ADR letter immediately follows claim page 6 (MAP1716). Press [F8] twice from claim page 6 to view the ADR letter. The ADR will consist of 2 or more pages. Press the [F6] key to page forward through the letter. Note: Do not use the [F9] function key with these claims. If you press [F9], the FISS will generate a new ADR.

INST Claim Inquiry Screen, Page 6 (MAP1716) – Field descriptions are provided in the tables following Figure 26.

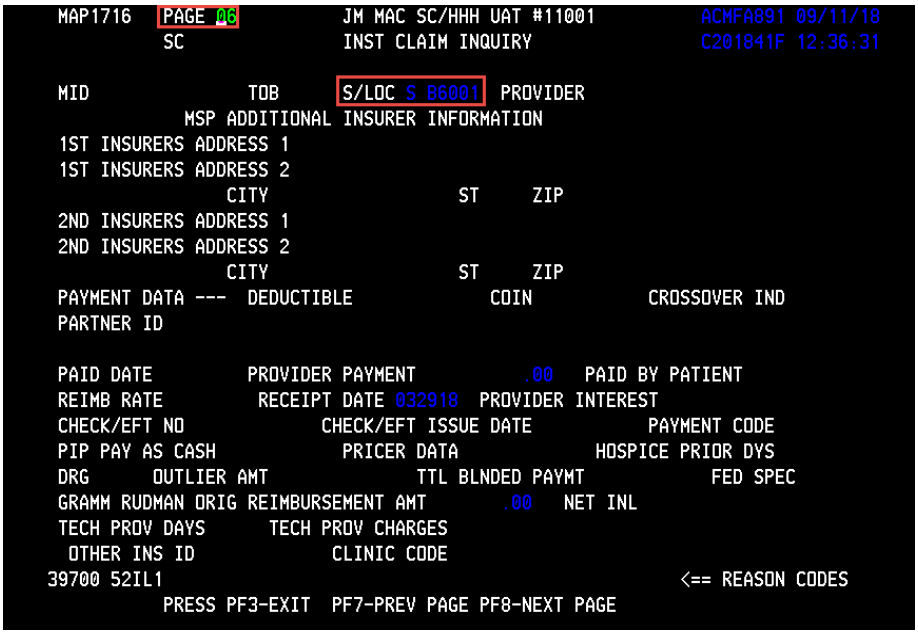

Figure 26 – UB-04 Claim Inquiry, Page 6

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.
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.

INST Claim Inquiry Screen, Page 6 (MAP1716) – Field descriptions are provided in the tables following Figure 27

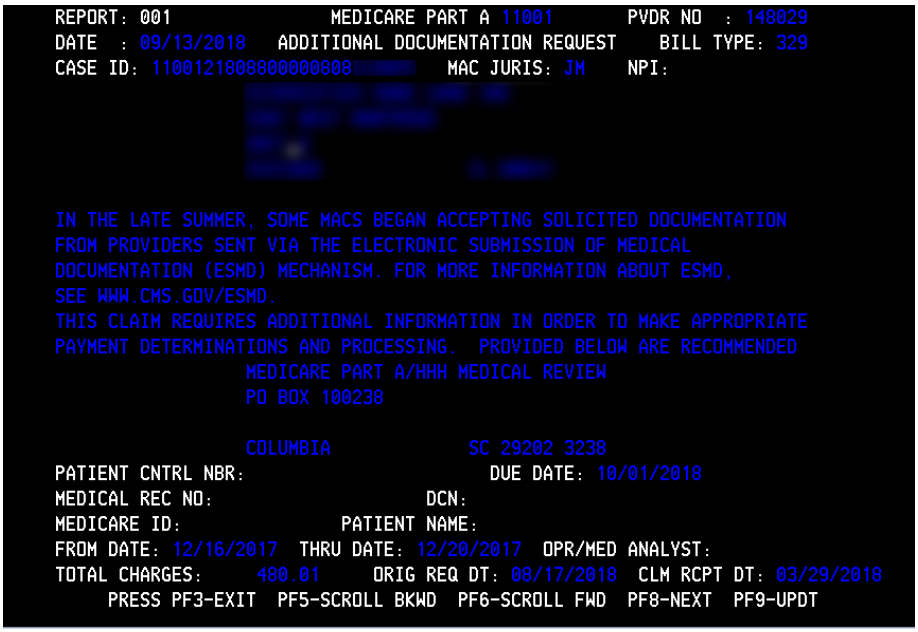

Figure 27 – UB-04 Claim Inquiry, ADR Letter Page 1

Field Name	Description
DATE	The date that the letter was accessed in the DDE system.
ADDITIONAL DOCUMENTATION REQUEST	Title only. No data is displayed.
BILL TYPE	The Type of Bill (TOB) for which the ADR letter was generated.
CASE ID	The case identification number assigned to the ADR for the claim selected for review.
MAC JURIS	The Medicare Administrative Contractor (MAC) jurisdiction in which the ADR letter was generated.
NPI	The provider's National Provider Identifier (NPI) of the provider for which the ADR letter was generated
Untitled	The provider address to which the ADR letter was mailed.
Untitled	The beginning of the body of the letter.
PATIENT CNTRL NBR	The Patient Control Number, if present, that was submitted on the claim.
DUE DATE	The date that the response to the ADR letter is due to Medicare.
MEDICARE ID	The beneficiary/patient's Medicare number.
PATIENT NAME	The name of the Medicare beneficiary/patient identified on the claim that was selected for review.
FROM DATE	The "From" date reported on the claim in the Statement Covers field for the claim that was selected for review.
THRU DATE	The "Through" date reported on the claim in the Statement Covers field for the claim that was selected for review.
OPR/MED ANALYST	The identification number of the analyst assigned to review the claim.
TOTAL CHARGES	The total charges submitted on the claim selected for review.
ORIG REQ DT	The date that the ADR letter was generated (the date the claim moved to status and location S B6001).
CLM RCPT DT	The date that the claim was received in the Medicare system.

3.D. Revenue Codes

Select option '**13**' from the Inquiry Menu to access the Revenue Code Table Inquiry screen. This screen provides information regarding revenue codes that are billable for certain types of bills with the Fiscal Medicare contractor's system. This should be referenced when you need to determine:

- The type of revenue codes that are allowed with certain types of bills
- If a HCPCS code is required
- If a unit is required
- If a rate is required

To start the inquiry, type in the revenue code (four digits – ex: 0550) about which you are inquiring and press **[ENTER]**.

Revenue Code Table Inquiry Screen (MAP1761) – Field descriptions are provided in the table following Figure 28.

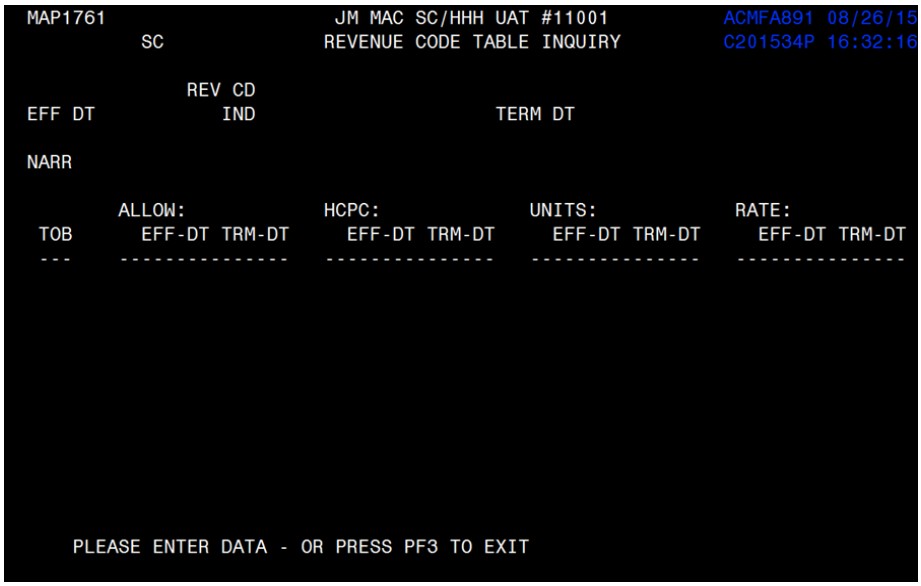

Figure 28 – Revenue Code Table Inquiry Screen

Field Name	Description
REV CD	Type the revenue code (0001-9999) that identifies a specific accommodation, ancillary service or billing calculation.
EFF DT	Date the code became effective/active.
IND	The effective date indicator instructs the system to either use the 'from' date on the claim or the System Run Date to perform edits for this revenue code. Valid codes are: F = From date R = Receipt date D = Discharge date
TERM DT	Date the code was terminated/no longer active.
NARR	English-language description of the code.
TOB	Identifies all Type of Bill codes within the Medicare Part A system that are allowed by Medicare.
ALLOW EFF-DT TRM DT	Identifies whether the revenue code is currently valid for a specific Type of Bill. Valid values are: Y = Yes N = No
HCPC EFF-DT TRM-DT	Identifies whether a Healthcare Common Procedure Code (HCPC) is required from specific types of providers for this Revenue Code by Type of Bill. Valid values are:

Field Name	Description
	Y = HCPC required for all providers N = HCPC not required V = Validation of HCPC is required F = HCPC required only for claims from free-standing ESRD facility H = HCPC required only for claims from hospital-based ESRD facility
UNITS EFF-DT TRM-DT	Identifies if the revenue code requires units to be present for a specific Type of Bill. Valid values are: Y = Yes N = No
RATE EFF-DT TRM-DT	Identifies if the revenue codes require a rate to be present for a specific Type of Bill. Valid values are: Y = Yes N = No

3.E. HCPC Inquiry

Select option '**14**' from the Inquiry Menu to access the HCPC Inquiry screen. This screen displays the current rate utilized to price specific outpatient services identified by a HCPCS code. The FISS does **pre-payment** processing of HCPCS codes for laboratory services; but Radiology, Ambulatory Surgery Center (ASC), Durable Medical Equipment (DME), and Medical Diagnostics HCPC service codes are processed **post-payment**.

To start the inquiry process, enter the HCPCS code and the Locality code, then press **[ENTER]**.

HCPC Inquiry Screen (MAP1771) – Field descriptions for the HCPC Inquiry screen are provided in the table following Figure 29.

