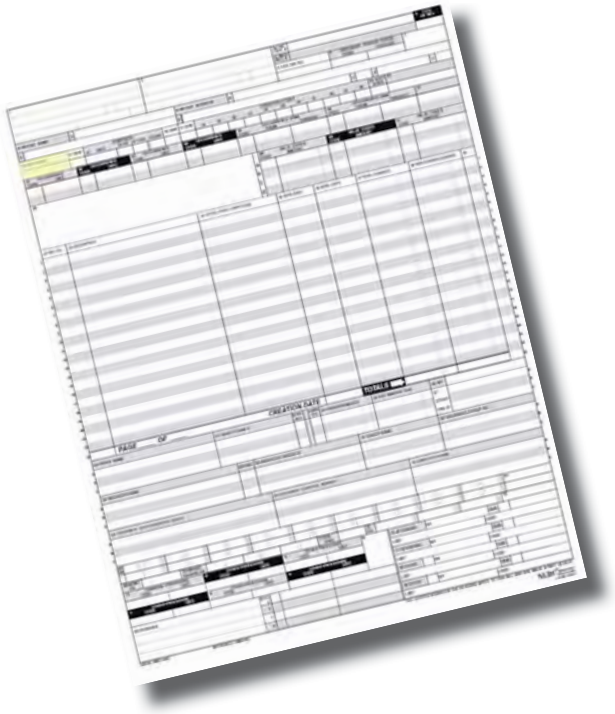

Medicare Part A Billing Guide

Palmetto GBA

May 2017

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E-mail Updates

Benefits of becoming a Listserv subscriber include having information delivered to you:

- Latest news and information from Palmetto GBA and CMS
- Medicare Advisories
- Up-to-date Medicare regulations
- Provider education event notices
- Medical policy updates
- Ability to comment on draft medical policies (LCDs)
- Payment and reimbursement updates

Website Resources

•Ambulance Overview
http://www.cms.gov/AmbulanceFeeSchedule
•Approved Facilities/Trials and Registries
http://www.cms.gov/medicareapprovedfacilitie/01_overview.asp
•Approved Transplant Centers
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/ApprovedTransplantPrograms.pdf
•Beneficiary Information and Publications
http://www.medicare.gov
•Centers for Medicare and Medicare Services (CMS) Website
http://www.cms.gov
•CMS Internet Only Manuals
http://www.cms.gov/Manuals/IOM/list.asp
•CMS Quarterly Provider Update
http://www.cms.gov/QuarterlyProviderUpdates/01_Overview.asp
•CMS Open Door Forums
http://www.cms.gov/OpenDoorForums
•Coding Hotline Information
http://www.ama-assn.org/go/cpt
•Correct Coding Initiative (NCCI) Edits
http://www.cms.gov/NationalCorrectCodInitEd
•Cost Report Information
https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/
•Critical Access Hospital Center
http://www.cms.gov/center/cah.asp
•Crossover Trading Partners
https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/COBA-Trading-Partners-Overview.html
•EDI WPC HIPAA Website Claim Adjustment Reason Codes
http://www.wpc-edi.com/codes/claimadjustment
•End Stage Renal Disease Center
http://www.cms.gov/center/esrd.asp
•ESRD PC Pricer
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/ESRD_Pricer.html
•Federal Register https://beta.gpo.gov/
•Federally Qualified Health Centers (FQHC) Center
http://www.cms.gov/center/fqhc.asp
•Fee Schedules
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html
•HCPCS Lookup
http://www.cms.gov/pfslookup
•Health Insurance Portability and Accountability Act (HIPAA)

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https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html
•HIPPS Codes
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
•Hospital Center
http://www.cms.gov/center/hospital.asp
•Hospital Inpatient PPS PC Pricer
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html
•HPSA and PSA Zip Codes
http://www.cms.gov/HPSAPSAphysicianbonuses
•ICD-10 Overview
http://www.cms.gov/ICD10
•Inpatient Psychiatric Facility (IPF) PPS
http://www.cms.gov/InpatientPsychFacilPPS/01_overview.asp
•Inpatient Psychiatric Facility (IPF) Pricer
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inppsy.html
•Inpatient Rehabilitation Facility (IRF) PPS
http://www.cms.gov/InpatientRehabFacPPS
•Inpatient Rehabilitation Facility (IRF) Pricer
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/IRF.html
•Long Term Care Hospital (LTCH) PPS
http://www.cms.gov/LongTermCareHospitalPPS
•Long Term Care Hospital (LTCH) Pricer
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/LTCH.html
•Managed Care Manual
http://www.cms.gov/healthplansgeninfo
•Managed Care Directory
http://www.cms.gov/MCRAdvPartDEnrolData/PDMCPDO/list.asp
•MLN Matters Articles
http://www.cms.gov/MLNMattersArticles
•MLN Matters Products
http://www.cms.gov/MLNProducts
•Medicare Secondary Payer (MSP) Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
•National Uniform Billing Committee
http://www.nubc.org/
•Outpatient Prospective Payment System (OPPS) Overview
http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp
•OPPS PC Pricer
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/Outpatient-PPS-Pricer-Code.html
•Palmetto GBA http://www.palmettogba.com/Medicare
•Palmetto GBA Event Registration Portal
http://www.palmettogba.com/event/pgbaevent.nsf/Home.xsp

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• Preventive Services Information http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
• Rural Health Center http://www.cms.gov/center/rural.asp
• Skilled Nursing Facility Center http://www.cms.gov/center/snf.asp
• Skilled Nursing Facility Consolidated Billing http://www.cms.gov/SNFConsolidatedBilling/01_Overview.asp
• SNF PPS Pricer https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/SNF.html

• Social Security Administration https://www.ssa.gov/
• Taxonomy Codes http://www.wpc-edi.com/codes/taxonomy
• Therapy Cap Information http://www.cms.gov/TherapyServices
• Time/Date Duration Calculator http://www.timeanddate.com/date/duration.html
• Social Yearly Updates to Medicare Deductible Coinsurance & Premium Rates
• 2016 – Change Request (CR) 9410
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R96GI.pdf
• 2017 – Change Request (CR) 9902
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R103GI.pdf
• Zip Code Lookup
http://zip4usps.com/zip4/welcome.asp

Timely Filing

As a result of the Patient Protection and Affordable Care Act (PPACA), all claims for services furnished on or after Jan 1, 2010, must be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service.

The line item date will be used to determine the date of service for claims with services that require reporting a line item date of service. For other claims, the claim statement's "From" date is used to determine the date of service. You may refer to IOM Publication 100-4, Medicare Claims Processing Manual, Chapter 1, Section 70, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.

Appeal

If you disagree with Medicare's decision on how a claim was processed, you may request an appeal. This is the only time you should use the appeals process.

Appeal Level	Time Limit for Filing Request	Monetary Threshold to be Met
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	For requests made on or after January 1, 2017, at least $160 must remain in controversy.
4. Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of DAB decision or declination of review by DAB	For requests made on or after January 1, 2017, at least $1560 must remain in controversy.

These time limits may be extended if good cause for late filing is shown. IOM Publication 100-04, Chapter 29, Section 240 of the Internet Only Manual (IOM), at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf, addresses the issue of good cause for extension of the time limit for filing appeals. If good cause is not found, the request for appeal will be dismissed by the contractor.

Requesting a Redetermination

A redetermination is an independent, re-examination of the claim file by the FI, A/B MAC and made by reviewers not involved in the initial claim decision. Contractors must handle and count incomplete redetermination requests as dismissals; make sure you include complete documentation.

- The Beneficiary's name
- The Medicare Health Insurance Claim (HIC) number of the beneficiary
- The specific service(s) and/or item(s) for which the redetermination is being requested.
- The correct dates of service (include all from and through dates).
- The name and signature of the person filing the redetermination request.
- Include all pertinent medical documentation

For further information on what to include in a redetermination request, you may refer to 'Redeterminations: What information should I send with the request?' on our website.

NOTE: Submitting a copy of the UB04 is not an acceptable appeal request. When submitting documentation, please include all documentation related to the redetermination including the Advanced Beneficiary Notice (ABN).

You can use any form or letter as long you've included all of the required information. CMS has standardized forms (CMS-20027 and CMS-20031) you can use. To help ensure all requirements are met, Palmetto GBA has developed Appeal Forms for providers to use available on our website.

Additional Documentation Requests (ADRs)

When a claim submitted is selected for prepayment medical review, we recommend that you return the requested medical records with a copy of the ADR letter to the specified P.O. Box indicated in the ADR letter generated by the system or via esMD. Please refer to Additional Way to Submit Medical Record Documentation at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf.

Providers with electronic claim submission are able to identify claims selected for prepayment medical review by accessing the Status/Locations SB6000 or SB6001. Those providers with FISS DDE access can get to this location by utilizing the Inquiries Menu (#1) and then the Claims Sub-Menu (#12).

CMS allows 45 days to return the medical records per the ADR request. The 45-day clock starts with the date the ADR letter is sent and continues until the records are date stamped as received at Palmetto GBA. Please keep this in mind and allow enough mailing time to ensure the records are received before the 45th day. Reviewer will not grant extensions; claims for which the requested documetnation was not received by day 46 will be denied.

CMS guidelines allow contractors the time frame of 60 days to complete the review of medical records submitted in response to an ADR documentation request. The goal of Palmetto GBA is to try to complete majority of complex claims within 30 days of receipt of documentation in our office. However, at times this is not possible due to the complexity of the review requiring additional research, missing documentation, or provider contact that may occur during the review process.

Palmetto GBA is requesting that providers pay close attention to the requested medical documentation items listed in the ADR and submit all requested documentation supporting the services rendered. Receipt of claim documentation that is incomplete may slow down the processing of the claim or may result in a denial of services.

Please refer to further Important Instructions for Those Providers Responding to Palmetto GBA Part A Medical Review Additional Documentation Requests on our website.

Additional Documentation (ADR) in Direct Data Entry (DDE)

To view any outstanding ADR requests for your facility, from the claim summary inquiry menu you will enter your provider number along with the status location of SB6001, currently this is the only location being utilized for ADRs:

- Type "**S B6**" in the S/LOC field.
- Press **[ENTER]** and all claims in an S B6000 or S B6001 status/location will display.
- Type an "**S**" in the SEL field of the desired claim and press **[ENTER]**.
- The ADR letter immediately follows claim page 6 (MAP 1716). The ADR will consist of 2 pages.

ADRs will stay in this status location only until the documentation is received. Do not use the [F9] function key with these claims. If you press [F9], the FISS will generate a new ADR.

After selecting a specific claim, you will type 7 in the page field to view the first page of information. Page 7 allows you to view any ADRs that have been requested by our medical review staff on the claim.

Continued on next page

The first page of the ADR displays the due date and address in which to send the requested information. When submitting your documentation, Please include a screen print of this page. F8 will allow you to view the second page, which will provide you with the ADR reason code, which identifies the specific information being requested, along with the narrative.

Direct Data Entry (DDE) Menu Guide

01 Inquiries

10 Beneficiary/CWF	Check Beneficiary Eligibility
11 DRG (Pricer/Grouper)	Verify DRG (Diagnosis Related Group)
12 Claims	Verify claim status
13 Revenue Codes	Revenue codes verification
14 HCPC Codes	HCPC Codes verification
15 DX/Proc Codes	Diagnosis & Procedure Codes verification
16 Adjustment Reason Codes	Verify adjustment reason codes *Required on adjustment claims (XX7 TOB)
17 Reason Codes	Reason code narratives
19 Zip Code File	Verification of zip codes Urban (U) vs. Rural (R) Rural Bonus (B)
56 Claim Count Summary	Summary claim totals by TOB in each Status Location
68 ANSI Reason Codes	Verification of ANSI Reason Codes on remittance advices
FI Check History	Verify the last 3 checks directed to provider

02 Claims/Attachments

Providers can enter claims via DDE for processing.

20 Inpatient	TOB 11X
22 Outpatient	TOBs 12X, 13X, 14X, 22X, 23X, 24X, 71X, 72X, 77X, 74X, 75X & 85X
24 SNF	TOBs 18X and 21X
26 Home Health	TOBs 32X, 33X and 34X
28 Hospice	TOBs 81X and 82X
49 NOE/NOA	N/A
87 Roster Bill Entry	Roster Bill Entry
ATTACHMENTS	
41 Home Health	N/A
54 DME History	N/A
57 ESRD - CMS-382 Submission	N/A (ESRD Beneficiary Selection Form)

03 Claim Corrections

*Updating or completing changes on claims in location TB9997

21 Inpatient	TOB 11X

Continued on next page

23 Outpatient	TOBs 12X, 13X, 14X, 22X, 23X, 24X, 71X, 72X, 77X, 74X, 75X AND 85X
25 SNF	TOBs 18X and 21X
27 Home Health	TOBs 32X, 33X and 34X
29 Hospice	TOBs 81X and 82X
CLAIMS ADJUSTMENTS *Resubmission with changes to finalized claims in locations PB9997and RB9997	
30 Inpatient	TOB 11X
31 Outpatient	TOBs 12X, 13X, 14X, 22X, 23X, 24X, 71X, 72X, 77X, 74X, 75X AND 85X
32 SNF	TOBs 18X and 21X
33 Home Health	TOBs 32X, 33X and 34X
35 Hospice	TOBs 81X and 82X
ATTACHMENTS	
42 Pacemaker	N/A
43 Ambulance	N/A
44 Therapy	N/A
45 Home Health	N/A
CLAIMS CANCELS *Cancellation of finalized claims in locations PB9997and RB9997	
50 Inpatient	TOB 11X
51 Outpatient	TOBs 12X, 13X, 14X, 22X, 23X, 24X, 71X, 72X, 77X, 74X, 75X AND 85X
52 SNF	TOBs 18X and 21X
53 Home Health	TOBs 32X, 33X and 34X
55 Hospice	TOBs 81X and 82X
ATTACHMENTS	
42 Pacemaker	N/A
43 Ambulance	N/A
44 Therapy	N/A
45 Home Health	N/A

04 Online Reports

R1	Summary of Reports View list of reports available to provider
R2	View a Report View provider specific reports
R3	Credit Balance Report To complete credit balance reports at the end of the Qtr

Point of Origin (PO) Codes

1	Non-Health Care Facility PO (Physician Referral) Usage note: Includes patients coming from home, a physician's office, or workplace.	Inpatient: The patient was admitted to this facility upon an order of a physician. Outpatient: Patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). *Includes non-emergent self-referrals.
2	Clinic or Physician's Office	Inpatient: Patient admitted to this facility. Outpatient: Patient presented to this facility for outpatient services.
4	Transfer from a Hospital (different facility). Usage Note: Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D).	Inpatient: Patient admitted to this facility as hospital transfer from an acute care facility where he/she was an inpatient or outpatient. Outpatient: Patient referred to this facility for outpatient or referenced diagnostic services by physician of a different acute care facility. *For transfers from hospital inpatient in the same facility, see code D.
5	Transfer from a SNF or ICF	Inpatient: Patient admitted to this facility as a transfer from a SNF or ICF where he/she was a resident. Outpatient: Patient referred to this facility for outpatient or referenced diagnostic services by physician of SNF or ICF where he/she was a resident.
6	Transfer from another Health Care Facility	Inpatient: Patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. Outpatient: Patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.