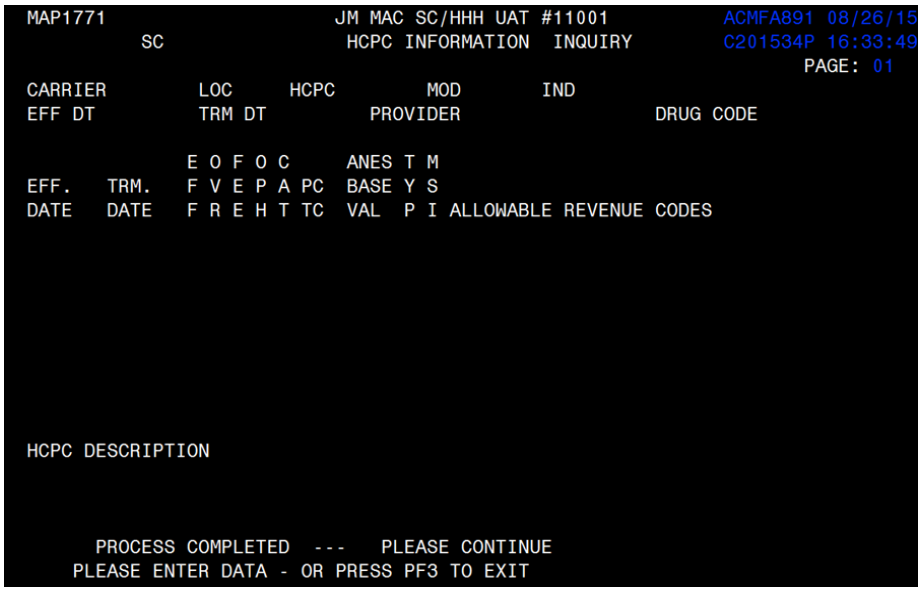

Figure 29 – HCPC Inquiry Screen

Field Name	Description
CARRIER	The Medicare contractor identification number.
LOC	The area (or county) where the provider is located. This field accepts as a valid value only the six **locality codes** entered on the Provider File and '01'. If a HCPC does not exist for the specific locality, the system will default to a '01', except for 90743 with a locality of '00'.
HCPC	Type the five-digit HCPC code to view.

Field Name	Description
MOD	This field identifies Multiple fees for one HCPC code based on the presence or absence of a modifier in this field. The default value is blank unless a valid modifier is entered for the HCPC.
IND	HCPC Indicator-this field is not used in DDE.
EFF DT	This field identifies the National Drug Code effective date.
TRM DT	This field identifies the National Drug Code termination date.
PROVIDER	This field identifies the identification number of the Alias Provider.
DRUG CODE	This field identifies whether the HCPC is a drug. 'E' The HCPC is a drug ' ' The HCPC is not a drug
EFF DT	This field identifies when the change in pricing went into effect. MMDDYY format.
TRM DT	This field identifies the termination date for each rate listed for this HCPC.
EFF	Effective Date Indicator: This indicator instructs the system to use From/Through dates on claims or use the system run date to perform edits for this particular HCPC date. Valid values are: R = Receipt Date F = From Date D = Discharge Date *Note: This field is displayed on the screen as: E F F
OVR	The override code instructs system in applying the services to the beneficiary/patient deductible and coinsurance. Valid values are: 0 = Apply deductible and coinsurance 1 = Do not apply deductible 2 = Do not apply coinsurance 3 = Do not apply deductible or coinsurance 4 = No need for total charges (used for multiple HCPC for single revenue code centers) 5 = RHC or CORF psychiatric M = EGHP (may only be used on the 0001 total line for MSP) N = Non-EGHP (may only be used on the 0001 total line for MSP) Y = IRS/SSA data match project; MSP cost avoided *Note: This field is displayed on the screen as: O V R
FEE	Displays the fee indicator received in the Physician Fee Schedule file. Valid values include: B = Bundled Procedure R = Rehab/Audiology Function Test/CORF Services ' ' = Space *Note: This field is displayed on the screen as: F E E

Field Name	Description
OPH	The Outpatient Hospital Indicator, with six occurrences, displays the outpatient hospital indicator received in the Physician Fee Schedule abstract test file. Valid values are: 0 = Fee applicable in Hospital Outpatient Setting 1 = Fee not applicable in Hospital Outpatient Setting ' ' = Space *Note: This field is displayed on the screen as: O P H
CAT	Category Code: This field identifies the CMS category of the DME equipment. '1' Inexpensive or routinely purchased DME '2' DME items requiring frequent maintenance and substantial servicing '3' Certain customized DME items '4' Prosthetic or orthotic devices '5' Capped rental DME items '6' Oxygen and oxygen equipment *Note: This field is displayed on the screen as: C A T
PCTC	Professional Component/Technical Component: This field identifies the indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) extract of the Medicare Physician Fee Schedule Supplementary File. This is used to identify professional services eligible for the Health Professional Shortage Area (HPSA) bonus payments. This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. This is a one-position alphanumeric field, with up to 40 occurrences. The valid values are: PC/TC — HPSA Payment Policy '0' Physician service codes '1' Diagnostic Tests for Radiology Services, '2' Professional component only. '3' Technical component only. '4' Global test only codes. '5' Incident codes, payment of the HPSA bonus may not be made by Medicare for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. '6' Laboratory physician interpretation codes. '7' Physical therapy service, payment of the HPSA bonus may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist. '8' Physician interpretation codes, payment of the HPSA bonus may be made for certain CPT codes. '9' Not applicable, concept of PC/TC does not apply *Note: This field is displayed on the screen as: PC TC
ANES BASE VAL	Identifies the anesthesia base values.

Field Name	Description
TYP	This field identifies whether other HCPCS originated from the Medicare Physician Fee Schedule (MPFS) database files and the fee rate. Valid values are: 'M' – Originated from MPFS database files ' ' – Did not originate from the MPFS database files *Note: This field is displayed on the screen as: T Y P
MSI	This field identifies the Multiple Service Indicator (MSI). *Note: This field is displayed on the screen as: M S I
ALLOWABLE REVENUE CODES	Billable UB-04 revenue codes for the HCPC entered. The fourth digit of the revenue code may be stored with an 'X' indicating it is variable. By leaving this field blank, the system will allow a HCPC on any revenue code.
HCPC DESCRIPTION	Narrative for the HCPC.

3.F. Diagnosis & Procedure Code Inquiry – ICD-9

Select option '**15**' from the Inquiry Menu to access the ICD-9-CM Code Inquiry screen. This screen displays an electronic description for the ICD-9-CM Codebook. This screen should be used as reference for ICD-9-CM code(s) to identify a specific diagnosis code or inpatient surgical procedure code for a related bill. To inquire about an ICD-9-CM diagnosis code, type the three-, four-, or five-digit code in the STARTING ICD9 CODE field. If more than one ICD-9 code is listed, review the most current effective date and termination date. To make additional ICD-9-CM inquiries type new information over the previously entered data.

To inquire about an ICD-9-CM procedure code, type the letter P followed by the three- or four-digit procedure code in the STARTING ICD9 CODE field. Do not type the decimal point or zero-fill the code. If the code entered requires a fourth and/or firth digit, an asterisk (*) will appear after the description. If an invalid code is entered, the system will select the nearest code.

ICD-9-CM Code Inquiry Screen (MAP1731) – Field descriptions are provided in the table following Figure 30.

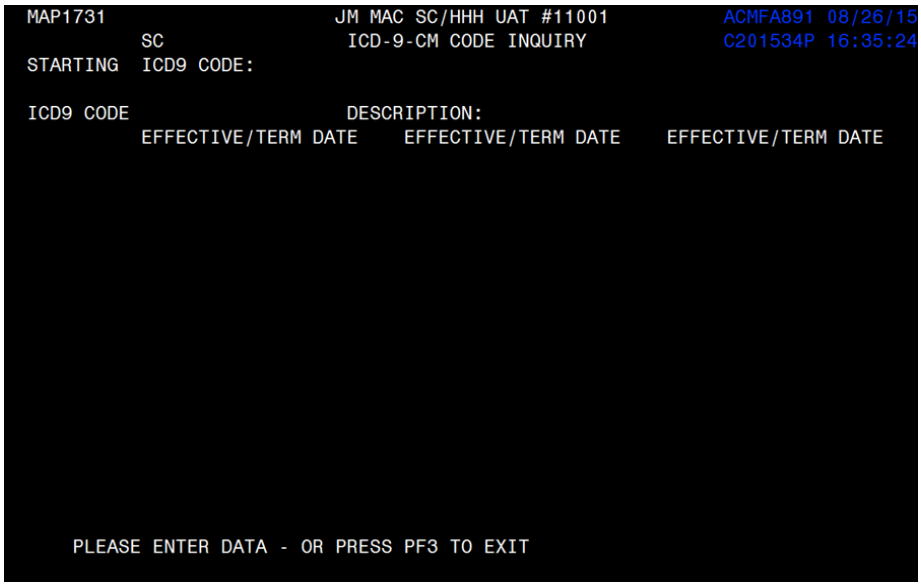

Figure 30 – ICD-9-CM Code Inquiry Screen

Field Name	Description
STARTING ICD-9 CODE	To view all ICD-9-CM codes, press [ENTER] in this field. The ICD-9-CM code is used to identify a specific diagnosis(ses) or inpatient surgical procedure(s) relating to a bill, which may be used to calculate payment (i.e., DRG) or make medical determination relating to a claim.
ICD-9 CODE	The specific ICD-9 code to be viewed.
DESCRIPTION	A description of ICD-9 code.
EFFECTIVE/ TERM DATE	The effective date of the program and the program ending date (both in MMDDYY format).

3.G. Adjustment Reason Code Inquiry

Select option '**16**' from the Inquiry Menu to access the Adjustment Reason Codes Inquiry screen. This screen provides an on-line access method to identify a two-digit adjustment reason code and a narrative description for the adjustment reason code. It can also be used to validate the adjustment reason code entered on an adjustment.

To start the inquiry process, type in an adjustment reason code and press **[ENTER]**, or just press **[ENTER]** and a list of adjustment reason codes will be displayed.

Adjustment Reason Codes Inquiry Selection Screen (MAP1821) – Field descriptions are provided in the table following Figure 31.