Continued on next page

8	Court/Law Enforcement Usage Note: Includes transfers from incarceration facilities.	Inpatient: Patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: Patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	
A	Reserved	
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of Same Hospital Resulting in a Separate Claim to the Payer	Inpatients: Patient admitted to this facility as a transfer from hospital inpatient within this hospital resulting in separate claim to payer. Outpatients: Patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim to the payer. For purposes of this code, “distinct unit” is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation service, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.
E	Transfer from Ambulatory Surgery Center	Effective 1/4/10
F	Transfer From Hospice and is Under a Hospice Plan of care or Enrolled in a Hospice Program	Effective 1/4/10
G-Z	Reserved	

Status Locations

F-Force	0-Off-line	02-Control	01-Common
I-Inactive	B-Batch	04-UB-04 Data	02-ADJ. Orbit
S-Suspense		05-Consistency (I)	10-Inpatient
M-Manual Move		06-Consistency (II)	11-Outpatient
P-Paid		15-Administrative	12-Special Claims
R-Reject		25-Duplicate	13-Med. Review
D-Deny		30-Entitlement	14-Program Integrity
T-Return to Provider		35-Lab/HCPC	16-MSP
U-Return to QIO		40-ESRD	18-Prod. QC
		50-Medical Policy	19-Sys. Research
		55-Utilization	21-Waiver
		60-ADR	65-Non DDE Pace
		65-PPS/Pricer	66-DDE Pacemaker
		70-Payment	67-DDE Home Health
		75-Post Payment	96-Payment Floor
		80-MSP Primary	97-Final On-Line
		85-MSP Secondary	98-Final Off-Line
		90-CWF	99-Final Purged
		99-Session Term	Awaiting CWF Response
		AA thru AA Customer Defined	22 thru 64 Customer Defined
			68-79 Customer Defined
			AA thru ZZ Customer Defined

Provider Transaction Access Numbers (last four digits)

TOB	Provider Transaction Access Numbers (last four digits)
XX7, XX8, XXF, XXG, XXH, XXI, XXJ, XXK, XXM, XXP	0001-0999, 1200-1299, 1300-1399, 1500-7999, 1800-1899, 1990-1999, 2000-2299, 3020-3099, 3500-3799, 3800-3999, 4000-4499, 4800-4899, 5000-6499, 6500-6899, 8500-8599, S000-S999, T001-T999, U001-U999, V001-V999, W001-W9999, Y000-Y999, Z300-Z399
11X Hospital Inpatient	0001-0999, 1200-1399, 2000-2299, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999, V001-V999, XXRXXX, XXMXXX, Z300-Z399, (POSITION 6 MAY ALSO = E OR F)
12X Hospital Ancillary	0001-0879, 1200-1399, 2000-2499, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999, V001-V999, XXRXXX, XXMXXX, Z300-Z399, (POSITION 6 MAY ALSO = E OR F)
13X Hospital Outpatient	0001-0879, 1200-1299, 1800-1999, 2000-2299, 3025-3099, 3300-3399, 4000-4499, V001-V999. (POSITION 6 MAY ALSO = E OR F)
14X Reference Lab	0001-0999, 1200-1399, 1800-1999, 2000-2299, 3025-3099, 3300-3899, 4000-4499, V001-V999. (POSITION 6 MAY ALSO = E OR F)
18X Swing Bed	U001-U999, W001-W999, Y001-Y999, Z300-Z399
21X SNF Inpatient	5000-6499, Y001-Y999, Z300-Z399
22X SNF/Swing Bed Ancillary	1800-1989, 5000-6499, W001-W999
23X SNF Ancillary Outpatient	5000-6499
71X RHC	3400-3499, 3800-3999, 8500-8999
72X ESRD	2300-2399, 2500-2599, 3500-3799
73X/77X (4/1/10) FQHC	1800-1989
74X ORF	6500-6899
75X CORF	3200-3299, 4500-4599, 4800-4899
76X Community Mental Health	1400-1499, 4600-4799, 4900-4999
85X CAH Outpatient	1300-1399, 1800-1989
CAH Facility	1300-1399, Z300-Z399, XXMXXX
Childrens	3300-3399
PSY Facility	4000-4499

Bill Type by Category

Category	Bill Type	PTAN Range(s)
Inpatient	11X, 41X	0001-0879, 1225-1299,2000-2499, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999, 1990-1999
Ancillary	12X, 22X	Same as 11X, 5000-6499
Outpatient	13X, 14X, 23X, 71X, 72X, 83X, 85X	Same as 11X, 1300-1399, 5000-6499, 3400-3499, 3800-3999, 8500-8999
Home Health	32X, 33X, 34X	7000-7999, 8000-8499, 9000-9499
Christian Science	41X,	1990-1999
Rural Health Clinic	71X	3400-3499, 3800-3999, 8500-8999
ESRD	72X	2300-2399, 2500-2599, 3500-3799
FQHC	77X (Effective 4/1/10)	1800-1989
OPT	74X	6500-6989
CORF	75X	3200-3299, 4500-4599, 4800-4899
Hospital Swing Bed	18X	U001-U999, W001-W999, Y001-Y999, Z001-Z999,
SNF	21X, 22X, 23X, 28X	5000-6499
CMHC	76X	1400-1499, 4600-4799, 4900-4999
Hospice	81X, 82X	1500-1799
CAH	85X	1300-1399, 1800-1989

Bill Types

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

The first digit identifies the type of facility.

1. Hospital
2. Skilled Nursing Facility
3. Home Health
4. Religious Nonmedical (Hospital)
5. Religious Nonmedical (Extended Care) discontinued 10/1/05
6. Intermediate Care
7. Clinic or Hospital based ESRD facility (requires Special second digit)
8. Special facility or hospital (CAH) (ASC) surgery (requires special second digit)
9. Reserved for National Assignment

Second Digit (Except Clinics & Special Facilities) - Bill Classification

1. Inpatient Part A
2. Inpatient Part B (includes Part B plan of treatment)
3. Outpatient (includes Part B plan of treatment)
4. Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "non-patients" and referenced diagnostic services.
5. Intermediate Care - Level I

Continued on next page

6. Intermediate Care - Level II
7. Sub-Acute Inpatient (Revenue Code 019X required) 17X, 27X discontinued 10/1/05
8. Swing Beds
9. Reserved for National Assignment

Second Digit (Clinics only) - Bill Classification

1. Rural Health Center (RHC)
2. Hospital based or Independent Renal Dialysis Center
3. Other Rehabilitation Facility (ORF)
4. Comprehensive Outpatient Rehabilitation Facility (CORF)
5. Community Mental Health Center (CMHC)
6. Free Standing/Provider-based Federally Qualified Health Center (FQHC)
7. Reserved for National Assignment
8. Other

Second Digit (Special Facilities only) - Bill Classification

1. Hospice (non-hospital based)
2. Hospice (hospital based)
4. Free Standing Birthing Center
5. Critical Access Hospital (CAH)

6-8. Reserved for National Assignment

9. Other

Initial Bill Third Digit – Frequencies

0	Non-payment/Zero Claim	Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care.
1	Admit Through Discharge	The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2	Interim - First Claim	Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. For HHAs: Used for submission of original or replacement RAPs.
3	Interim-Continuing Claims (Not valid for PPS Bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4	Interim – Last Claim (Not valid for PPS Bills)	This code is used for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment
7	Replacement of Prior Claim (See adjustment third digit)	This is used to correct a previously submitted bill. The provider applies this code to corrected or "new" bill.

Continued on next page

8	Void/Cancel of Prior Claim (See adjustment third digit)	The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.
9	Final claim for a Home Health PPS Episode	XX9 HH PPS
A	Admission/Election Notice for Hospice	Used when the hospice or Religious Non-medical Health Care Institution is submitting Form CMS-1450 as an Admission Notice.
B	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/ Revocation Notice	Used when the Form CMS-1450 is used as a notice of termination/ revocation for a previously posted Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.
C	Hospice Change of Provider Notice	Used when CMS Form-1450 is being used as a Notice of Change to the Hospice provider
D	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel	Used when Form CMS-1450 is used as a Notice of a Void/Cancel of Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution election.
E	Hospice Change of Ownership	Used when Form CMS-1450 is used as a Notice of Change in Ownership for the hospice.
F	Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For FI/ MAC use only.
G	CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For FI/MAC use only.
H	CMS Initiated Adjustment Claim	Used to identify adjustments initiated by CMS. For FI/MAC use only.
I	FI/MAC Adjustment Claim (Other than QIO or Provider)	Used to identify adjustments initiated by the FI/MAC. For FI/MAC use only.
J	Initiated Adjustment Claim - Other	Used to identify adjustments initiated by other entities. For FI/MAC use only.
K	OIG Initiated Adjustment Claim	Used to identify adjustments initiated by the OIG. For FI/MAC use only.
M	MSP Initiated Adjustment Claim	Used to identify adjustments initiated by MSP. For FI/MAC use only. Note: MSP takes precedence for other adjustment sources.
P	QIO Adjustment Claim	Used to identify adjustments initiated by the QIO. For FI/MAC use only.

Patient Status Codes

01	Discharged to home or self-care; jail or law enforcement; group home, foster care, & other residential care arrangements; Outpatient programs e.g. partial hospitalization, OP chemical dependency programs; assisted living facilities that are not state designated (routine discharge)
02	Discharged/transferred to short-term general hospital for Inpatient Care
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care. Do not use this for transfers to a non-Medicare certified area. For Swing Beds see Code 61 below
04	Discharged/transferred to an Intermediate Care Facility e.g. non-certified SNF beds, State designated Assisted Living Facilities
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care. Discharge/Transfer to home with written plan of care, foster care facility with home care & under home health agency with DME
07	Left against medical advice or discontinued care. Patients who leave before triage or seen by physician.
08	Reserved for National Assignment
09	Admitted as an inpatient to this hospital-only use on Medicare OP claims when services begin when those Medicare OP services are greater than 3 days prior to an admission
20	Expired -used only when the patient dies
21	Discharges or transfers to court/law enforcement; includes transfers to incarceration facilities such as jail, prison or other detention facilities.
22-29	22-29 Reserved for National Assignment
30	Still a patient or expected to return for outpatient services-used when billing for LOA days or interim bills. It can be used for both IP or OP claims, for IP claims the claim needs to be greater than 60 days
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only) used only on Medicare and TRICARE claims for hospice care
41	Expired in a medical facility (hospital, SNF, Intermediate Care Facility, or free standing hospice) for hospice use only
42	Expired - place unknown: this is used only on Medicare & TRICARE claims for Hospice only
43	Discharged/transferred to a Federal hospital, Dept. of Defense hospitals, VA hospitals, VA Psych unit or VA nursing facilities
44-49	Reserved for National Assignment
50	Discharged/transferred to Hospice (home)-or alternative setting that is the patient's home such as nursing facility, and will receive in-home hospice services
51	Discharged/transferred to Hospice medical facility- patient went to an IP facility that is qualified and the patient is to receive the general IP hospice level of care or hospice respite care. Used also if the patient is discharged from an IP acute care hospital to remain in hospital under hospice care

Continued on next page

52-60	Reserved for National Assignment
61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed. This is also used when discharged from an acute care hospital to a CAH swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to a long term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. If the facility has some Medicare certified beds you should use patient status code 03 or 04 depending on the level of care the patient is receiving and if they are placed in a Medicare certified bed or not
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
67-69	Reserved for National Assignment
70	Discharged/Transferred to another type of Health Care Institution not defined elsewhere in this code list.
71-79	Reserved for National Assignment

Patient Status Codes (effective for discharge on or after October 1, 2013.