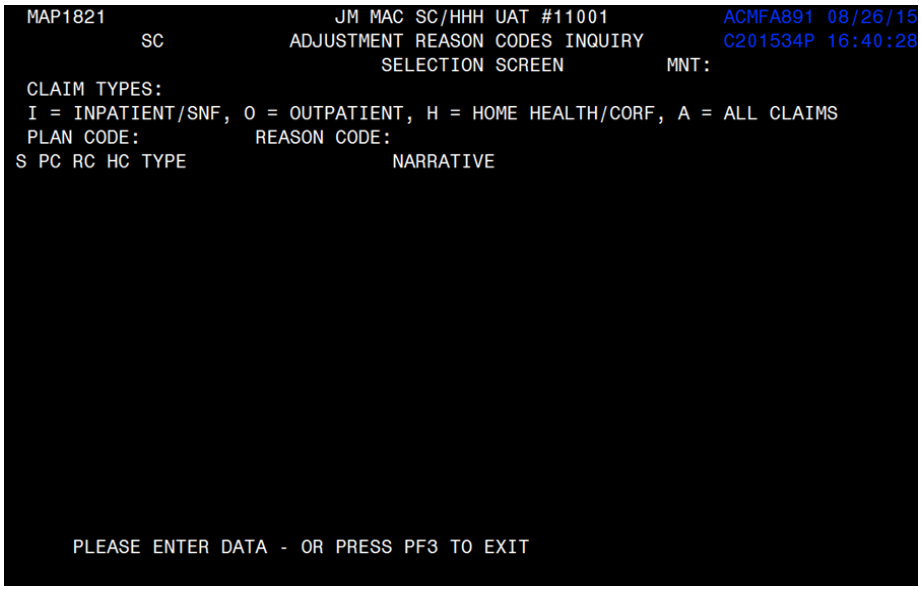

Figure 31 – Adjustment Reason Codes Inquiry Selection Screen

Field	Description
CLAIM TYPES	Describes the claim types identified for each adjustment reason code.
PLAN CODE	Differentiates between plans (Intermediaries) that share a processing site. The home/host site is considered '1' by the system. It is the number assigned to the site on the System Control file. Valid values are 1-9.
REASON CODE	To view a specific adjustment reason code, enter the value in this field. To view all adjustment reason codes, press [ENTER] in this field. There are hard-coded and user-defined codes. *PRO Review Code letters are indicated in brackets.
S	Selection – Used to view information for a particular code. To select an adjustment reason code, tab to desired code, enter '**S**' in the selection field, and press [ENTER].
PC	The Plan Code differentiates between plans (Intermediaries) that share a processing site. The home or host site is considered '1' by the system. It is the number assigned to the site on the System Control file. Valid values are 1-9.
RC	Displays the adjustment reason code. To review a particular adjustment reason code, enter the adjustment reason code value in this field.
HC	**HIGLAS Adjustment Reason Code**: This field identifies the Healthcare Integrated Ledger Accounting System (HIGLAS) adjustment reason code. This is a two-position alphanumeric field. NOTE: This field only displays on NON-HIGLAS sites.
TYPE	Displays the type of claim type associated with this reason code when a valid adjustment reason code is entered. Valid values are: I = Inpatient/SNF O = Outpatient H = Home Health/CORF A = All Claims
NARRATIVE	The narrative provides a short description for the adjustment reason code.

3.H. Reason Codes Inquiry

Select option '**17**' from the Inquiry Menu to access the Reason Codes Inquiry screen. Reason codes are applied to all claims processed in FISS. There can be one or more reason codes applied to a claim. This screen displays the narrative for the reason code(s) assigned to the claim. For claims that are Returned to

the Provider (RTP) for correction, rejected or denied, the narrative also explains the error that was identified on the claim. For RTP claims, the narrative may also explain what fields need to be changed or completed in order to resubmit the claim for processing. The Reason Codes File contains the following data:

- Reason code identification number and effective/termination date
- Alternative reason code identification number and effective/termination date
- Status and location set on the claim
- Post payment location
- Reason code narrative
- Clean claim indicator
- Additional Development Request (ADR) orbit counter and frequency

To start the inquiry process, enter the five-digit numeric reason code applied to the claim and press **[ENTER]**. To make additional inquiries, type over the reason code with next reason code and press **[ENTER]**.

Reason Codes Inquiry Screen (MAP1881) – Field descriptions are provided in the table following the examples shown in Figure 32.

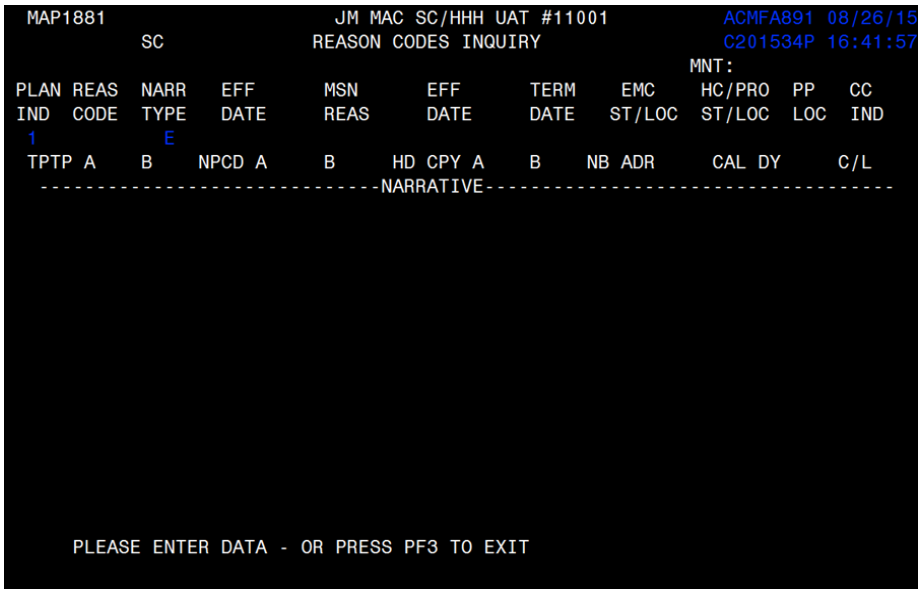

Figure 32 – Reason Codes Inquiry Screen, Example 1

Field Name	Description
MNT	Identifies the last date the reason code was updated.
PLAN IND	Plan Indicator. All FISS shared maintenance customers will be '1'; the value for FISS shared processing customers will be determined at a later date.
REAS CODE	Identifies a specific condition detected during the processing of a record.
NARR TYPE	The 'type' of reason code narrative provided. This field defaults to 'E' for external message.
EFF DATE	Identifies the effective date for the reason code or condition.
MSN REAS	The Medicare Summary Notice reason code is used when MSN's requiring BDL messages are produced. The reason code on the claim will be tied to a specific MSN reason code on the reason code file that will point to a specific MSN message on the ACS/MSN file.
EFF DATE	Effective date for the MSN reason code.
TERM DATE	Termination date for the MSN reason code.

Field Name	Description
EMC ST/LOC	Identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. If it is the same for both hard copy and EMC claims, the data will only appear in the hard copy category and the system will default to the hard copy claims for action on EMC claims.
HC/PRO ST/LOC	Hardcopy/Peer Review Organization status and location code for hard copy (paper) and peer review organization claims. This is the path DDE will follow.
PP LOC	This field identifies the five-position alphanumeric post pay location of 'B75XX'.
CC IND	The clean claim indicator instructs the system whether to pay interest or not if applicable.
TPTP A	Tape-to-tape Flag indicator for Part A, which controls the flow of the claim to CWF, to the provider via the remittance advice, to the PS&R system and for counting the claim for workload purposes.
B	Tape-to-tape Flag indicator for Part B.
NPCD A	The Non-pay code for Medicare Part A, which identifies the reason for Medicare's decision not to make payment.
B	The Non-pay code for Medicare Part B, which identifies the reason for Medicare's decision not to make payment.
HD CPY A	This field instructs the system to generate a specific hardcopy document during the claim process on a Medicare Part A claim.
B	This field instructs the system to generate a hardcopy document during the claim process on a Medicare Part B claim.
NB ADR	This field identifies the number of times an Additional Documentation Request (ADR) form is to be generated. Identified by a '1' or a '2'.
CAL DY	This field identifies the number of calendar days a claim is to orbit after the generation of an ADR.
C/L	This field identifies if the reason code has been has been depicted as applying to the Claim or Line.
NARRATIVE	This field displays the description for the reason code.

Press [F8] on the Reason Codes Inquiry screen to display the ANSI Related Reason Codes Inquiry screen (Figure 33). This screen provides the ANSI reason code equivalent to the FISS reason code, which can also be accessed through option 68 from the Inquiry Menu screen. Press [F7] to return to the Reason Codes Inquiry screen.

ANSI Related Reason Codes Inquiry Screen (MAP1882) – Field Descriptions are in the table following Figure 33.

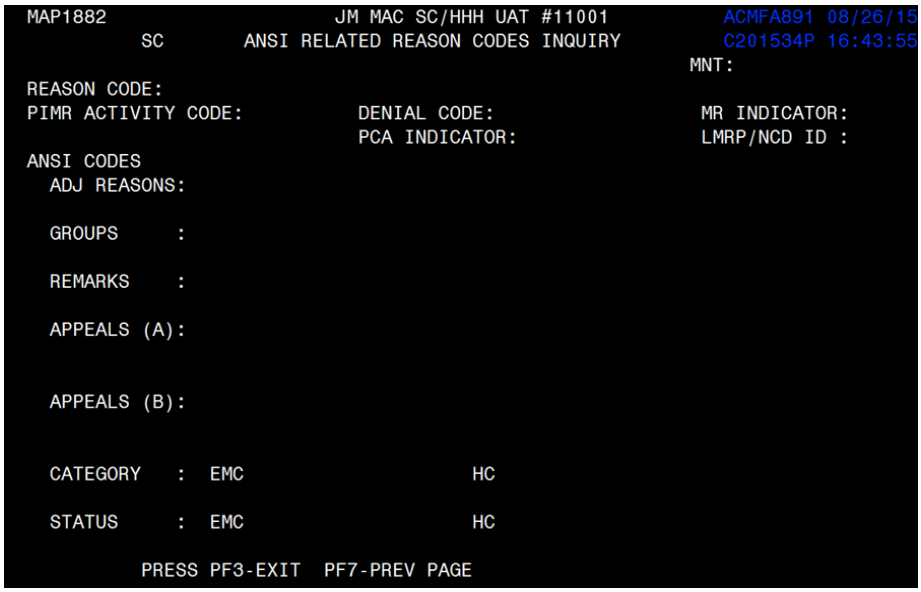

Figure 33 – ANSI Related Reason Codes Inquiry Screen

Field Name	Description
REASON CODE	This field will display the reason code entered on MAP1881 described in Figure 32.
MNT	Identifies the last date the reason code was updated.
PIMR ACTIVITY CODE	**Program Integrity Management Reporting (PIMR) Activity Code**: This field identifies the PIMR activity code for which the reason code is being categorized. This is a two-position alphanumeric field and is protected. The valid values are: 'AI' = Automated CCI Edit 'AL' = Automated Locally Developed Edit 'AN' = Automated National Edit 'CP'' = Prepay Complex Probe Review 'DB' = TPL or Demand Bill Claim Review 'MR' = Manual Routine Review 'PS' = Prepay Complex Provider Specific Review 'RO' = Reopening 'SS' = Prepay Complex Service Specific Review

Field Name	Description
DENIAL CODE	**Denial Reason Code**: This field identifies the PIMR Denial reason code that is being categorized (applies to all contractors). This is a six-position alphanumeric field and is protected. The valid values are: 'NOPIMR' = Default '100001' = Documentation Does Not Support Service '100002' = Investigation/Experimental '100003' = Item/Services Excluded From Medicare Coverage '100004' = Requested Information Not Received '100005' = Services Not Billed Under The Appropriate Revenue Or Procedure Code (Include Denials Due To Unbundling In This Category '100006' = Services Not Documented In Record '100007' = Services Not Medically Reasonable And Necessary '100008' = Skilled Nursing Facility Demand Bills '100009' = Daily Nursing Visits Are Not Intermittent/ Part Time '100010' = Specific Visits Did Not Include Personal Care Service '100011' = Home Health Demand Bills '100012' = Ability To Leave Home Unrestricted '100013' = Physician's Order Not Timely '100014' = Service Not Ordered/Not Included In Treatment Plan '100015' = Services Not Included In Plan Of Care '100016' = No Physician Certification (E.G. Home Health) '100017' = Incomplete Physician Order '100018' = No Individual Treatment Plan '100019' = Other
MR INDICATOR	**Medical Review Indicator**: This field identifies whether or not the service received complex manual medical review. This is a one-position alphanumeric field. The valid values are: ' ' = 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.
PCA INDICATOR	**Progressive Correction Action (PCA) Indicator**: This field identifies the PCA indicator. This is a one-position alphanumeric field. The valid values are: ' ' = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files. 'Y' = The Medical Policy Parameter is PCA-related and is included in the PCA transfer files. 'N' = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID	**Local Medical Review Policy (LMRP) and/or National Coverage Determination (NCD) Identification Number**: This field identifies the LMRP/NCD identification numbers, which are assigned to the FMR reason code for reporting on the beneficiaries Medicare Summary Notice. This is an eleven-position alphanumeric field, with five occurrences. The values for the LMRP are user defined and the NCD is CMS defined.
ANSI CODES	
ADJ REASONS	**Adjustment Reason Codes**: This is the ANSI reason code that is related to the FISS reason code. This is a three-digit alphanumeric field with ten occurrences.
GROUPS	**Group Codes**: The group code associated with the ANSI Reason code. This is a two-digit field with four occurrences. Valid values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PR = Patient Responsibility

Field Name	Description
REMARKS	The Remarks describe the reason for non-payment. This is a five-digit alphanumeric field that displays up to four occurrences.
APPEALS (A)	**ANSI Appeals-A Code**: These codes are used for inpatient only. This is a five-digit alphanumeric field that displays up to 20 occurrences.
APPEALS (B)	**ANSI Appeal-B Codes**: These codes are used for outpatient only. This is a five-digit alphanumeric field that displays up to 20 occurrences.
CATEGORY	
EMC	**Electronic Media Claim Category Code**: This field identifies the EMC category of the claim that is returned on a 277 claim response. This is a three-digit alphanumeric field.
HC	**Hard Copy Claim Category Code**: This field identifies the Hard Copy category of the claim that is returned on a 277 claim response. This is a three-digit alphanumeric field.
STATUS	
EMC	**Electronic Media Claim Status Code**: This field identifies the EMC status of the claim that is returned on a 277 claim response. This is a four-digit alphanumeric field.
HC	**Hard Copy Claim Status**: This field identifies the Hard Copy status of the claim that is returned on a 277 claim response. This is a four-digit alphanumeric field.

3.I. Invoice NO/DCN Trans

Select option '88' from the Inquiry Menu to access the Invoice Number/DCN Translator screen. The purpose of the Invoice Number/DCN Translator is to allow providers who use DDE to look up the claims associated with an Accounts Receivable (AR) by using the invoice number on the AR to find the Document Control Number (DCN), and then using the DCN to look up the claims. This update will improve provider customer service, allowing providers to find the claim associated with the AR and reconcile it back to their patient accounts.

Invoice NO/DCN Trans Screen (MAPDCN) – Field descriptions are in the table below Figure 34.

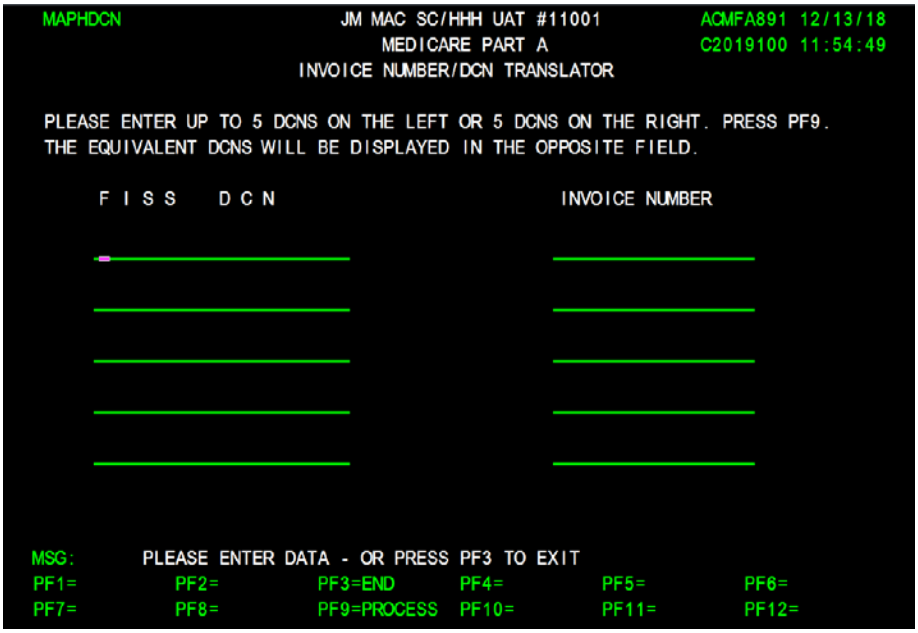

Figure 34 – Invoice Number/DCN Translator

Field Name	Description
FISS DCN	This field will display the Document Control Number (DCN)
Invoice Number	This field will display the Accounts Receivable (AR) Invoice Number

3.J. OSC Repository Inquiry

The purpose of the OSC (Occurrence Span Code) Repository Inquiry screen is to display the occurrence span code repository record. Up to three occurrences can display on a page. Specific occurrences can be displayed by typing a page number in the PG field at the upper left hand corner of the screen. Select Option 1A from the inquiry screen to access this screen.

OSC Repository Inquiry Screen (MAP11A1) – Field descriptions are in the table below Figure 35.

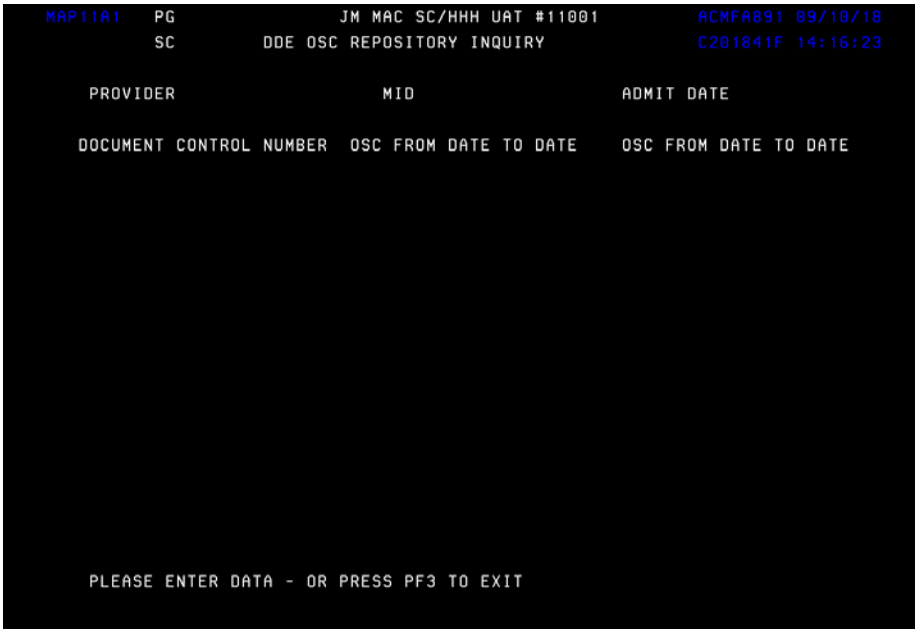

Figure 35 – DDE OSC Repository Inquiry

Field Name	Description
PROVIDER	This field displays the provider identification number.
MID	This field displays the beneficiary/patient's Medicare number as shown on the Medicare card.
ADMIT DATE	This field identifies the patient's admission date in MM/DD/YY format.
DOCUMENT CONTROL NUMBER	This field displays the claim identification number.
OSC	The Occurrence Span Code that identifies events that relate to the payment of the claim.
FROM DATE	This field identifies the beginning of an event that relates to the payment of the claim.
TO DATE	This field identifies the ending date of the event that relates to the payment of the claim.