81	Discharged to Home or Self-Care with a Planned Acute Care Hospital Inpatient Readmission
82	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
83	Discharged/Transferred to Skilled Nursing Facility with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
84	Discharged/Transferred to a Facility That Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
85	Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
86	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission
87	Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
88	Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
89	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
90	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
91	Discharged/Transferred to a Medicare Certified Long-term Care Hospital with a Planned Acute Care Hospital Inpatient Readmission

Continued on next page

92	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission
93	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
94	Discharged/Transferred to a Critical Access Hospital with a Planned Acute Care Hospital Inpatient Readmission
95	Discharged/Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission

Patient Discharge Status Codes 81 – 95, effective for discharges on or after October 1, 2013, are intended for use on the original discharge claim with an intended readmission of the patient as documented in the medical record's discharge plan. There is no time limitation included in the definition of planned readmission.

Readmission is defined as 'an intentional readmission after discharge from an acute care hospital that is a scheduled part of the patient's plan of care'.

Condition Codes

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

National Uniform Billing Committee (NUBC) assigned payers only codes are not submitted by providers. Payer only codes may be viewed in the CMS IOM Publication 100-4, Chapter 1; Section 190 – Payer Only Codes Utilized by Medicare at:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

Condition Code	Description
01	Military Service Related - This code indicates that the medical condition being treated was incurred during military service. Coordinate coverage with the Department of Veterans Affairs
02	Condition is Employment Related - Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment
03	Patient Covered by Insurance Not Reflected Here - Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill (i.e. HMO) - Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk based managed care plan and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed - The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance - Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 30 months of end stage renal disease entitlement

Continued on next page

07	Treatment of Non-terminal Condition for Hospice Patient - The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage – The beneficiary would not provide information concerning other insurance coverage. The FI develops to determine proper payment
09	Neither Patient Nor Spouse is Employed - In response to development questions; the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists - In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled beneficiary but no LGHP - In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP.
17	Patient is Homeless
18	Maiden Name Retained
19	Child Retains Mother's Name
Special Conditions	
20	Beneficiary requested billing - Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Limited to Home Health, Inpatient and SNF Claims)
21	Billing for denial notice - The provider realizes services are at a non-covered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers
26	VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility
27	Patient referred to a sole community hospital for a diagnostic lab test - (Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or spouse's EGHP is secondary to Medicare - In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.

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29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare – In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) LGHP is a single employer plan and the employer has fewer than 100 full and part time employees; or (2) LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials - Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (full time day)
32	Patient is a Student (Coop/Work Study Program)
33	Patient is a Student (Full-Time Night)
34	Patient is Student (Part-Time)
Accommodations	
35	Reserved for National Assignment
36	General Care Patient in a Special Unit - (Not used by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available. Accommodation charges for this period are at the prevalent semi-private rate.
37	Ward Accommodation at Patient's Request - Not used by PPS Hospitals
38	Semi-private room not available- Not used by PPS Hospitals
39	Private room medically necessary - Not used by PPS Hospitals
40	Same Day Transfer - The patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization - The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).
42	Continued care not related to IP admit - Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continued care not provided within post discharge window
44	Inpatient Admission Changed to Outpatient (effective April 1,2004) - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. (Note: For Medicare, the change in patient status from inpatient to outpatient is made prior to discharge or release while the patient is still a patient of the hospital).
45	Reserved for National Assignment
46	Non-Availability Statement on File
47	Admitted to Home Health Agency as transfer from another home health agency
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTC's) TRICARE
49	Product replacement within product lifecycle - Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

Continued on next page

50	Product replacement for known recall of a product - Manufacturer or FDA has identified the product for recall and therefore replacement.
51	Attestation of Unrelated Outpatient Non-diagnostic Services.
52-54	Reserved for National Assignment
SNF Information	
55	SNF Bed Not Available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness - The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission - The patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
Hospital PPS	
58	Terminated Medicare + Choice Organization Enrollee
59	Non-primary ESRD facility - Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.
66	Hospital Does Not Wish Cost Outlier Payment - The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days
69	IME/DGME/N& A Payment Only Billing
Renal Dialysis Setting	
70	Self-administered Anemia Management Drug - code indicates the billing is for a home dialysis patient who self-administers an anemia management drug such as erythropoetin alpha (EPO) or darbopoetin alpha
71	Full Care in Unit - The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit - The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training - The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home - The bill is for a patient who received dialysis services at home.
75	Home 100-Percent - Not Used for Medicare
76	Back-up In-Facility Dialysis - The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider accepts or is obligated/required due to contractual arrangement or law to accept payment by a primary payer as payment in full
78	Newly covered Medicare service for which an HMO doesn't pay - The bill is for a newly covered service under Medicare for which a managed care plan does not pay. (For outpatient bills, condition code 04 should be omitted.)

Continued on next page

79	CORF Services Provided Off-Site - Physical therapy, occupational therapy, or speech pathology services were provided offsite.
80	Home Dialysis SNF or Nursing Facility
Special Program Indicators	
A0	Special Zip Code Reporting-Ambulance
A3	Special Federal Funding
A5	Disability
A6	PPV/Medicare Pneumococcal Pneumococcal/Influenza
A7	Induced Abortion - Danger to Life
A9	Second Opinion Surgery
AA	Abortion performed due to Rape
AB	Abortion performed due to Incest
AC	Abortion performed due to serious fetal genetic defect, deformity, abnormality
AD	Abortion performed due to life endangering condition
AE	AE Abortion performed due to physical health of mother that is not life endangering
AF	Abortion performed due to emotional/psychological health of mother
AG	Abortion performed due to social economic reasons
AH	Elective abortion
AI	Sterilization
AJ	Payer responsible for Co-payment
AK	Air ambulance required
AL	Specialized treatment/bed unavailable
AM	Non-emergency Medically Necessary Stretcher Transport Required
AN	Preadmission Screening Not Required
AO-AZ	Reserved for National Assignment
B0	Medicare coordinated care demonstration program
B1	Beneficiary is ineligible for demonstration program
B2	Ambulance-CAH exempt from fee schedule if not exempt CAH don't use B2
B3	Pregnancy indicator
B4	Admission Unrelated to Discharge - Admission unrelated to discharge on same day.
BP	BP Gulf Oil Spill Related, all services on claim
DR	Disaster Related
G0	Distinct Medical visit - multiple medical visits occurred same day in same revenue center - Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 (zero) allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0 (zero).
G1-GZ	Reserved for National Assignment

Continued on next page

H0	Delayed filing, statement of intent submitted
N0-OZ	Reserved for National Assignment
P0-PZ	Reserved for National Assignment
Q0-VZ	Reserved for National Assignment
W0	United Mine Workers of America Demonstration Indicator
QIO approval Indicators	
C1	Approved as billed
C3	Partial approval
C4	Admission denied
C5	Post Payment review applicable
C6	Pre-Admission/pre-procedure reviewed the services provided
C7	Extended authorization
Claim Change Reason Code Refer to Adjustment Condition Codes list for additional instructions & order of priority.	
D0	Changes to service dates, change in date of admission use D9
D1	Changes to covered charges, adding a modifier to make a line covered on xx7 TOB
D2	Changes in revenue codes/HCPCs/HIPPS Rate Code XX7 TOB
D3	Second or subsequent interim PPS bill
D4	Change in adding a ICD diagnosis and/or procedure code, change in RUG III codes, only allowed on xx7 TOB
D5	Cancel only to correct a HICN or Provider Number, only allowed on xx8 TOB
D6	Cancel only to repay a duplicate payment, include outpatient charges on inpatient bill or OIG overpayment, only allowed on xx8 TOB
D7	Change to make Medicare the secondary payer, only allowed on xx7 TOB
D8	Change to make Medicare the primary payer, only allowed on xx7 TOB
D9	Any other change. Used when adding/changing occurrence, occurrence span and/or value codes that don't affect covered charges. Remarks are required.
E0	Change in patient status

Occurrence Codes

Code	Description
01	Accident/Medical Coverage - Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
02	No-Fault Insurance Involved-including auto accident/other - Date of an accident, including auto or other, where State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/TORT liability - Date of an accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.

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04	Accident/employment related
05	Accident/No medical or liability coverage - Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
06	Crime Victim
07-08	Reserved for National Assignment
09	Start of infertility treatment Cycle
10	Last menstrual period
11	Onset of Symptoms/Illness - (outpatient claims only). If beneficiary receiving a combination of PT/OT/SLP only one 11 occurrence code is required
12	Date of Onset for a Chronically Dependent Individual (CDI)
13-15	Reserved for National Assignment
16	Date of last therapy - Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).
17	Date occupational therapy plan established or last reviewed
18	Date of patient/beneficiary retirement
19	Date of retirement of spouse
20	Guarantee of Payment Began-(Part A hospital claims only) - Date hospital begins claiming payment
21	UR Notice Received (Part A SNF Claims Only) - date of receipt by the SNF and hospital of URC finding an admission or further stay was not medically necessary.
22	Date Active Care Ended - date a covered level of care ended in SNF or general hospital or date active care ended in psych or tuberculosis hospital or date patient was released on trial basis from residential facility. *Code not required if code “21” is used.
24	Date Insurance Denied
25	Date coverage benefits are terminated by primary payer.
26	Date SNF bed available to the Inpatient who requires only SNF level care
27	Date of Hospice Certification or re-certification
28	Date CORF Plan established or last reviewed
29	Date outpatient physical therapy plan established or last reviewed
30	Date outpatient speech language pathology plan established or last reviewed
31	Date beneficiary notified of intent to bill (accommodations) - beneficiary does not (or no longer) require covered level of inpatient care.
32	Date beneficiary notified of intent to bill (diagnostic procedures or treatment) is not reasonable or necessary under Medicare
33	First day of the Medicare Coordination Period for ESRD Beneficiaries covered by an EGHP. Required only for ESRD beneficiaries.
34	Date of the election of extended care services (used by Religious Nonmedical Health Care Institutions ONLY)
35	Date physical therapy treatment started
36	Date of Inpatient hospital discharge for a covered transplant procedure(s). NOTE: When patient received a covered & non-covered transplant the covered transplant predominates.

Continued on next page

37	Date of Inpatient hospital discharge - patient received a non-covered transplant
38	Date treatment started for Home IV Therapy
39	Date discharged on a continuous course of IV therapy
40	Scheduled date of Admission (this code may only be used on an outpatient claim)
41	Date of First Test for Pre-admission Testing (this code may be used only if date of admission was scheduled prior to administration of test(s))
42	Date of discharge (Hospice claims only)
43	Scheduled date of Cancelled Surgery
44	Date treatment started for occupational therapy
45	Date treatment started for speech-language pathology
46	Date treatment started for cardiac rehabilitation
47	Date cost outlier status begins, beneficiary must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges to receive cost outlier payments
50	Assessment Date for IRF, SNF and SB PPS Note: Not required for SNF HIPPS code AAAxx
51	Date of last Kt/V reading
A1	Birth Date Insured A - birth date of insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy - first date insurance is in force.
A3	Benefits Exhausted - last date benefits are available & no payment can be made by Payer A.
A4	Split Bill Date (date patient became Medicaid eligible due to medically needy spend down)
A5-AZ	Reserved for National Assignment
B1	Birth Date - Insured B
B2	Effective Date-Insured B Policy
B3	Benefits Exhausted
B4-BZ	Reserved for National Assignment
C1	Birth Date-Insured C
C2	Effective Date-Insured C Policy
C3	Benefits Exhausted
C4-CZ	Reserved for National Assignment
D0-DQ	Reserved for National Assignment
DR	Reserved for Disaster Related code
DS-DZ	Reserved for National Assignment
E0	Reserved for National Assignment
E1	Birthdate-Insured D
E2	Effective Date-Insured D Policy
E3	Benefits Exhausted
E4-EZ	Reserved for National Assignment
F0	Reserved for National Assignment
F1	Birthdate-Insured E
F2	Effective Date-Insured E Policy

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F3	Benefits Exhausted
F4-FZ	Reserved for National Assignment
G0	Reserved for National Assignment
G1	Birthdate-Insured F
G2	Effective Date-Insured F Policy
G3	Benefits Exhausted
G4-GZ	Reserved for National Assignment
H0-HZ	Reserved for National Assignment
M0-ZZ	See Instructions in Form Locator 36-Occurrence Span Codes and Dates

Occurrence Span Codes

Code	Description
70	SNF Qualifying Stay Dates - SNF TOB 3-day hospital stay qualifying stay dates for SNF use only.
70	Non-utilization Dates - PPS inlier (free days) stay for which beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates - (Part A Claims Only) From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit Dates - The from/through dates of outpatient services. For use on outpatient bills where the entire billing record is not represented by the actual From/Through service dates of Form Locator 06 (Statement Covers Period). AND On inpatient bills to denote contiguous outpatient hospital services that preceded the inpatient admission. (12/1/13) Voluntary code, but may be evaluated for medical review purposes. Information in the medical record will support whether total outpatient and inpatient time met the 2-midnight benchmark.
74	Non-covered Level of Care - From/through dates of a period at a non-covered level of care or leave of absence in an otherwise covered stay. Also used for Part B repetitive services to show a period of inpatient hospital care or outpatient surgery during the billing period.
75	SNF Level of Care - From/through dates of a period at a non-covered level of care during an inpatient hospital stay - only used when SNF bed is not available.
76	Patient Liability-From/through dates of a period of non-covered care for which the hospital/SNF is permitted to charge the Medicare beneficiary.
77	Provider Liability-Utilization Charged - The from/through dates of a period of non-covered care for which the provider is liable
78	SNF Prior Stay Dates - From/through dates given by the patient of any SNF or nursing home stay that ended within 60 days of this hospital/SNF admission
79	Verified non-covered stay dates for which the provider is liable
M0	QIO/UR stay dates - if a code “C3” is in FL 24-30, the provider enters the From and Through dates of the approved billing period.

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M1	Provider liability - no utilization - code indicating From/Through dates of non-covered care denied for lack of medical necessity. Provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care for hospice patients
M3	ICF Level of Care - From/through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care - From/through dates of period of residential level of care during an inpatient stay
M5-MQ	Reserved for National Assignment
MR	Reserved for Disaster related code
MS-WZ	Reserved for National Assignment

Value Codes

When reporting numeric values that do not represent dollars and cents, put whole numbers to the left of the dollar/cents delimiter and tenths to the right of the delimiter.

Code	Description
01	Most common Semi-Private Rate - to provide for recording hospital's most common semiprivate rate.
02	Hospital has no semi-private rooms - using this code requires $0.00 amount.
04	Inpatient Professional Component Charges Which Are Combined Billed - (Used only by some all-inclusive rate hospitals)
05	Professional component included in charges & billed separately to carrier - (Do not use)
06	Medicare Part A and Part B Blood Deductible for un-replaced deductible pints of blood supplied times the charge per pint. If all deductible pints have been replaced this code is not used
07	Reserved for National Assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period
10	Medicare Lifetime Reserve Amount in Second Calendar Year in Billing Period
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period
12	Working Aged Beneficiary Spouse With an EGHP (Payer Code A)
13	ESRD Beneficiary in Medicare Coordination Period With an EGHP (Payer Code B). Enter 6 zeros (0000.00) in the amount field if claiming conditional pay because EGHP has denied coverage
14	No-fault, including Auto/other liability insurance (Payer Code D). Enter 6 zeros (0000.00) in the amount field if claiming conditional pay because other insurer has denied coverage and there has been a substantial delay in payment
15	Worker's compensation (WC) (Payer Code E). Enter 6 zeros (0000.00) in the amount field if claiming conditional pay because there has been a substantial delay in payment.
16	PHS or other federal agency (Payer Code F). Enter 6 zeros (0000.00) in the amount field if claiming conditional pay because there has been a significant delay in payment

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NOTE: A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (0000.00) (Payer Code C).		
23	Recurring Monthly Income.	Medicaid-eligibility requirements to be determined at state level.
31	31 Patient liability amount for non-covered services	FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.
36	Reserved for National Assignment	RNA
37	Pints of Blood Furnished	Total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced.
38	Blood Deductible Pints	Number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of Blood Replaced	Total number of pints of blood donated on patient's behalf
40	New Coverage Not Implemented by HMO	(For inpatient service only) Inpatient charges for newly covered services not paid by the HMO. Must also report condition codes 04 and 78
41	41 Black Lung (Payer Code H)	Portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it's billing conditionally for substantially delayed payment.
42	42 Veterans Affairs (VA) (Payer Code I)	Portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on bill
43	Disabled beneficiary under 65 with LGHP (Payer Code G)	Portion of a higher priority LGHP payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it's billing conditionally for substantially delayed payment
44	Amount provider agreed to accept from primary payer when amount is less than charges but higher than payment received	A Medicare secondary payment is due.
45	Accident Hour	

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46	Number of grace days following QIO/UR determination	If C3 or C4 condition code is on the claim for QIO denial provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient's post discharge. The field contains 1 numeric digit.
47	Any liability insurance (Payer Code L)	Portion of a higher priority liability insurance payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it's billing conditionally for substantially delayed payment.
48	Latest Hemoglobin reading taken during this billing cycle	Patient's most recent hemoglobin reading taken before the start of the billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.
49	Hematocrit reading taken prior to the last administration of EPO during the billing cycle	The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.
54	Newborn birth weight in grams	Actual birth weight or weight at the time of admission for extramural birth
55	Eligibility Threshold for Charity Care	Corresponding value amount the health care facility determines eligibility threshold for charity care
56	Skilled Nurse--Home visit hours (HHA only)	Number of hours provided during billing period
57	Home Health Aide--Home visit hours (HHA only)	Number of hours provided during the billing period
58	Arterial Blood Gas (PO2/PA2)	Indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. The provider reports right justified in the cents area. Round to nearest whole percentage, i.e., report 56.5 as 57 to the right of the cents delimiter.

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59	Oxygen Saturation(02 Sat/Oximetry)	Indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill. The hospital reports right justified in the cents area. Round to nearest whole percentage, i.e., report 56.5 as 57 to the right of the cents delimiter.
NOTE: Codes 58 & 59 are not money amounts. They represent arterial blood gas or oxygen saturation levels.		
60	HHA Branch MSA	The MSA in which the HHA branch is located
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health/hospice service is delivered
66	Medicare spend down amount	Dollar amount used to meet recipient's spend down liability
67	Peritoneal Dialysis	Number of hours provided during billing period
68	Number of units of EPO administered and or supplied during the billing period	Number of units of EPO administered and/or supplied relating or billing period
69	State Charity Care Percent	Percentage of charity care eligibility for patient.
80	Covered Days	Hardcopy UB04 Claims
81	Non-Covered Days	Hardcopy UB04 Claims
82	Coinsurance Days	Hardcopy UB04 Claims
83	Lifetime Reserve Days	Hardcopy UB04 Claims
84-99	Reserved for National Assignment	RNA
A0	Special Zip Code Reporting	5 digit zip code of the location the beneficiary is initially placed on board the ambulance
A1	Deductible Payer A	
A2	Coinsurance Payer A	
A3	Estimated Responsibility Payer A	
A4	Covered Self-Administrable Drugs-Emergency	The amount included in covered charges for SAD administered to the patient in an emergency situation e.g. insulin for diabetic coma. Must be used with Rev Code 0637
A5	Covered Self-Administrable Drugs-Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for SAD administered to the patient because the drug wasn't self-administrable in the form and situation in which it was furnished to the patient. Must be used with Rev Code 0637

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A6	Covered-Self-Administrable Drugs-Diagnostic Study and Other	The amount included in covered charges for SAD administered to the patient because the drug was necessary for diagnostic study or other reason. Must be used with Rev Code 0637
A7	Co-payment Payer A	
A8	Patient Weight. Code indicates weight of patient in kilograms.	The weight of the patient should be measured after dialysis during the last dialysis session of the month. For newborns, use value code 54.
A9	Patient Height. Code indicates the height of the patient in centimeters.	The height should be measured during the last dialysis session of the month.
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	
AC-AZ	Reserved for National Assignment	
B1	Deductible Payer B	
B2	Coinsurance Payer B	
B3	Estimated Responsibility Payer B	
B4-B6	Reserved for National Assignment	
B7	Co-payment Payer B	
B8-B9	Reserved for National Assignment	
BA	BA Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer B	
BB	BB Other Assessments or Allowances (e.g., Medical Education) Payer B	
BC-C0	Reserved for National Assignment	
C1	Deductible Payer C	
C2	Coinsurance Payer C	
C3	Estimated Responsibility Payer C	
C4-C6	Reserved for National Assignment	
C7	Co-payment Payer C	
C8-C9	Reserved for National Assignment	
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer C	
CB	Other Assessments or Allowances (e.g., Medical Education Payer C	
CC-CZ	Reserved for National Assignment	

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D0-D2	Reserved for National Assignment	
D3	Estimated Responsibility Patient	
D4	Clinical Trial Number	8-digit numeric
D5	Result of last Kt/V	In-center hemodialysis - last reading during billing period; peritoneal/home dialysis-within 4 months of claim date of service. IF not Kt/V test performed use value of 9.99 with D5
DR	Reserved by Disaster Related code	
DS-DZ	Reserved for National Assignment	
E0	Reserved for National Assignment	
E1	Deductible Payer D	
E2	Coinsurance Payer D	
E3	Estimated Responsibility Payer D	
E4-E6	Reserved for National Assignment	
E7	Co-payment Payer D	
E8-E9	Reserved for National Assignment	
EA	EA Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes	
EB	Other Assessments or Allowances (e.g., Medical Education) Payer D	
EC-EZ	Reserved for National Assignment	
F0	Reserved for National Assignment	
F1	Deductible Payer E	
F2	Coinsurance Payer E	
F3	Estimated Responsibility Payer E	
F4-F6	Reserved for National Assignment	
F7	Co-payment Payer E	
F8-F9	Reserved for National Assignment	
FA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer E FB Other Assessments or Allowances (e.g., Medical Education) Payer E	
FC	Patient Prior Payments	
FD-FZ	Reserved for National Assignment	
G0	Reserved for National Assignment	
G1	Deductible Payer F	
G2	Coinsurance Payer F	
G3	Estimated Responsibility Payer F	

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G4-G6	Reserved for National Assignment	
G7	Co-payment Payer F	
G8	Facility where inpatient hospice service is delivered	
G9	Reserved for National Assignment	
GA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer F	
GB	Other Assessments or Allowances (e.g., Medical Education) Payer F	
GC-GZ	Reserved for National Assignment	
H0-WZ	Reserved for National Assignment	
X0-Y0	Reserved for National Assignment	
Y1	Part A Demonstration Payment	Part A payment under demonstration instead of DRG payment
Y2	Part B Demonstration Payment	Part B payment under demonstration
Y3	Part B Coinsurance (Demonstration Claims)	Part B coinsurance payment under demonstration
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	Amount Medicare would have reimbursed the provider if there had been no demonstration
Y5-ZZ	Reserved for National Assignment	

Revenue Codes

Revenue Code	**Description** **Refer to National Uniform Billing Committee (NUBC) information for expanded definitions of codes http://www.nubc.org**
0001	Total Charges
001X	Reserved for internal payer use
002X	Health Insurance Prospective Payment System (HIPPS) 0020-0021 Reserved 0022 – Skilled Nursing Facility (SNF) PPS 0023 – Home Health PPS 0024 – Inpatient Rehabilitation Facility (IRF) PPS 0025-0029 - Reserved
003X-009X	Reserved
010X	All-inclusive Rate 0100 – All inclusive room and board plus ancillary 0101 – All inclusive room and board

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011X	Room and Board Private (one bed) 0110 - General 0111 – Medical/Surgical/GYN 0112 – OB 0113 – Pediatric 0114 – Psychiatric 0115 – Hospice 0116 – Detoxification 0117 – Oncology 0118 – Rehabilitation 0119 - Other
012X	Room and Board Semiprivate (two beds) 0121 – Medical/Surgical/GYN 0122 – OB 0123 – Pediatric 0124 – Psychiatric 0125 – Hospice 0126 – Detoxification 0127 – Oncology 0128 – Rehabilitation 0129 - Other
013X	Room and Board (3 and 4 beds) 0130 - General 0131 – Medical/Surgical/GYN 0132 – OB 0133 – Pediatric 0134 – Psychiatric 0135 – Hospice 0136 – Detoxification 0137 – Oncology 0138 – Rehabilitation 0139 - Other
014X	Room and Board Deluxe Private 0140 - General 0141 – Medical/Surgical/GYN 0142 – OB 0143 – Pediatric 0144 – Psychiatric 0145 – Hospice 0146 – Detoxification 0147 – Oncology 0148 – Rehabilitation 0149 - Other

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015X	Room and Board Ward 0150 - General 0151 – Medical/Surgical/GYN 0152 – OB 0153 – Pediatric 0154 – Psychiatric 0155 – Hospice 0156 – Detoxification 0157 – Oncology 0158 – Rehabilitation 0159 - Other
016X	Other Room and Board 0160 – General 0164 – Sterile 0167 – Self-care 0169 - Other
017X	Nursery 0170 – General 0171 – Newborn Level I 0172 – Newborn Level II 0173 - Newborn Level III 0174 – Newborn Level IV 0179 – Other
018X	Leave of Absence 0180 – General 0182 – Patience convenience – charges billable 0183 – Therapeutic leave 0185 – Nursing home (for hospitalization) 0189 - Other
019X	Subacute Care 0190 – General 0191 – Level I 0192 – Level II 0193 – Level III 0194 – Level IV 0199 - Other

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020X	Intensive Care Unit 0200 – General 0201 – Surgical 0202 – Medical 0203 – Pediatric 0204 – Psychiatric 0206 – Intermediate ICU 0207 – Burn Care 0208 – Trauma 0209 - Other
021X	Coronary Care Unit 0210 – General 0211 – Myocardial Infarction 0212 – Pulmonary Care 0213 – Heart Transplant 0214 – Intermediate CCU 0219 – Other
022X	Special Charges 0220 – General 0221 – Admission Charge 0222 – Technical Support Charge 0223 - UR Service Charge 0224 – Late Discharge – Medically Necessary 0229 - Other
023X	Incremental Nursing Charge 0230 – General 0231 – Nursery 0232 – OB 0233 – ICU 0234 – CCU 0235 – Hospice 0239 - Other
024X	024X All-inclusive Ancillary 0240 – General 0241 – Basic 0242 – Comprehensive 0243 – Specialty 0249 - Other

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025X	Pharmacy 0250 – General 0251 – Generic drugs 0252 – Nongeneric drugs 0253 – Take-home drugs 0254 – Drugs incident to Other diagnostic services 0255 – Drugs incident to radiology 0256 – experimental drugs 0257 – Nonprescription 0258 – IV solutions 0259 - Other
026X	IV Therapy 0260 – General 0261 – Infusion pump 0262 – Pharmacy services 0263 – Drug/supply delivery 0264 – Supplies 0269 - Other
027X	Medical/Surgical Supplies and Devices 0270 – General 0271 – Non-sterile 0272 – Sterile 0273 – Take-home supplies 0274 – Prosthetic/orthotic devices 0275 – Pacemaker 0276 – Intracular lens 0277 – Take-home oxygen 0278 – Other implants 0279 - Other
028X	Oncology 0280 – General 0289 - Other
029X	Durable Medical Equipment (Other than Renal) 0290 – General 0291 – Rental 0292 – Purchase of new DME 0293 – Purchase of used DME 0294 - Supplies/Drugs for DME 0299 - Other