3.K. Claims Count Summary

Select option '**56**' from the Inquiry Menu to access the Claim Summary Totals Inquiry screen. This screen provides a mechanism for providers to obtain information on:

- Total number of pending claims
- Total charges billed

- Total reimbursement for claims in each FISS status/location

The data on this screen updates with each nightly FISS cycle. Palmetto GBA recommends that providers review this screen at the start of each day to monitor the progress of submitted claims.
Press **[ENTER]** to display the data applicable to the provider number identified, **or** you can type in a specific status/location or category type to narrow the search.

Claim Summary Totals Inquiry Screen (MAP1371) – Field descriptions are provided in the table following Figure 36.

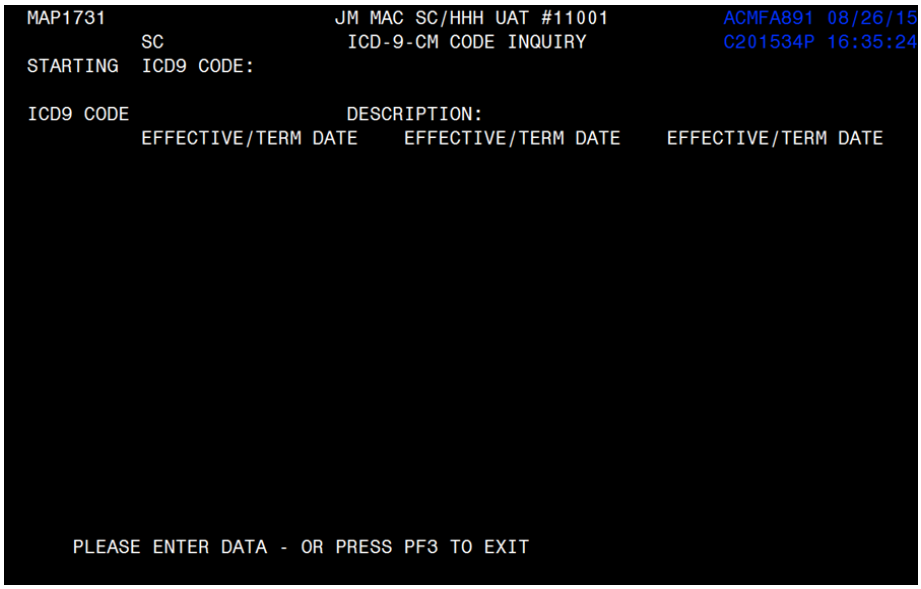

Figure 36 – Claim Summary Totals Inquiry Screen

Field Name	Description
PROVIDER	Automatically filled with the provider number, but accessible if the provider is authorized to view other provider numbers.
S/LOC	The status/location of the claim can be used as search criteria.
CAT	The category can be used as search criteria.
NPI	Identifies the provider's National Provider Identifier (NPI).
S/LOC	The status/location identifies the condition of the claim and/or location of the claim.
CAT	The Bill Category identifies the type of claims in specific locations by Type of Bill. In addition, a value that identifies the total claim number for each status/location. Valid values include: NN = First two digits of any TOB appropriate to the provider; e.g., 11, 13, 32, 72, etc. MP = Medical Policy – Medical policy applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code **is** a 5. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. NM = Non-Medical Policy – Applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code **is not** a 5. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. AD = Adjustments – Within each status/location. Claims in this category are also counted under the standard bill category. Therefore, claims in this category **are not** included in the total count (TC).

Field Name	Description
	TC = Total Count – Is the total within each status/location **excluding** claims with a category of AD, MN, or MP. GT = Grand Total – For the provider of all categories in all status/locations. This total will print at the beginning of the listing and associated status/locations will be blank. The grand total is displayed only when the total by Provider is requested.
CLAIM COUNT	The total claim count for each specific status/location.
TOTAL CHARGES	The total dollar amount accumulated for the total number of claims identified in the claim count.
TOTAL PAYMENT	The total dollar payment amount that has been calculated by the system. This is an accumulated dollar amount for the total number of claims identified in the claim count. For those claims suspended in locations prior to payment calculations, the total payment will equal zeros.

3.L. Home Health Payment Totals

Select option '67' from the Inquiry Menu to access the Home Health Payment Totals Screen. This screen displays the total outlier payments as well as the total amount paid to the home health agency during the calendar year.

Home Health Payment Totals Inquiry Screen (MAP1B41) – Field descriptions are provided in the table following Figure 37.

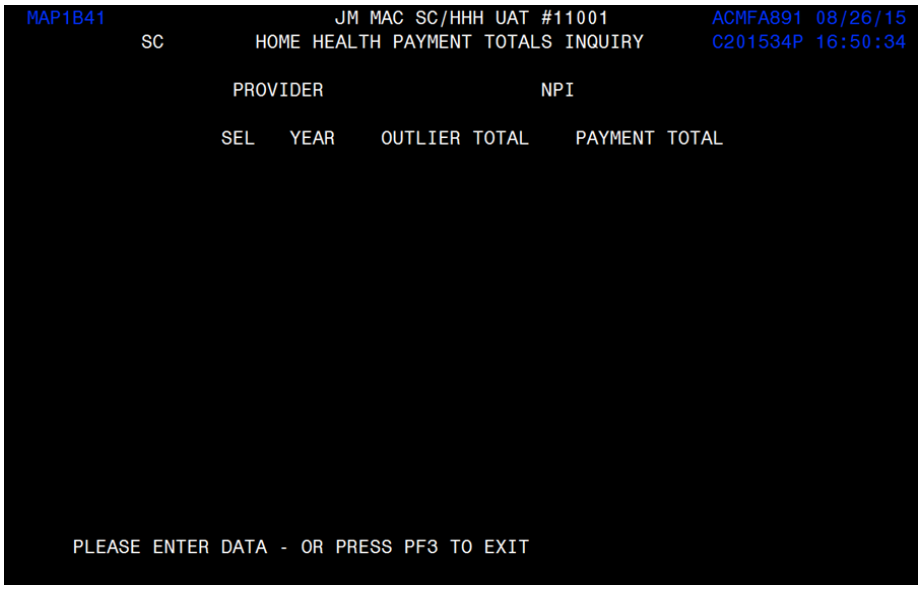

Figure 37 – Home Health Payment Totals Inquiry Screen

Field Name	Description
PROVIDER	This field identifies the provider number.
NPI	This field identifies the provider's National Provider Identifier (NPI) number.
SEL	This field identifies the detail records for the selected Total Record, and will display on the second Nap. The valid value is: 'S' = Select
YEAR	This field identifies claim information for that year by entering an 'S' by that year in CCYY format.
OUTLIER TOTAL	This field identifies the Outlier total.
PAYMENT TOTAL	This field identifies the total amount of payment.

3.M. ANSI Reason Code Inquiry

Select option '**68**' from the Inquiry Menu to access the ANSI (American National Standard Institute) Reason Codes Inquiry Selection Screen. This screen displays the remark codes that appear on both the standard paper remittance advice and the electronic remittance advice. These codes signify the presence of service-specific Medicare remarks and informational messages that cannot be expressed with a reason code.

To start the inquiry process, enter the option for which you wish to obtain information (e.g., C for claim adjustment reason codes) in the Record Type field, and the specific code (e.g., 45). To obtain the information for a specific ANSI reason code, select 'A', enter the code and press **[ENTER]**, or you can leave the Record Type field blank, press **[ENTER]** and a list of ANSI reason codes will display.

ANSI Reason Code Inquiry Screen (MAP1581) – Field descriptions are provided in the table following Figure 38

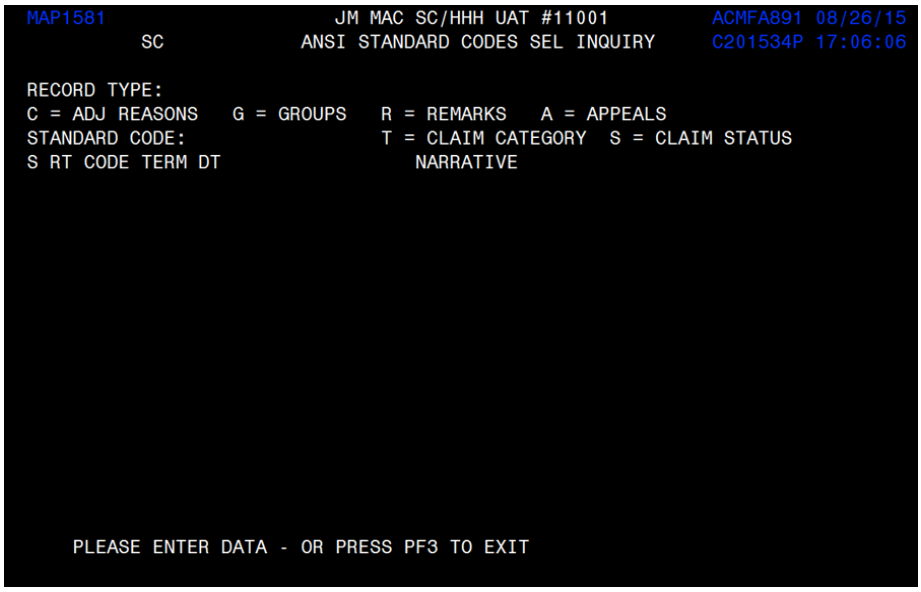

Figure 38 – ANSI Related Reason Codes Inquiry Selection Screen

Field Name	Description
RECORD TYPE	Identifies the ANSI record type for the standard code for inquiry or updating. Enter the value for the type of code you want to view. Valid values are: C = Claim adjustment reason G = Group codes R = Remittance Advice Remark A = ANSI Reason Code T= Claim category S= Claim Status
STANDARD CODE	The standard code within the above record type for inquiry or updating. Enter the code needed or press [Enter] and the entire list of codes for the record type selected above will be displayed. If both record and standard codes are present, the information for that code will be displayed. Otherwise, all ANSI codes will be displayed in record type/ standard code sequence.
S	Code selection field to select a specific code from the listing.
RT	The record type selected.
CODE	The standard code selected.
TERM DT	The date the ANSI standard code is deactivated in MMDDYY format.
NARRATIVE	The description of the standard code. This is the only field that can be updated for a standard code.

3.M.1. ANSI Reason Code Narrative

When the entire list of codes is displayed for a specific Record Type, to display the entire narrative for one specific ANSI code:

1. Type an '**S**' in the S (Select) field to view the entire narrative for the ANSI code. Figure 39 provides an example of the list that displayed for record type 'A'.

ANSI Standard Codes Selection Inquiry Screen (MAP1581) – Field descriptions are provided in the table following Figure 39.

```
MAP1581                    JM MAC SC/HHH UAT #11001          ACMFA891 08/26/15
          SC             ANSI STANDARD CODES SEL INQUIRY     C201534P 17:08:33

RECORD TYPE: A
C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
STANDARD CODE:                   T = CLAIM CATEGORY  S = CLAIM STATUS
S RT CODE TERM DT                   NARRATIVE
  A MA01         ALERT: IF YOU DO NOT AGREE WITH WHAT WE APPROVED FOR THESE
  A MA02         ALERT: IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAV
  A MA03  111805 IF YOU DO NOT AGREE WITH THE APPROVED AMOUNTS AND $100 OR M
  A MA04  110407 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTIFY
  A MA05  101603 INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL EN
  A MA06  080104 INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
  A MA07  110407 THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID F
S A MA08  110407 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSU
  A MA09  110407 CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YO
  A MA10  110407 THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU
  A MA100 110407 MISSING/INCOMPLETE/INVALID DATE OF CURRENT ILLNESS, INJURY
  A MA101 110407 A SKILLED NURSING FACILITY (SNF) IS RESPONSIBLE FOR PAYMENT
  A MA102 080104 MISSING/INCOMPLETE/INVALID NAME OR PROVIDER IDENTIFIER FOR
  A MA103 110407 HEMOPHILIA ADD ON.
  A MA104 013104 MISSING/INCOMPLETE/INVALID DATE THE PATIENT WAS LAST SEEN O
     PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

Figure 39 – ANSI Related Reason Codes Inquiry Selection Screen, ANSI Reason Code List

2. Press **[ENTER]** to display the ANSI Standard Codes Inquiry screen (see Figure 40).

ANSI Standard Reason Codes Inquiry Screen (MAP1582) – Field descriptions are provided in the table following Figure 40.

```
MAP1582                    JM MAC SC/HHH UAT #11001          ACMFA891 08/26/15
          SC           ANSI STANDARD REASON CODES INQUIRY    C201534P 17:10:46
                                                        MNT: SYSTEM   03/24/08

 RECORD TYPES ARE:
C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
                                 T = CLAIM CATEGORY S = CLAIM STATUS
                          RECORD TYPE   : A        TERM DT  :  110407
                                                   EFF DT   :
                          STANDARD CODE : MA08

                          NARRATIVE:

 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSURER. WE DID
 NOT SEND THE CLAIM DATA AS THE OTHER INSURER IS NOT A MEDIGAP PLAN, OR
 YOU DO NOT PARTICIPATE IN MEDICARE.