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030X	Laboratory 0300 – General 0301 – Chemistry 0302 – Immunology 0303 – Renal patient (home) 0304 – Non-routine dialysis 0305 - Hematology 0306 – Bacteriology and Microbiology 0307 – Urology 0309 - Other
031X	Laboratory Pathology 0310 – General 0311 – Cytology 0312 – Histology 0314 – Biopsy 0319 - Other
032X	Radiology Diagnostic 0320 – General 0321 – Angiocardiography 0322 – Arthrography 0323 – Arteriography 0324 – Chest X-ray 0329 - Other
033X	Radiology Therapeutic and/of Chemotherapy Administration 0330 – General 0331 – Chemotherapy administration – injection 0332 – Chemotherapy administration – oral 0333 – Radiation therapy 0335 – Chemotherapy administration – IV 0339 - Other
034X	Nuclear Medicine 0340 – General 0341 – Diagnostic 0342 – Therapeutic 0343 – Diagnostic radiopharmaceuticals 0344 – Therapeutic radiopharmaceuticals 0349 - Other
035X	CT Scan 0350 – General 0351 – Head scan 0352 – Body scan 0359 - Other

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036X	Operating Room Services 0360 - General 0361 – Minor surgery 0362 - Organ transplant – other than kidney 0367 – Kidney transplant 0369 - Other
037X	Anesthesia 0370 – General 0371 – Incident to radiology 0372 – Incident to Other Diagnostic services 0374 – Acupuncture 0379 - Other
038X	Blood and Blood Products 0380 – General 0381 – Packed red cells 0382 – Whole blood and blood products 0383 – Plasma 0384 – Platelets 0385 – Leukocytes 0386 – Other components 0387 – Other derivatives (cryoprecipitates) 0389 - Other
039X	Administration, Processing & Storage for Blood & Blood Components 0390 – General 0391 – Administration (e.g., transfusions) 0392 – Processing and storage 0399 – Other processing and storage
040X	Other Imaging Services 0400 – General 0401 – Diagnostic mammography 0402 – Ultrasound 0403 – Screening mammography 0404 – Positron Emission Tomography 0409 - Other
041X	Respiratory Services 0410 – General 0412 – Inhalation services 0413 – Hyperbaric oxygen therapy 0419 - Other

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042X	Physical Therapy 0420 - General 0421 – Visit charge 0422 – Hourly charge 0423 – Group rate 0424 – Evaluation or reevaluation 0429 – Other
043X	Occupational Therapy 0430 – General 0431 – Visit charge 0432 – Hourly charge 0433 – Group rate 0434 – Evaluation or reevaluation 0439 - Other
044X	044X Speech Therapy Language Pathology 0440 – General 0441 – Visit charge 0442 – Hourly charge 0443 – group rate 0444 – Evaluation or reevaluation 0449 - Other
045X	Emergency Room 0450 – General 0451 – EMTALA emergency medical screening services 0452 – ER beyond EMTALA screening 0456 – Urgent care 0459 – Other
046X	Pulmonary Function 0460 – General 0469 - Other
047X	Audiology 0470 – General 0471 – Diagnostic 0472 – Treatment 0479 - Other
048X	Cardiology 0480 – General 0481 – Cardiac cath lab 0482 – Stress test 0483 – Echocardiology 0489 - Other

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049X	Ambulatory Surgical Care 0490 – General 0499 - Other
050X	Outpatient Services 0500 – General 0509 - Other
051X	Clinic 0510 – General 0511 – Chronic pain center 0512 – Dental clinic 0513 – Psychiatric clinic 0514 – OB/GYN clinic 0515 – Pediatric clinic 0516 – Urgent care clinic 0517 – Family practice clinic 0519 - Other
052X	Freestanding Clinic 0520 – General 0521 – Clinic visit by member to RHC/FQHC 0522 – Home visit by RHC/FQHC practitioner 0523 – Family practice clinic 0524 – Visit by RHC/FQHC practitioner to member in a Part A covered stay in SNF 0525 - Visit by RHC/FQHC practitioner to member in a stay not covered by Part A in a SNF, NF or ICF MR or other residential facility 0526 – Urgent care clinic 0527 – Visiting nurse services to member's home in a home health shortage area 0528 – Visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident) 0529 - Other
053X	Osteopathic Services 0530 – General 0531 – Osteopathic therapy 0539 - Other
054X	Ambulance 0540 – General 0541 – Supplies 0542 – Medical transport 0543 – Heart mobile 0544 - Oxygen 0545 – Air ambulance 0546 – Neonatal ambulance 0547 – Pharmacy 0548 – EKG transmission 0549 - Other

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055X	Skilled Nursing 0550 – General 0551 – Visit charge 0552 – Hourly charge 0559 - Other
056X	Home Health Medical Social Services 0560 – General 0561 – Visit charge 0562 – Hourly charge 0569 - Other
057X	Home Health Aide 0570 – General 0571 – Visit charge 0572 – Hourly charge 0579 - Other
058X	Home Health Other Visits 0580 – General 0581 – Visit charge 0582 – Hourly charge 0583 – Assessment 0589 - Other
059X	Home Health Units of Service 0590 - General
060X	Home Health Oxygen 0600 - General 0601 – Stat/Equip/Supply or contents 0602 - Stat/Equip/Supply Under 1 LPM 0603 - Stat/Equip Over 4 LPM 0604 – Portable Add-on 0609 - Other
061X	Magnetic Resonance Technology (MRT) 0610 – General 0611 – Brain/brain stem 0612 – Spinal cord/spine 0614 – Other MRI 0615 – Head and neck 0616 – Lower extremities 0618 – Other MRA 0619 – Other MRT

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062X	Medical/Surgical Supplies – Extension of 027X 0621 – Incident to Radiology 0622 - Incident to Other Diagnostic services 0623 – Surgical Dressings 0624 – FDA investigational devices
063X	Pharmacy – Extension of 025X 0631 – Single source drug 0632 – Multiple source drug 0633 – Restrictive prescription 0634 – Erythropoietin (EPO) less than 10,000 units 0635– Erythropoietin (EPO) 10,000 or more units 0636 – Drugs requiring detailed coding 0637 – Self-administerable drugs
064X	Home IV Therapy Services 0640 – General 0641 – Non-routine nursing, central line 0642 – IV site care, central line 0643 – IV start/care, peripheral line 0644 – Non-routine nursing, peripheral line 0645 – Training patient/caregiver, central line 0646 – Training disabled patient, central line 0647 – Training patient/caregiver, peripheral line 0648 - Training disabled patient, peripheral line 0649 - Other
065X	Hospice Service 0650 – General 0651 – Routine home care 0652 – Continuous home care 0655 – Inpatient respite care 0656 – General inpatient care (nonrespite) 0657 – Physician services 0658 – Hospice room and board – nursing facility 0659 - Other
066X	Respite Care 0660 – General 0661 – Hourly charge/nursing 0662 – Hourly charge/aide/homemaker/companion 0663 – daily respite charge 0669 - Other
067X	Outpatient Special Residence Charges 0670 – General 0671 – Hospital owned 0672 – Contracted 0679 - Other

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068X	068X Trauma Response 0681 – Level I 0682 – Level II 0683 – Level III 0684 – Level IV 0689 - Other
069X	Reserved
070X	Cast Room 0700 - General
071X	Recovery Room 0710 - General
072X	Labor Room/Delivery 0720 – General 0721 – Labor 0722 – Delivery 0723 – Circumcision 0724 – Birthing center 0729 - Other
073X	EKG/ECG Electrocardiogram 0730 – General 0731 – Holter monitor 0732 – Telemetry 0739 - Other
074X	EEG Electroencephalogram 0740 - General
075X	Gastrointestinal Services 0750 - General
076X	Specialty Services 0760 – General 0761 – Treatment room 0762 – Observation hours 0769 - Other
077X	Preventive Services 0770 – General 0771 – Vaccine administration
078X	Telemedicine 0780 - General
079X	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) 0790 – General

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080X	Inpatient Renal Dialysis 0800 – General 0801 – Inpatient hemodialysis 0802 – Inpatient peritoneal (non-CAPD) 0803 – Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD) 0804 – Inpatient Continuous Cycling Peritoneal Dialysis (CCPD) 0809 - Other
081X	Acquisition of Body Components 0810 – General 0811 – Living donor 0812 – Cadaver donor 0813 – Unknown donor 0814 – Unsuccessful organ search – donor bank charges 0819 - Other
082X	Hemodialysis – Outpatient or Home 0820 – General 0821 – Composite or other rate 0822 – Home supplies 0823 – Home equipment 0824 – Maintenance/100% 0825 – Support Services 0829 - Other
083X	Peritoneal Dialysis – Outpatient or Home 0830 – General 0831 – Composite or other rate 0832 – Home supplies 0833 – Home equipment 0834 - Maintenance/100% 0835 – Support Services 0839 - Other
084X	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home 0840 – General 0841 – Composite or other rate 0842 – Home supplies 0843 – Home equipment 0844 - Maintenance/100% 0845 – Support Services 0849 - Other

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085X	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home 0850 – General 0851 – Composite or other rate 0852 – Home supplies 0853 – Home equipment 0854 - Maintenance/100% 0855 – Support Services 0859 - Other
086X	Magnetoencephalography 0860 – General 0861 - MEG
087X	Reserved
088X	Miscellaneous Dialysis 0880 – General 0881 – Ultrafiltration 0882 – Home dialysis aid visit 0889 - Other
089X	Reserved
090X	Behavioral Health Treatments/Services (also see 091X, Extension of 090X) 0900 – General 0901 – Electroshock 0902 – Milieu therapy 0903 – Play therapy 0904 – Activity therapy 0905 – Intensive outpatient services - psychiatric 0906 – Chemical dependency 0907 – Community behavioral health program – day treatment
091X	Behavioral Health Treatments/Services – Extension of 090X 0911 – Rehabilitation 0912 – Partial hospitalization – less intensive 0913 – Partial hospitalization - intensive 0914 – Individual therapy 0915 – Group therapy 0916 – Family therapy 0917 – Biofeedback 0918 – Testing 0919 – Behavioral health treatments

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092X	Other Diagnostic Services 0920 – General 0921 – Peripheral vascular lab 0922 – Electromyelogram 0923 – Pap smear 0924 – Allergy test 0925 – Pregnancy test 0929 - Other
093X	Medical Rehabilitation Day Program 0931 – Half day 0932 – Full day
094X	Other Therapeutic Services – See alos 095X 0940 – General 0941 – Recreational 0942 – Education/training 0943 – Cardiac rehabilitation 0944 – Drug rehabilitation 0945 – Alcohol rehabilitation 0946 – Complex medical equipment – routine 0947 - Complex medical equipment – ancillary 0948 – Pulmonary rehabilitation 0949 - Other
095X	Other Therapeutic Services (Extension of 094X) 0951 – Athletic training 0952 - Kinesiotherapy
096X	Professional Fees 0960 – General 0961 – Psychiatric 0962 – Ophthalmology 0963 – Anesthesiologist (MD) 0964 – Anesthesiologist (CRNA) 0969 - Other
097X	Professional Fees (Extension of 096X) 0971 – Laboratory 0972 – Radiology – diagnostic 0973 – Radiology – therapeutic 0974 – Nuclear medicine 0975 – Operating room 0976 – Respiratory therapy 0977 – Physical therapy 0978 – Occupational therapy 0979 – Speech pathology

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098X	Professional Fees (Extension of 096X and 097X) 0981 – Emergency room 0982 – Outpatient services 0983 – Clinic 0984 – Medical social services 0985 – EKG 0986 – EEG 0987 – Hospital visit 0988 – Consultation 0989 – Private-duty nurse
099X	Patient Convenience Items 0990 – General 0991 – Cafeteria/guest tray 0992 – Private linen service 0993 – Telephone/telegraph 0994 – TV/radio 0995 – Non-patient room rentals 0996 – Late discharge charge 0997 – Admission kits 0998 – Beauty shop/barber 0999 - Other
100X	100X Behavioral Health Accommodations 1000 – General 1001 – Residential treatment – psychiatric 1002 – Residential treatment – chemical dependency 1003 – Supervised living 1004 – Halfway House 1005 – Group Home
101X-209X	Reserved
210X	Alternative Therapy Services 2100 – General 2101 – Acupuncture 2102 – Acupressure 2103 – Massage 2104 – Reflexology 2105 – Biofeedback 2106 – Hypnosis 2109 – Other
211x – 300X	Reserved

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310X	Adult Care 3101 – adult daycare, medical and social – hourly 3102 – Adult daycare, social – hourly 3103 – Adult daycare, medical and social – daily 3104 – Adult daycare, social – daily 3105 – Adult foster care – daily 3109 - Other
311X-999X	Reserved

Patient Marital Status

Valid Values under HIPAA (Not Required for Medicare)

S	Single	X	Legally Separated	W	Widowed
M	Married	D	Divorced	U	Unknown
L	Life Partner				

Modifiers

Modifiers indicate a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

When selecting the appropriate modifier to be reported with your claim, please ensure that the modifier is valid for the date of service being submitted. Examples of when modifiers may be used are:

- Identification of only a professional or technical component
- Repeat services by the same or different provider
- An increased, reduced or unusual service
- Billing for components of a global surgical package
- Identification of a specific body area
- To designate a bilateral procedure
- Identification of service in a clinical trial

Periodically CMS may establish new modifiers for use in addition to the following lists. Palmetto GBA will publish any new additions on the website. Please ensure you make note of any new additions that are not reflected in this material.

- Anesthesia Modifiers
- Global Surgery Modifiers
- Surgical Modifiers
- Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Modifiers
- Provider Quality Reporting Initiative (PQRI) Modifiers
- Ambulance Modifiers
- Additional CPT Modifiers
- Additional HCPCS Modifiers

Anesthesia Modifiers

- One of the following modifiers must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service:

HCPCS Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures.
QK	Medically directed by a physician: two, three, or four concurrent procedures
QY	Anesthesiologist medically directs one CRNA
QX	CRNA service: with medical direction by a physician
QZ	CRNA service: without medical direction by a physician

- The following modifiers can be reported in the 2nd position under appropriate circumstances in addition to one of the previous anesthesia modifiers:

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HCPCS Modifier	Description
QS	Monitored anesthesia care service

CPT Modifier	Description
23	Unusual anesthesia Note: When using CPT modifier 23, appropriate documentation must be submitted with the claim.

Global Surgery Modifiers

- The following modifiers are used by physicians to indicate a billed service is not part of a global surgical package and is eligible for separate reimbursement:

CPT Modifier	Description
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the CPT modifier 24 to the appropriate level of E/M service. An excision of a malignant lesion on the left arm is performed in the office on January 10, 2013. The post-operative period designated for excision CPT code 11606 is 10 days. The patient returns to the office on January 15, 2009 and is treated for contact dermatitis. The physician should report the appropriate evaluation and management code followed by the 24 CPT modifier, e.g., 9921224 (CPT code/CPT modifier). In order for the evaluation and management service to be payable in the post-operative period with the 24 CPT modifier, the diagnosis code supporting the E/M service must be different from the diagnosis code reported for the previously performed surgery. CPT modifier 24 should not be used for the medical management of a patient by the surgeon following surgery. Medicare recognizes CPT modifier 24 only for the care following a discharge under these circumstances: • The care is for immunotherapy management furnished by the transplant surgeon; • The care is for critical care (CPT codes 99291, 99292) for a burn or trauma patient; or • The documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.

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25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or be beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding CPT modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform major surgery. See CPT modifier 57. For significant, separately identifiable non-E/M services, see CPT modifier 59.
57	Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding CPT modifier 57 to the appropriate level of E/M service. E/M services on the day before or on the day of major surgery (90 day global period) which result in the initial decision to perform the surgery are not included in the global surgery payment. These E/M services may be billed separately and identified with the 57 CPT modifier. This modifier should not be used for visits furnished during the global period of minor procedures (0 or 10 day global period) unless the purpose of the visit is a decision for major surgery. This modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. When the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure. See CPT modifier 25.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding the CPT modifier 58 to the staged or related procedure. Note: For treatment of a problem that required a return to the operating or procedure room (e.g., unanticipated clinical condition), see CPT modifier 78.

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59	Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. CPT modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area in injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than CPT modifier 59. CPT modifier 59 should only be used if there is no other more descriptive modifier available and the use of CPT modifier 59 best explains the circumstances. Note: CPT modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see CPT modifier 25.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating room, it may be reported by adding CPT modifier 78 to the related procedure. (For repeat procedures, see CPT modifier 76).
79	Unrelated Procedure by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the CPT modifier 79. (For repeat procedures on the same day, see CPT modifier 76).

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Surgical Modifiers

CPT Modifier	Description
50	Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the CPT modifier 50 to the appropriate five digit code. Report such procedures as a single line item with a unit of 1. For example, when CPT code 19303 (Mastectomy, simple, complete) is performed bilaterally, report the service as 1930350 (CPT code/modifier). If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), do NOT report the procedure code with CPT modifier 50. For example, CPT code 68810 to 68815, (probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral) includes terminology which indicates the procedure is performed either unilaterally or bilaterally. Therefore it's not appropriate to report this modifier with this code. Additionally some procedure codes, i.e., CPT code 52000 (Cystourethroscopy, separate procedure) should NOT be reported with the 50 CPT modifier since anatomy does not permit this procedure to be performed bilaterally.
51	Multiple Procedures: When multiple procedures, other than E/M services, physical medicine and rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the CPT modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes.

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53	Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the CPT modifier 53 to the code reported by the physician for the discontinued procedure. CPT modifier 53 is used for "unusual (discontinued) circumstances". Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances that may threaten the well-being of the patient. In many instances, attachments, medical records, etc. are not required to be sent in if an explanation for the discontinuation is in the narrative field of the claim. For example, submit "discontinued due to elevated blood pressure". When additional information to support the use of the 53 CPT modifier cannot be contained in the narrative of the claim, additional documentation may be submitted. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see CPT modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use)
54	Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the CPT modifier 54 to the usual procedure code. Services billed with a 54 CPT modifier will be reimbursed at the intraoperative allowance for the surgical procedure. The intraoperative allowance includes the one day preoperative care, the intraoperative service, as well as any in-hospital visits that are performed.
55	Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the CPT modifier 55 to the usual procedure number. This modifier is used to identify postoperative, out of hospital medical care associated with a given surgical procedure. When billing for postoperative care only, report the original date of surgery as your date of service and the procedure code for the surgical procedure followed by the 55 CPT modifier. In rare situations where the out of hospital postoperative care is split between physicians, each physician must also indicate the period of his/her responsibility for the patient's postoperative care by reporting the appropriate range of dates. Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service.

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62	Two surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding CPT modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with CPT modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with CPT modifier 80 or modifier 82 added, as appropriate.
66	Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the CPT modifier 66 to the basic procedure number used for reporting services. Documentation establishing that a surgical team was medically necessary is required for certain services identified by Centers for Medicare & Medicaid Services (CMS). All claims for team surgeons must contain sufficient information i.e., operative reports, to allow pricing "by report".
73	Discontinued Out-patient Hospital/Ambulatory Surgical Center (ASC) Procedure Prior to the Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the CPT modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see CPT modifier 53.
74	Discontinued Out-patient Hospital/Ambulatory Surgical Center (ASC) Procedure after Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s) or general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of the CPT modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see CPT modifier 53.

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80	Assistant Surgeon: Surgical assistant services may be identified by adding the CPT modifier 80 to the usual procedure number(s). This modifier should be reported to identify surgical assistant services performed in a non-teaching setting or in a teaching setting when a resident was available but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare. When the surgical services are performed in a non-teaching setting, report "Non-teaching" in the narrative section of an electronic claim submission.
81	Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding CPT modifier 81 to the usual procedure number.
82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of CPT modifier 82 appended to the usual procedure code number(s). This modifier is used in teaching hospitals if there is no approved training program related to the medical specialty required for the surgical procedure or no qualified resident was available.

Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Modifiers

HCPCS Modifier	Description
AQ	Service performed in a Health Professional Shortage Area. This modifier is used by physicians to indicate the services reported were rendered in a qualified Health Professional Shortage Area (HPSA) and are eligible for the 10% incentive payment.
AR	Physician providing services in a physician scarcity area.

Provider Quality Reporting Initiative (PQRI) Modifiers

These modifiers are only to be used for PQRI, no other modifiers should be used when reporting PQRI.

CPT Modifier	Description
1P	Performance Measure Exclusion Modifier Due to Medical Reasons
2P	Performance Measure Exclusion Modifier Due to Patient Choice
3P	Performance Measure Exclusion Modifier Due to System Reasons
8P	Performance Measure Reporting Modifier - Action Not Performed, Reason Not Otherwise Specified

Ambulance Modifiers

- For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates.
- Origin and destination modifiers used for ambulance services are created by combining two alpha characters. The first position alpha code equals origin; the second position alpha code equals destination.

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Origin/ Destination	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital based ESRD facility
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital Note: This is a destination code only

- In addition, institutional-based providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly.

HCPCS Modifier	Description
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
QL	Patient pronounced dead after ambulance called

Additional CPT Modifiers

CPT Modifier	Description
22	Increased Procedural Services: When the work required to provide a service is substantially is greater than typically required, it may be identified by adding CPT modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service. It should only be reported with procedure codes that have a global period of 0, 10, or 90 days.

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26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the CPT modifier 26 to the usual procedure number. This modifier must be reported in the first modifier field.
32	Mandated Services: Services related to mandated consultation and/or related services (e.g., third-party payer governmental, legislative or regulatory requirement) may be identified by adding CPT modifier 32 to the basic procedure.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the CPT modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. CPT modifier 52 is used for "unusual (reduced) circumstances." It designates that the service performed was significantly less than usually required. In many instances, attachments, medical records, etc. are not required to be sent in if an explanation for the reduction is in the narrative field of the claim. For example, submit "one view only" in the narrative when only one view of a two view study is performed. Similarly "right side only" may be submitted when a procedure code that is bilateral by definition is not performed bilaterally. When additional information to support the use of the 52 CPT modifier cannot be contained in the narrative of the claim, additional documentation may be submitted.
76	Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the CPT modifier 76 to the repeated procedure or service.
77	Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding CPT modifier 77 to the repeated procedure or service.
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the CPT modifier 90 to the usual procedure number. For the Medicare program, this modifier is used by independent clinical laboratories when referring tests to a reference laboratory for analysis.
91	Repeat Clinical Diagnostic Laboratory Test: In the same course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the CPT modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other codes describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory tests performed more than once on the same day for the same patient.

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92	Alternative Laboratory Platform Testing: When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding CPT modifier 92 to the usual laboratory procedure code (HIV testing CPT codes 86701-86703). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

Additional HCPCS Modifiers

HCPCS Modifier	Description
AE	Registered Dietician
AF	Specialty Physician
AG	Primary Physician
AH	Clinical Psychologist
AI	Principal Physician of Record
AJ	Clinical Social Worker
AK	Non-Participating Physician
AM	Physician, team member service
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. Must be reported with a Assistant Surgeon CPT modifier (i.e. 80, 81, 82)
AT	Acute Treatment For dates of service on or after October 12, 2007, HCPCS modifier AT is required on all claims for tetanus or rabies injection(s). Chiropractors must bill the AT HCPCS modifier when reporting CPT codes 98940, 98941, 98942 to indicate active/corrective treatment. Claims submitted without the AT HCPCS modifier will be denied for maintenance therapy.
AX	Item furnished in conjunction with dialysis services
AY	Item or service furnished to an ESRD patient that is not for the treatment of ERSD
AZ	Physician providing a service in a dental Health Professional Shortage Area for the purpose of an Electronic Health Record Incentive Payment
BL	Special Acquisition of blood and blood products
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires or is transferred prior to admission.
CB	Services ordered by a dialysis physician as part of an ESRD beneficiary's dialysis benefit; is not part of the composite rate and is separately reimbursable.
CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable

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CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.
CF	AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted
CR	Catastrophe/Disaster Related
CS	Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities.
DA	Oral health assessment by a licensed Health Professional other than a dentist
EA	Erythropetic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy
EB	Erythropetic stimulating agent (ESA) administered to treat anemia due to anti-cancer radiotherapy.
EC	Erythropetic stimulating agent (ESA) administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy
ED	Hematocrit level has exceeded 39% (or Hemoglobin level has exceeded 13.0 G/DL) for 3 or more consecutive billing cycles immediately prior to and including the current cycle
EE	Hematocrit level has not exceeded 39% (or Hemoglobin level has not exceeded 13.0 G/DL) for 3 or more consecutive billing cycles immediately prior to and including the current cycle.
EJ	Subsequent claims for a defined course of therapy, (e.g., EPO, Sodium Hyaluronate, Infliximab
EM	Emergency supply ESRD
ET	Emergency Treatment; used to report ER services that are excluded from SNF Consolidated Billing for a beneficiary in a Medicare Part A stay and to report ESRD-related laboratory tests furnished to ESRD patients on a day other than the date of the ER visit.
EY	No physician or other Licensed Health Care Provider order for this item or service
E1	Upper left, eyelid
E2	Lower left, eyelid

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E3	Upper right, eyelid
E4	Lower right, eyelid
ET	Emergency Services
FA	Left Hand, thumb
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples).
FC	Partial credit received for replaced device
FX	X-rays using film
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
G6	ESRD patient for whom less than six dialysis sessions have been provided in a month
G7	Pregnancy resulted from rape or incest or pregnancy certified by physicians as life threatening.
GA	Beneficiary authorization: Report this modifier to indicate that advance written notice was provided to the beneficiary of the likelihood of denial of a service as being not reasonable and necessary under Medicare guidelines.
GC	This service has been performed in part by a resident under the direction of a teaching physician.
GD	Units of service exceed medically unlikely edit value and represents reasonable and necessary services.
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception. Note: HCPCS modifier GE for this purpose is for use on all services except ambulance.
GG	Performance and payment of screening mammogram and diagnostic mammogram on the same patient, on the same day
GH	Diagnostic mammogram converted from screening mammogram on the same day
GM	Multiple patients on one ambulance trip

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GN	Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care
GO	Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care
GP	Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care
GR	This service was performed in whole or in part by a resident in a department of Veterans Affairs Medical Center or clinic supervised in accordance with VA policy.
GT	Via interactive audio and video telecommunication systems
GU	Waiver of liability statement issued as required by a payer policy, routine notice
GV	Attending physician not employed or paid under arrangement by the patient's hospice provider
GW	Service not related to the hospice patients terminal condition
GX	Notice of liability issued, voluntary under payer policy
GY	Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for Non-Medicare Insurers, is not a contract benefit. The GY HCPCS modifier should be used when billing for items or services that are statutorily excluded or do not meet the definition of any Medicare benefit. Example: routine physical exam. All services reported with the GY HCPCS modifier will be denied by Medicare.
GZ	Item or service expected to be denied as not reasonable and necessary
J1	Competitive Acquisition Program, no-pay submission for a prescription number
J2	Competitive Acquisition Program, restocking of emergency drugs after emergency administration
J3	Competitive Acquisition Program, (CAP) drug not available through CAP as written, reimburse under ASP Methodology
JA	Administered Intravenously
JB	Administered Subcutaneously
JC	Skin substitute used as a graft
JD	Skin substitute NOT used as a graft
KC	Replacement of special power wheelchair interface
KD	Drug or biological infused through DME
KE	Bid under round one of the DMEPOS competitive bidding program for use with non-competitive bid base equipment
KF	Item designated by FDA as Class III device
KX	Requirements specified in the Medical Policy have been met