      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE
```

Figure 40 – ANSI Standard Codes Inquiry Screen

Field Name	Description
MNT	This field identifies the last operator who created or revised this record. This is a nine eight-position alphanumeric field. This field also identifies the date the screen was last accessed by the maintenance operator in the MM/DD/YY format.
RECORD TYPES ARE	This field displays the types of records that can be displayed on the screen.
RECORD TYPE	This field identifies the ANSI Record Type for the standard code that was selected on the previous screen. This is a one-position alphanumeric field. A = Appeals C = Adjustment Reasons G = Groups R = Remarks S = Claim status T = Claim category
TERM DT	This field identifies the termination date of the ANSI Standard Code deactivation. This is a six-digit field in MMDDYY format.
EFF DT	This field identifies the effective date of the ANSI Standard Code activation. This is a six-digit field in MMDDYY format.
STANDARD CODE	This field identifies the standard code within the above record type that is added. This is a five-digit alphanumeric field.
NARRATIVE	This is the narrative description of the standard code. This is an alphanumeric field that will display up to 70 characters with up to five screens.

3.N. Check History Inquiry

Select option '**FI'** from the Inquiry Menu to access the Check History screen. This screen lists Medicare payments for the last three issued checks, paid hardcopy or electronically. If you are interested in electronic payment, contact the EDI Department. Press **[ENTER]** and the last three checks issued by Medicare will display.

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

Check History Screen (MAP1B01) – Field descriptions for the Check History screen are provided in the table following Figure 41.

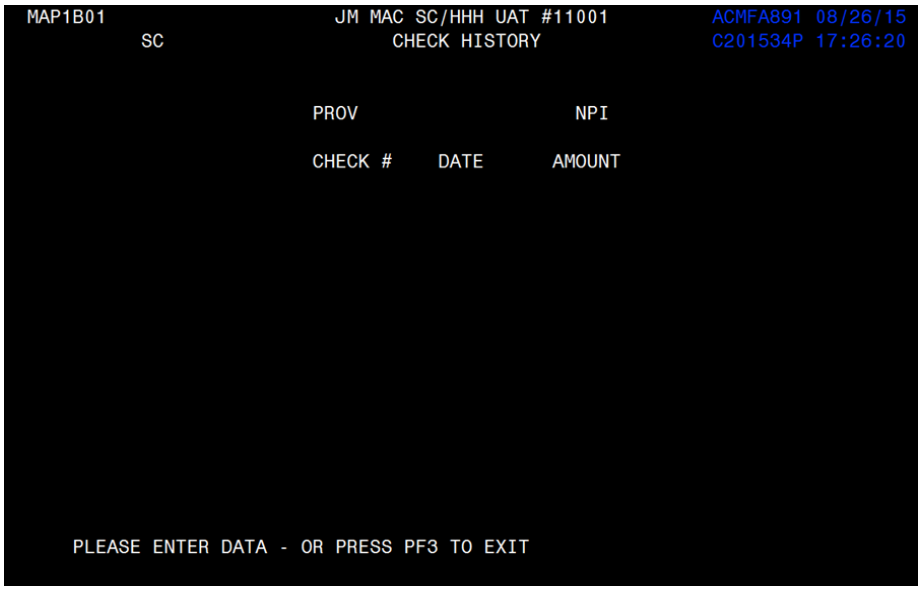

Figure 41 – Check History Screen

Field Name	Description
PROV	The Medicare assigned provider number.
NPI	The provider's National Provider Identifier (NPI) number.
CHECK #	The last three payments issued to the provider by Medicare. Leading zeros indicate a check. 'EFT' indicates electronic fund transfer.
DATE	The date when the payments were issued.
AMOUNT	The dollar amount of the last three payments issued to the provider.

3.O. Diagnosis & Procedure Code Inquiry – ICD10

Select option '**1B**' from the Inquiry Menu to access the ICD-10-CM Code Inquiry screen. This screen displays an electronic description for the ICD-10-CM Codebook. This screen should be used as reference for ICD-10-CM code(s) to identify a specific diagnosis code or inpatient surgical procedure code for a related bill. An effective date will be listed below each code and, if applicable, a termination date is also provided.

To inquire about an ICD-10-CM diagnosis code, type a 'D' in the DIAG/PROC field then tab to the STARTING ICD 10 CODE field and type in the code.

To inquire about an ICD-10-CM procedure code, type the letter 'P' in the DIAG/PROC field and tab to the STARTING ICD 10 CODE field and type in the code.

ICD-10-CM Code Inquiry Screen (MAP1C31) – Field descriptions are provided in the table following Figure 42.

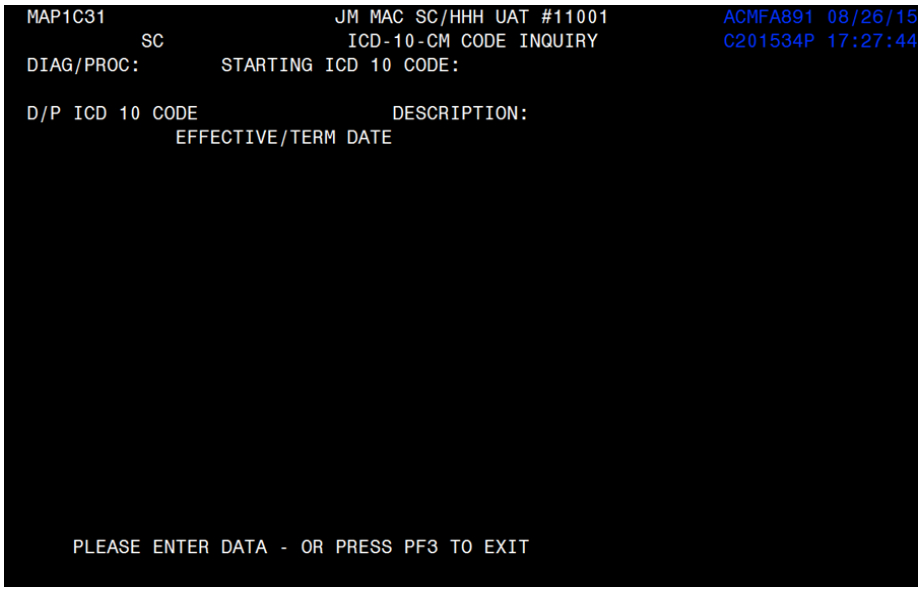

Figure 42 – ICD-10-CM Code Inquiry Screen

Field Name	Description
DIAG/PROC	This field identifies whether or not this is an ICD-10 diagnosis or procedure. Valid values are: 'D' = Diagnosis code being entered/updated 'P' = Procedure code being entered/updated
STARTING ICD 10 CODE	The ICD-10 code is used to identify a specific diagnosis(ses) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim.
D/P	This field identifies whether or not this is an ICD-10 diagnosis or procedure. This is a one-position alphanumeric field. The valid values are: 'D' = Diagnosis code being entered/updated 'P' = Procedure code being entered/updated
ICD-10 CODE	The ICD-10 code is used to identify a specific diagnosis(ses) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim
DESCRIPTION	This field displays the description for the ICD-10 code.
EFFECTIVE/ TERM DATE	This field identifies the effective and/or termination date of the program.

3.P. Community Mental Health Centers (CMHC) Services Payment Totals

Select option '1C' from the Inquiry Menu to access the CMHC Payment Totals Screen. This screen displays the total outlier payments as well as the total amount paid to the CMHC during the calendar year.

Community Mental Health Centers (CMHC) Services Payment Totals (MAP1D61) – Field descriptions are provided in the table following Figure 43.

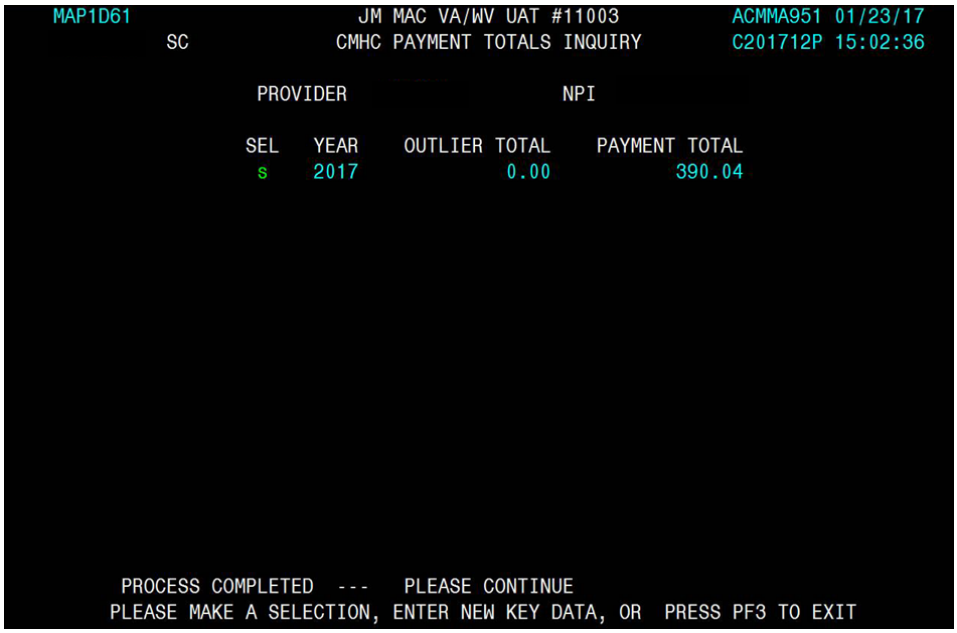

Figure 43 – CMHC Payment Totals Inquiry Screen

Field Name	Description
PROVIDER	This field identifies the provider number. This is a twelve-position alphanumeric field.
NPI	This field identifies the provider's National Provider Identifier (NPI) number. . This is a ten-position alphanumeric field.
SEL	This field identifies the detail records for the selected Total Record, and will display on the second Map. This is a one position alphanumeric field. The valid value is: S = Select
YEAR	This field identifies claim information for that year by entering an 'S' by that year in CCYY format. This is a four-position alphanumeric field in CCYY format.
OUTLIER TOTAL	This field identifies the Outlier payment total. This is an eleven-position numeric field in 999,999,999.99 format.
PAYMENT TOTAL	This field identifies the total amount of payment. This is an eleven-position numeric field in 999,999,999.99 format.

CMHC Payment Totals Detail Screen (MAP1D62) – Field descriptions are provided in the table following Figure 44

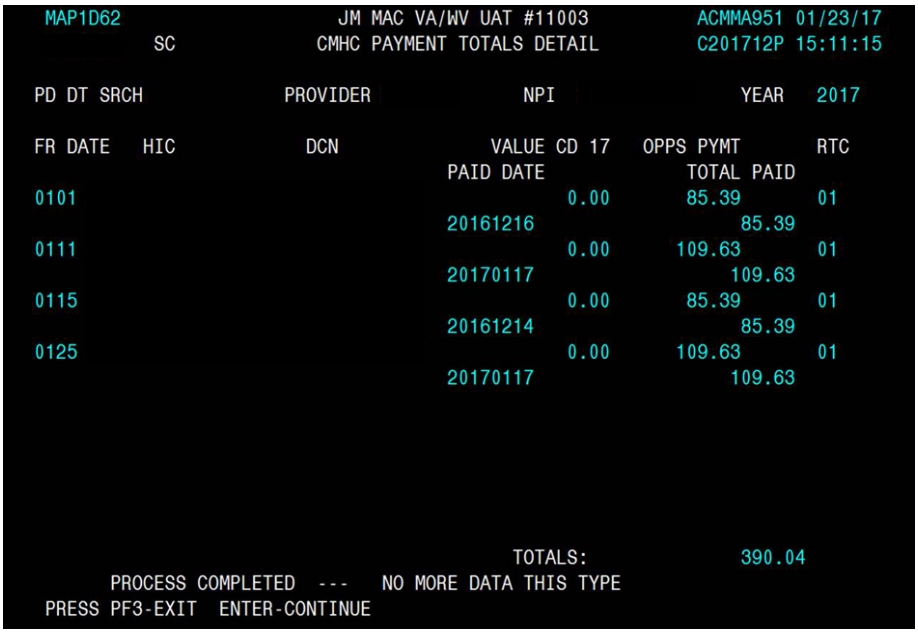

Figure 44 – CMHC Payment Totals Inquiry Detail Screen

Field Name	Description
PD DT SRCH	This field identifies the ability to search using the paid date for specific records of the provider and NPI number. This is an eight-position alphanumeric field.
PROVIDER	This field identifies the provider number. This is a twelve-position alphanumeric field.
NPI	This field identifies the National Provider Identifier number. This is a ten-position alphanumeric field.
YEAR	This field identifies claim information for the year by entering an S (by that year.) This is a four-position alphanumeric field in CCYY format.
FR DATE	This field identifies the From date of the paid claims. This is a four-position alphanumeric field in MMDD format.
HIC	This field identifies the Medicare Number assigned to the beneficiary by CMS.
DCN	This field identifies the Document Control Number. This is the identification number for a claim. This is a 23-position alphanumeric field.
VALUE CD 17	This field identifies the amount for Value Code 17. This is a nine-position numeric field in 9999,999.99 format.
OPPS PYMT	This field identifies the amount for OPPS Payment. This is a nine-position numeric field in 9999,999.99 format.
RTC	This field identifies the amount for Return Code from IOCE/OCE. This is a two-position numeric field.
PAID DATE	This field identifies date the claim was paid. This is an eight-position alphanumeric field in CCYYMMDD format.
TOTAL PAID	This field identifies the total amount paid. This is a 14-position numeric field in 999,999,999,999.99 format.
TOTALS	This field identifies the total amount of value code 17 and OPPS Payment, for all records. This is a 15-position numeric field in 9999,999,999,999.99.

3.Q. Provider Practice Address Query Summary

Select option '1D' from the Inquiry Menu to access the Provider Practice Address Query Summary screens. Theses screen houses practice address information. Providers can compare what is on file with Provider Enrollment, Chain and Ownership System (PECOS) for their practice locations to ensure that their claims submitted for their practice locations is an exact match. Providers need to ensure that the claims data matches their provider enrollment information. Providers who need to add a new or correct an existing practice location address will still need to submit a new 855A enrollment application in PECOS.

Providers need to enter their NPI or OSCAR (Medicare Provider Number) and press enter. The Summary screen will then return the NPI, OSCAR, practice effective and termination dates, zip, and the first 15 bytes of the address line 1 information.

Provider Practice Address Query Summary Screen (MAP1AB1) – Field descriptions are provided in the table following Figure 45

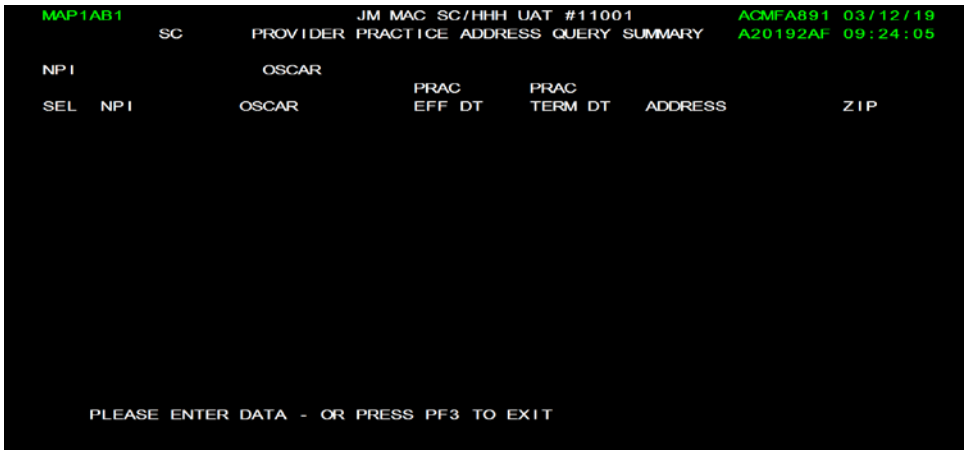

Figure 45 – Provider Practice Address Query Summary Screen

Field Name	Description
NPI	This field identifies the National Provider Identifier number. This is a ten-position alphanumeric field.
OSCAR	This field identifies the Medicare provider number as assigned by CMS for identification of the provider rendering Medicare services. This is a 13-position alphanumeric field.
SEL	This field identifies the selection key that allows access to each Provider Practice Address Query record found for an OSCAR and / or NPI. This is a one-position alphanumeric field, with 16-occurrences. **Valid Value:** S - Inquiry / Update access
PRAC EFF DT	This field identifies the Effective Date of the Practice. This is an eight-position numeric field in MMDDCCYY format.
PRAC TERM DT	This field identifies the Termination Date of the Practice. This is an eight-position numeric field in MMDDCCYY format. When there is no actual Practice Termination Date a default value of 12319999 will display.
ADDRESS	This field identifies the first 15 bytes of the Practice Provider's Address 1 information. This is a 15-position alphanumeric field.
ZIP	This field identifies the Practice Provider's zip. This is a nine-position numeric field.