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LM	Left main coronary artery
KZ	New coverage not implemented by managed care
LM	Left main coronary artery
LT	Left Side (used to identify procedures performed on the left side of the body) If used to substantiate different body sites, this modifier can exclude services from rebundling.
M2	Medicare Secondary Payer for CAP
NB	Nebulizer system, any type, FDA-Cleared fo ruse with specific drug
PA	Surgery, wrong body part
PB	Surgery, wrong patient
PC	Wrong surgery on patient
PD	Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days
PI	PET Tumor init tx strategy
PN	Non-excepted service at an off-campus, outpatient, provider-based department of hospital
PO	Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient department
PS	PET Tumor subsq tx strategy
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study.
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study.
Q3	Live kidney donor surgery and related services Services will be reimbursed at 100% of the allowed charge as required in Section 1881 (d) of the Social Security Act. The following bullets are some reporting notes and tips for submitting kidney donor services: • In the event that more than two modifiers are required when reporting postoperative physician services furnished to live kidney donors, it is important that the Q3 HCPCS modifier is reported in the first modifier position. This is necessary to ensure that these services are reimbursed at 100%. • Services are to be reported under the name and HIC number of the recipient of the kidney donation. • CPT code 50320, Donor nephrectomy from living donor CPT code 50547
Q4	Service for ordering/referring physician qualifies as a service exemption for laboratory services
Q5	Service furnished by a substitute physician under a reciprocal billing arrangement

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Q6	Service furnished by a locum tenens physician
Q7	One Class A Finding Note: HCPCS modifiers Q7, Q8, and Q9 are to be used to bill podiatric services.
Q8	Two Class B Findings Note: HCPCS modifiers Q7, Q8, and Q9 are to be used to bill podiatric services.
Q9	One Class B and Two Class C Findings Note: HCPCS modifiers Q7, Q8, and Q9 are to be used to bill podiatric services.
QL	Patient pronounced dead after ambulance called
QP	Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile CPT codes 80002-80019, and HCPCS codes G0058, G0059 and G0060.
QW	CLIA Waived Tests
QZ	Non-medically directed CRNA services
RA	Replacement of a DME item, Orthotic or Prosthetic Item
RB	Replacement of a Part of DME, Orthotic or Prosthetic Item furnished as Part of a Repair
RD	Drug provided to beneficiary, but not, administrated incident-to
RE	Furnished in full compliance with FDA-Mandated Risk Evaluation and Mitigation Strategy (REMS)
RP	Replacement and repair
RT	Right side (used to identify procedures performed on the right side of the body) If used to substantiate different body sites, this modifier can exclude services from rebundling.
SF	Second opinion ordered by a Professional Review Organization (PRO) per section 9401, P.L. 99-272 (100 % reimbursement – no Medicare deductible or coinsurance)
SS	Home infusion services provided in the infusion suite of the IV therapy provider
SW	Services provided by a certified diabetes educator
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit

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T9	Right foot, fifth digit Note: These modifiers can be used to indicate that comprehensive or component code combinations were performed on different digits. Separate payment will be allowed when column I & II services are performed on different digits.
TC	Technical component: Under certain circumstances a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding HCPCS modifier TC to the usual procedure code number. This modifier must be reported in the first modifier field.
TS	Follow-up service
UN	Two Patients Served: This modifier is needed when transportation of portable x-ray equipment (HCPCS code R0075) is billed.
UP	Three Patients Served: This modifier is needed when transportation of portable x-ray equipment (HCPCS code R0075) is billed.
UQ	Four Patients Served: This modifier is needed when transportation of portable x-ray equipment (HCPCS code R0075) is billed
UR	Five Patients Served: This modifier is needed when transportation of portable x-ray equipment (HCPCS code R0075) is billed.
US	Six Patients Served: This modifier is needed when transportation of portable x-ray equipment (HCPCS code R0075) is billed.
V5	Any Vascular Catheter (alone or with any other vascular access) - Part A only modifier
V6	Arteriovenous Graft (or other vascular access not including a vascular catheter) - Part A only modifier
V7	Afteriovenous Fistula (or other vascular access not including a vascular catheter) - Part A only modifier
V8	Dialysis related infection present during the billing month - Part A only modifier
V9	No dialysis related infection present during the billing month - Part A only modifier

Patient Relationship Codes

HIPAA Individual Relationship Codes	Valid Values	Convert to CWF Patient Relationship Codes Effective October 16, 2003
1	Spouse	2
4	Grandfather or Grandmother	19
5	Grandson or Grandaughter	13
7	Nephew or Niece	14
10	Foster Child	6
15	Ward of the Court	7
17	Stepson or Stepdaughter	5
18	Self	1
19	Child	3
20	Employee	8
21	Unknown	9
22	Handicapped/Dependent	10
23	Sponsored Dependent	16
24	Dependent of Minor Dependent	17
29	Significant Other	none*
32	Mother	none
33	Father	none
36	Emancipated Minor	none
39	Organ Donor	11
40	Cadaver Donor	12
41	Injured Plaintiff	15
43	Child Where Insured Has No Financial Responsibility	4
53	Life Partner	none*
G8	Other Relationship	none

* No 1:1 map for Significant Other and Life Partner

Type of Admission or Visit Code

1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
9	Information Not Available

Payer Codes

No.	Payer Code Description
1	Medicaid
2	Blue Cross
3	Other
4	None
A	Working Aged (Value Code 12)
B	ESRD beneficiary in 30 month coordination period with EGHP (Value Code 13)
C	Conditional Payment
D	Auto no-fault (Value Code 14)
E	Workers Comp (Value Code 15)
F	Public Health or Federal Agency (Value Code 16)
G	Disabled (Value Code 43)
H	Black Lung (Value Code 41)
I	Veterans Administration (Value Code 42)
L	Liability (Value Code 47)
Z	Medicare

Note: Payer codes 1 through 4 are used when the other payer is secondary. The alpha payer codes are used when the other payer is primary.

Repetitive Services

Reference: IOM 100-4, Chapter 1, Sec 50.2.2

Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services. Repetitive services are required to be billed monthly or at the end of treatment. Any items and/or services in support of the repetitive service should be reported on the same claim (example: disposable supplies, drugs or equipment used to furnish the repetitive service).

Type of Service	Revenue Code
DME Rental	0290 - 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 - 0429
Occupational Therapy	0430 - 0439
Speech-Language Pathology	0440 - 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 - 0859
Cardiac Rehab Services	0482, 0943
Pulmonary Rehabilitation Services	948

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Note: Report occurrence span code 74 on the monthly repetitive service bill to encompass any inpatient stay dates, day of outpatient surgery, or outpatient hospital services subject to OPPS.

Note: If a non-repetitive OPPS service is provided on the same date of a repetitive service, report the non-repetitive OPPS service (along with any packaged and/or services related to the non-repetitive service) on a separate OPPS claim.

One Day Payment Window

Reference: IOM 100-4, Chapter 3, Sec 40.3B and 40.3C

This provision applies to hospitals excluded from IPPS. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long term care hospitals (LTCH); children's hospitals; and cancer hospitals.

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 1 day prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

Note: For hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.
Critical Access Hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services when the line item date of service (LIDOS) falls on the day of admission or one day prior to admission for hospitals excluded from IPPS.

The following revenue codes and/or HCPCS codes are defined as diagnostic services:

Revenue Codes	Description
254	Drugs incident to other diagnostic services
255	Drugs incident to radiology
	Laboratory
30X	Laboratory pathological
31X	Radiology diagnostic
32X	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
341, 343	CT scan
35X	Anesthesia incident to radiology
371	Anesthesia incident to other diagnostic services

Continued on next page

40X	Other imaging services
46X	Pulmonary function
471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 diagnostic
482	Cardiology, Stress Test
483	Cardiology, Echocardiology
53X	Osteopathic services
61X	MRT
62X	Medical/surgical supplies, incident to radiology or other diagnostic services
73X	EKG/ECG
74X	EEG
918	Testing- Behavioral Health
92X	Other diagnostic services

Non-diagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the day immediately preceding and including the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment.

Three Day Payment Window

Reference: IOM 100-4, Chapter 3, Sec 40.3B and 40.3C

Note: For hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. Critical Access Hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

The following revenue codes and/or HCPCS codes are defined as diagnostic services:

Revenue Codes	**Description**
254	Drugs incident to other diagnostic services
255	Drugs incident to radiology
30X	Laboratory

Continued on next page

31X	Laboratory pathological
32X	Radiology diagnostic
341, 343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
35X	CT scan
371	Anesthesia incident to radiology
372	Anesthesia incident to other diagnostic services
40X	Other imaging services
46X	Pulmonary function
471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 diagnostic
482	Cardiology, Stress Test
483	Cardiology, Echocardiology
53X	Osteopathic services
61X	MRT
52X	Medical/surgical supplies, incident to radiology or other diagnostic services
73X	EKG/ECG
74X	EEG
918	Testing- Behavioral Health
92X	Other diagnostic services

Non-diagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment.

Note: CMS defines all non-diagnostic services except ambulance and maintenance renal dialysis services as related to the inpatient admission unless the hospital attests to specific non-diagnostic services as being unrelated to the inpatient hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 to the separately billed outpatient non-diagnostic services claim.

Outpatient PPS Outpatient Code Editor (OCE) Payment Flags

OCE Flags appear on MAP171A (claim line item detail page), and explain the OPPS payment computations applied to HPCPS/CPT codes, such as multiple procedure discounting and packaging.

The claim line item detail contains nine payment flags:
- Flag 1 – Status Indicator
- Flag 2 – Payment Indicator
- Flag 3 – Discounting Formula Number
- Flag 4 – Line Item Denial or Rejection

Continued on next page

- Flag 5 – Packaging
- Flag 6 – Payment Adjustment
- Flag 7 – Payment Method
- Flag 8 – Line Item Action
- Flag 9 – Composite Adjustment

Flag 1 - OPPS Payment Status Indicators

Values	Description
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS e.g. Ambulance, lab, PT/OT/SLP, Routine Dialysis for ESRD patients, Screening/Diagnostic Mammography, Non-Implantable Prosthetic/Orthotics devices, EPO for ESRD patients
B	Codes that are not recognized by OPPS when submitted on an 12x or 13x TOB - there may be an alternative code or alternate type of bill
C	Inpatient-only procedures; not paid under OPPS. Admit patient, Bill as inpatient
D	Discontinued Codes
E	Items, Codes, and Services that are not covered by Medicare based on statutory exclusion, or there may be an alternate code for the same service or separate payment is not provided by Medicare
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines
G	Pass-through Drugs and Biologicals; separate APC payment; Paid at a reasonable cost
H	Pass-through Device Categories; separate cost-based pass-through payment, not subject to copayment
K	Non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals; Paid under OPPS, separate APC payment
L	Flu/PPV vaccines-not paid under OPPS, paid at reasonable cost, not subject to deductible or coinsurance
M	Service not billable to the FI or MAC
N	Items or services packaged into APC rates therefore no separate payment is made
P	Partial hospitalization service- per diem APC payment
Q1	STVX-Packaged Codes - Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator S, T, V or X. Otherwise, payment is made through separate APC.
Q2	T-Packaged Codes - Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator T. Otherwise, payment is made through separate APC.
Q3	Codes that may be paid through a composite APC. Composite APC payment based on OPPS composite-specific payment criteria. Payment packaged into a single payment for specific combination of service. In all other circumstances, payment is made through a separate APC or packaged into payment for other services. OPPS Final Rule Addendum M lists composite APC assignments.
R	Blood and Blood Products; separate APC payment
S	Significant procedure not subject to multiple procedure discounting; Separate APC payment
T	Significant procedure subject to multiple procedure discounting; Separate APC payment

Continued on next page

U	Brachytherapy Sources; separate APC payment
V	Clinic or Emergency Department Visit; separate APC payment
X	Ancillary service; Separate APC payment
Y	Non-implantable Durable Medical Equipment; not paid under OPPS, all institutional providers except home health agencies bill to DMERC.