From the Provider Practice Address Query Summary Screen (MAP1AB1), select a record by inputting an "S" in the "SEL" field. The Provider Practice Address Query Inquiry screen contains the practice full

address information, practice and NPI effective and termination dates. Providers can PF6 to scroll forward for addition practice locations on file.

Provider Practice Address Query Inquiry Screen (MAP1AB2) – Field descriptions are provided in the table following Figure 45

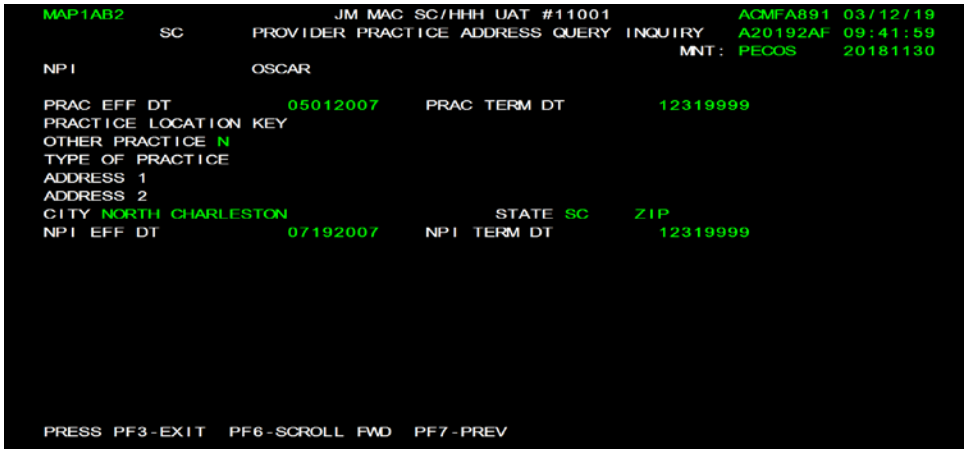

Figure 46 – Provider Practice Address Query Inquiry Screen

Field Name	Description
NPI	This field identifies the National Provider Identifier number. This is a ten-position alphanumeric field. This field is populated by the PECOS File Extract.
OSCAR	This field identifies the Medicare provider number as assigned by CMS for identification of the provider rendering Medicare services. This is a 13-position alphanumeric field. This field is populated by the PECOS File Extract.
PRAC EFF DT	This field identifies the Effective Date of the Practice. This is an eight-position numeric field in MMDDCCYY format. This field is populated by the PECOS File Extract.
PRAC TERM DT	This field identifies the Termination Date of the Practice. This is an eight-position numeric field in MMDDCCYY format. When there is no actual Practice Termination Date a default value of 12319999 will display. This field is populated by the PECOS File Extract.
PRACTICE LOCATION KEY	This field identifies the Practice Location Key from the PECOS File. This is a 20-positon alphanumeric field.
OTHER PRACTICE	This field identifies whether the PECOS record is for an Other Practice as noted on positon 81 of the PECOS File on the Child Record 04. This field is populated by the PECOS File Extract.
TYPE OF PRACTICE	This field identifies the Practice type. This is a 20-position alphanumeric field. This field is populated by the PECOS File Extract.
ADDRESS	This field identifies the Address Line 1 for the Provider's Practice location. This is a 55-position alphanumeric field. This field is populated by the PECOS File Extract.
ADDRESS 2	This field identifies the Address Line 2 for the provider's practice location. This is a 55-position alphanumeric field. This field is populated by the PECOS File Extract.
CITY	This field identifies the city for the provider's practice location. This is a 30-position alphanumeric field. This field is populated by the PECOS File Extract.
ZIP	This field identifies the Zip for the provider's practice location. This is a 15-position numeric field. This field is populated by the PECOS File Extract.
NPI EFF DT	This field identifies the effective date of the provider's NPI. This is an eight-position numeric field in MMDDCCYY format. This field is populated by the PECOS Extract File.

Field Name	Description
NPI TERM DT	This field identifies the termination date of the provider's NPI. This is an eight-position numeric field in MMDDCCYY format. When there is no actual Practice Termination Date a default value of 12319999 displays.

3.R. New HCPC Information Inquiry Screen

Select option '1E' from the Inquiry Menu to access the New HCPC Inquiry screen. The purpose of this screen is to provide information related to Healthcare Common Procedure Coding System (HCPC) pricing and allowable Revenue Codes related to HCPCS.

To start the inquiry process, enter the HCPCS code and the Locality code, then press [ENTER].

HCPC Inquiry Screen (MAP1E01) – Field descriptions for the HCPC Inquiry screen are provided in the table following Figure 29.

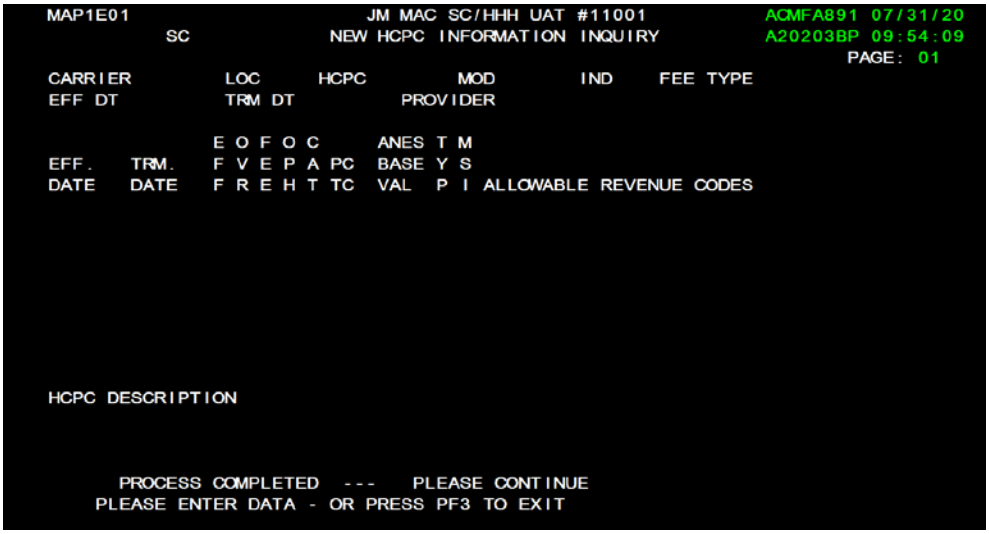

Figure 47 – HCPC Inquiry Screen

Field Name	Description
CARRIER	This field identifies the carrier number assigned to the HCPC being displayed. System generated. This is a five-position alphanumeric field.
LOC	This field identifies a two position alphanumeric identification number for the area (or county) where the provider is located. This field accepts as a valid value only the six locality codes entered on the Provider File (MAP1101) and 01. If a HCPC does not exist for the specific locality, the system defaults to 01. If you enter an invalid value in this field, the system defaults to the most recent locality code on the Provider File.
HCPC	Type the five-digit HCPC code to view. This field identifies the Health Care Common Procedure Coding System code to be reviewed on the screen. This is a five-position alphanumeric code assigned by CMS to identify certain medical procedures or equipment for special pricing.
MOD	This field identifies Multiple fees for one HCPC code based on the presence or absence of a modifier in this field. The default value is blank unless a valid modifier is entered for the HCPC.
IND	HCPC Indicator-this field is not used in DDE.

Field Name	Description
FEE-TYPE	This key field identifies the fee file the HCPC was received on. This is a four-position alphanumeric field. If a Fee Type isn't entered, the field will default to the first Fee Type that has a valid HCPC Record. Valid Values: • ISNF • RHHI • OTHR • CLAB • CLFS • IDME • ABST • MAMM • DRUG • AMBF • SUP1 • SUP2
EFF DT	This field identifies the National Drug Code effective date. This is a six-position numeric field in MMDDYY format.
TRM DT	This field identifies the National Drug Code termination date. This is a six-position numeric field in MMDDYY format.
PROVIDER	This field identifies the identification number of the Alias Provider.
EFF DT	This field identifies when the change in pricing went into effect. This is a six-position numeric field in MMDDYY format.
TRM DT	This field identifies the termination date for each rate listed for this HCPC. This is a six-position numeric field in MMDDYY format.
EFF	Effective Date Indicator: This indicator instructs the system to use From/Through dates on claims or use the system run date to perform edits for this particular HCPC date. Valid values are: R = Receipt Date F = From Date D = Discharge Date *Note: This field is displayed on the screen as: E F F
OVR	This field identifies the Override Code which instructs the system in applying the services to the beneficiary's deductible and to coinsurance. This is a one-position alphanumeric field with four occurrences.
FEE	This field identifies the fee indicator that is received from CMS in the physician fee schedule abstract test file. This is a one-position alphanumeric field with four occurrences. Valid Values: Blank - Default value B - Bundled procedure R - Rehab/audiology function test/CORF services
OPH	This field identifies the outpatient hospital indicator that is received from CMS in the physician fee schedule abstract test file. This is a one-position alphanumeric field with four occurrences. Valid Values: Blank - Default value O - Fee is applicable 1 - Fee is not applicable

Field Name	Description
CAT	This field identifies the CMS category code of the DME equipment. This is a one-position alphanumeric field with four occurrences. Valid Values: 1 - Inexpensive or other routinely purchased DME 2 - DME items requiring frequent maintenance and substantial servicing 3 - Certain customized DME items 4 - Prosthetic and orthotic devices 5 - Capped rental DME items 6 - Oxygen and oxygen equipment
PCTC	This field identifies the Professional Component/Technical Component (PC/TC) indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) extract of the Medicare Physician Fee Schedule Supplementary File. This is used to identify professional services eligible for the Health Professional Shortage Area (HPSA) bonus payments. This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. This is a one-position alphanumeric field with four occurrences. The valid values are: PC/TC — HPSA Payment Policy '0' Physician service codes '1' Diagnostic Tests for Radiology Services, '2' Professional component only. '3' Technical component only. '4' Global test only codes. '5' Incident codes, payment of the HPSA bonus may not be made by Medicare for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. '6' Laboratory physician interpretation codes. '7' Physical therapy service, payment of the HPSA bonus may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist. '8' Physician interpretation codes, payment of the HPSA bonus may be made for certain CPT codes. '9' Not applicable, concept of PC/TC does not apply *Note: This field is displayed on the screen as: PC TC
ANES BASE VAL	This field identifies the Anesthesia Base Unit Value. This is a three-position numeric field with four occurrences. The valid values are 001-199.
TYP	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 with four occurrences. Valid Values: M - Originated from MPFS database files Blank - 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-position zip code record is a '1', then the provider master address must contain a valid 4-position 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.

Field Name	Description
MSI	This field identifies the Multiple Service Indicator (MSI). *Note: This field is displayed on the screen as: M S I
ALLOWABLE REVENUE CODES	This field identifies the allowable revenue code(s) that this particular HCPC code may use in billing. This is a four-position alphanumeric field, with ten occurrences within each of the four Eff Date occurrences. The fourth position of the revenue code may be stored with an 'X' indicating that it is a variable. For example, by storing the revenue code 029X, the system allows this HCPC code with any revenue code that begins with '029'. By leaving this field blank, the system allows a HCPC code on any revenue code.
HCPC DESCRIPTION	Narrative for the HCPC.