Flag 2 - OPPS Payment Indicator

Value	Description
1	Paid standard hospital OPPS amount (status indicators K, S, T, V, X)
2	Services not paid under OPPS (status indicator A)
3	Not paid (status indicators M, Q1, Q2, Q3, Y), or not paid under OPPS (status indicators B, C, Z)
4	Paid at reasonable cost (status indicators F, L)
5	Paid standard amount for pass-through drug or biological (status indicator G)
6	Payment based on charge adjusted to cost (status indicator H)
8	Paid partial hospitalization per diem (status indicator P)
9	No additional payment, payment included in line items with APCs (status indicator N; or no HCPCS code and certain revenue codes; or HCPCS codes G0176 - activity therapy, G0129 - occupational therapy, or G0177 - patient education and training services

Flag 3 - Discounting Formula Number

Discounting Formula Number	
'D'	Discounting Fraction (currently 0.5)
'U'	Number of Units
'T'	Terminated Procedure Discount (currently 0.5)
Value	Description
1	1.0
2	(1.0+D(U-1))/U
3	T/U
4	(1+D)/U
5	D
6	TD/U
7	D(1+D)/U
8	2.0

Flag 4 – Line Item Denial of Rejection

Value	Description
1	Line item not denied or rejected
2	Line item denied or rejected (procedure edit return buffer for line item contains a '9', '13', '18', '19', '20', '21', '28', '39', '40', '45', '47' ,'49', '50', '53', '64')
3	Not in Use

Continued on next page

Flag 5 – Packaging

Value	Description
0	Not packaged
1	Packaged service (status indicator 'N' or no HCPCS code and certain revenue codes)
2	Packaged as part of partial hospitalization Per Diem or daily mental health service Per Diem

Flag 6 – Payment Adjustment

Value	**Description**
0	No payment adjustment
1	Paid standard amount for pass-through drug or biological (status indicator G)
2	Payment based on charge adjusted to cost (status indicator H)
3	Additional payment for new drug or new biological applies to APC (status indicator 'J')*
4	Deductible not applicable (specific list of HCPCS codes)
5	Blood/blood product used in blood deductible calculation
6	Blood processing/storage not subject to blood deductible
7	Item provided without cost to provider
8	Item provided with partial credit to provider
91-99	Each composite APC present, same value for prime and non-prime codes.

Flag 7 – Payment Method

Value	**Description**
0	OPPS Pricer determines payment for service
1	Based on OPPS coverage, or billing rules, the service is not paid
2	Service is not subject to OPPS
3	Service is not subject to OPPS, and has an OCE line item denial or rejection
4	Line item is denied or rejected by you; OCE not applied to line item

Flag 8 – Line Item Action

Transferred from input, for Pricer, and can impact selection of discounting formula

Value	**Description**
0	OCE line item denial or rejection is not ignored
1	OCE line item denial or rejection is ignored
2	External line item denial. Line item is denied even if no OCE edits
3	External line item rejection. Line item is rejected even if no OCE edits
4	External line item adjustment. Technical charge rules apply

Flag 9 – Composite Adjustment

Value	**Description**
01	No composite group assigned
01	First composite group on claim

Continued on next page

02	Second composite group on claim
03-ZZ	Nth composite group on claim

PC/TC - Professional Component/Technical Component Indicators

0	Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.
1	Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.
2	Professional Component Only Codes--This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010--Electrocardiogram; Interpretation and Report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.
3	Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is 93005--Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.
4	Global Test Only Codes. This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe: (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

Continued on next page

5	Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.
6	Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.
7	Physical therapy service, for which payment may not be made--Payment 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: This indicator identifies the processional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to codes 88141, 85060 and P3001-26. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for codes 88141, 85060 or P3001-26 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.
9	Not Applicable--Concept of a professional/technical component does not apply.

Adjustment Reason

Adjustment reason codes are required on DDE adjustments (TOB XX7) and are entered on page 3. Adjustment Reason Codes are not used on paper or electronic claims.

Code	Description
AA	Automated Adjustment
AD	Admission Denial - Technical Denial (PRO Review Code - A)
AM	Admission Denial - No Payment (Medical Denial) (PRO Review Code - A)
AR	Admission Reversal - Hard Copy Adjustment
AW	Admission Denial-Payable Per Waiver
CA	Cost Outlier Approved
CB	This Reason Code will be to Identify Credit Balance Accounts
CC	Covered Charges Changes
CD	Covered Days Changes (PRO Review Code - B)
CO	Cost Outlier - No Payment (PRO Review Code - E)
CP	Cost Outlier Partial Approved
CR	Claim Reconsideration
CW	Cost Outlier Denial-Payable Per Waiver
DA	Day Outlier Approved

Continued on next page

DC	Diagnosis Changes (PRO Review Code - C)
DD	Discharge Destination Code Changes (PRO Review Code - C)
DG	DRG Change and Day Outlier Denial (PRO Review Code - G)
DH	DRG Change and Cost Outlier Denial (PRO Review Code - H)
DI	DRG and Beneficiary Liability Change (PRO Review Code - I)
DO	Day Outlier Denial - No Payment (PRO Review Code - D)
DP	Diagnosis and Procedure Changes (PRO Review Code - C)
DS	Discharge Status Change
DV	DRG Validation (PRO Review Code - C)
DW	Day Outlier Denial-Payable Per Waiver
EF	ESRD Adjustment Fix to Correct Original Claims
FB	Beneficiary Liability Change (PRO Review Code - F)
FC	HHPPS Final claim
FD	Full Denial (PRO Review Code - A)
FR	Full Reversal (PRO Review Code - N)
FT	Full Denial - Technical Denial (PRO Review Code - A)
HA	Home Health 485/486 Post-payment Audits
HC	Home Health Covered Compliance Reviews
HD	HMO Disenrollment
HP	HMO Pay
IB	PPS Interim Bill
IC	Non-Billable Revenue Codes Invalid Revenue Codes
ID	Inpatient or Blood Deductible
JP	Deemed Admission Change in Days (PRO Review Code - J)
KB	Deemed Admission Change in Days (PRO Review Code - J)
KD	Deemed Admission/Diagnosis Code Change (PRO Review Code - K)
KP	Deemed Admission/Procedure Code Change (PRO Review Code - K)
LD	Deemed Admission/Day Outlier Denial (PRO Review Code - L)
LI	Liability
LS	Length of Stay Denial-No Payment
LW	Length of Stay Denial-Payable Per Waiver
MC	Deemed Admission/Cost Outlier Denial (PRO Review Code - M)
NF	HHPPS No Final Claim
OC	Procedure Codes Changed, Denied, or Added (PRO Review Code - R)
OP	Day Outlier Approved
OT	Other Change
PC	Procedure Changes (PRO Review Code - C)
PD	Procedural Denial - No Payment
PI	Program Integrity

Continued on next page

PN	Provider Number Change
PP	Discharge Status Change (PRO Review Code - P)
PR	Previous Adjustment Modified (Modifies the PROs Last Action) (PRO Review Code - O)
PT	Admission Denial and DRG Change (PRO Review Code - T)
PW	Procedural Denial - Payable Per Waiver
QC	Procedure Codes (HCPCS) Changed/Deleted/Added (PRO Review Code - R)
QD	Ancillary Services Denied or Approved (PRO Review Code - Q)
QR	HCPC Added/Deleted/Changed with Ancillary Change (PRO Review Code-S)
RI	Recovery Audit Contractor (RAC) Identified Overpayment
RC	Complete Reversal of Previous Adjustment (PRO Review Code - N)
RP	Partial Reversal of Previous Adjustment (PRO Review Code - O)
SB	Same Benefit Period
SD	Seven Day Readmission Denial
SW	Seven Day Re-admission Denial - Payable Per Waiver
TD	Transfer Denial - No Payment
TW	Transfer Denial - Payable Per Waiver
YA	Pacemaker Denial - No Data
YB	Pacemaker Denial - With Errors
YC	Pacemaker Reversal to Denial
YD	Pacemaker Reversal to Denial and not going to pay
ZW	Debit Adjustment being processed for Provider and Intermediary and an initial bill is being processed to CWF

Adjustment/Cancel Condition Codes

Use this reference guide to determine which condition code would be most appropriate in coding your adjustment/cancel claim.

D0 (zero)	This code should be used when the From and Thru date of a claim is changed. *When you are only changing the admit date use condition code D9.
D1	If another condition code does not apply and there is a change to the COVERED charges, this code should be used. *Use this code when adding a modifier to a line that would make the charges covered on the adjustment claim that were non-covered on the previous claim. *Use this code when the previous claim rejected for home health, hospice, HMO and other overlap reasons that have been updated.
D2	This code is used when there is a change to the revenue codes, HCPC codes or HIPPS code. *This code is not used for a change in the RUG code.
D3	This code is used for a second or subsequent interim PPS bill by inpatient PPS hospitals only.
D4	Change in grouper input (ICD Diagnosis codes, ICD Procedure codes, and RUG codes) *This code is only used if a provider is changing or adding an ICD or RUG code. * If the provider is only deleting these codes, then the D9 with remarks would be more appropriate.

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D5	This code is used when canceling a claim to correct the HIC number or provider number. *Condition code only applicable on an xx8 type of bill.
D6	This code is used when canceling a claim for reasons other than the HIC number or provider number. Used when canceling a claim to repay a payment. *Condition code only applicable to an xx8 type of bill.
D7	This code should be used when the original claim shows Medicare on the primary payer line and now the adjustment claim shows Medicare on the secondary payer line.
D8	This code should be used when the original claim shows Medicare on the secondary payer line and now the adjustment claim shows Medicare on the primary payer line.
D9	This code is used for adjustments not described in any other condition codes. Remarks are required when using the D9 condition code to make a change. *This code is used in place of the D7 when adjusting the claim for "conditional payment". *This code is used if adding a modifier to change liability and there is no change to the covered charge amount. *This code is used when adding or changing occurrence, occurrence span and/or value codes that do not affect the covered charges.
E0 (zero)	This code is used when the ONLY change on the claim is a correction to the patient status.

Outpatient Coding Questions

In a joint effort to improve billing and data quality, the American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS) have joined together in establishing the AHA clearinghouse to handle coding questions on established Healthcare Common Procedure Coding System (HCPCS) usage. The American Health Information Management (AHIMA) will also provide input through the Editorial Advisory Board.

The clearinghouse serves as a centralized point of contact to educate hospitals, policy makers and the public on HCPCS coding. Hospitals and health care professionals have experienced a growing need for greater consistency and improved understanding of HCPCS coding in the wake of implementation of prospective payment methods that utilize HCPCS coding for billing and payment purposes.

The AHA's Central Office handles the clearinghouse functions and provide open access to any person or organization that has questions regarding a subset of HCPCS coding, particularly hospitals and other health professionals who bill under the hospital outpatient prospective payment system (OPPS). Inquiries on the application of level I HCPCS codes (CPT-4) for physicians will be referred to the American Medical Association.

Level II HCPCS codes related to durable medical equipment, prosthetics, orthotics, and other supplies should be referred to the Statistical Analysis Durable Medical Equipment Regional Carriers (SADMERC). The SADMERC is responsible for providing suppliers and manufacturers with assistance in determining which HCPCS code should be used to describe DMEPOS items for the purpose of billing Medicare. The SADMERC has a toll free helpline for this purpose, (877) 735-1326, which is operational during the hours of 9 a.m. to 4 p.m. ET. In addition, the SADMERC publishes a product classification list on its website that lists individual items to code categories.

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HCPCS-related questions must be submitted in the approved form, which you can download from the AHA website at http://www.ahacentraloffice.org, and either faxed or mailed directly to the AHA Central Office. Be advised that it is difficult to provide coding responses to generic scenarios without specific information. Refer to the form for additional information that should be submitted with your coding question(s).

The mailing address and fax number for HCPCS-related questions are as follows:

Central Office on HCPCS
American Hospital Association
One North Franklin
Chicago, IL 60606
Fax: 312-422-4583

Coding question information is also available at:
http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp on the CMS website. For general HCPCS information, go to: http://www.cms.hhs.gov/MedHCPCSGenInfo/ on the CMS website.

MSP Form Locators

Form Locators Required for Billing Medicare Secondary Payer (MSP) Claims

Description	**Payer Code**	**Value Code Billed**
Working Aged	A	12
End Stage Renal Disease (ESRD)	B	13
Conditional Payment	C	Appropriate Valued Code for Primary Payer
No- Fault	D	14
Workers Compensation	E	15
Federal Black Lung Program	H	41
Veteran Affairs	I	42
Disability	G	43
Liability	L	47

NOTE: When billing electronically, the Payer Code is automatically entered by the system based on the value code entered by the provider.

When Medicare is secondary to other payers, the following Form Locators must be filled out when filling MSP claims:

Form Locator	**Description**	**Value Codes Associated**
31-34	Occurrence code for the beginning date of coordination period for ESRD patients	13, 14, 15, 47(only for liability claims)
39-41 a-d	Bill appropriate value code and amount paid by the other insurance. Amount is the actual amount paid by the insurance	12,13, 14, 15, 43, 47

Continued on next page

50a	Report specific Payer Code and the group insurance name.	12,13,14,15,41,42,43
58a	Name of individual who carries the insurance.	12,13,14,15,41,42,43
59a	Patient relationship to the insured	12,13,14,15,41,42,43
60a	Insured Unique ID (Medicare number)	12,13,14,15,41,42,43
61a	Insurance group name – Name of the group or plan through which that insurance is provided	12,13,14,15,41,42,43
62a	Insurance group number	12,13,15,43
65a	Name of employer providing health benefits to individual identified in FL58a	12,13,14,15,41,42,43
80	Remarks - Additional information	12,13,14,15,41,42,43

Effective October 5, 2009 per Change Request 6426, MSP claims cannot be adjusted, submitted, corrected or cancelled via Direct Data Entry (DDE).

Providers must include Claim Adjustment Segments (CAS) related group codes, Claim Adjustment Reason Codes (CARC) and associated adjustment amounts on MSP 837 claims sent to Medicare for processing. This includes all adjustments made by the primary payer, which explains why the claim's billed amount was not fully paid.
If the primary payer denied the service(s), submit the appropriate CARC to explain the reason for the denial. Certain CARC combinations cannot be processed by Medicare and may result in a denial due to insufficient explanation or conflicting information. Claims denied for these reasons must be resubmitted with the correct CARC codes. Do not include CARC codes that are not applicable to the claim. The CARC codes may be found at http://www.wpc-edi.com.

NOTE: Palmetto GBA cannot inform providers the correct CARC code to use.

References:
Change Request 6427 http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf Change Request http://www.cms.hhs.gov/Transmittals/downloads/R70MSP.pdf

Present on Admission Indicators

Value	Description
Y	Diagnosis was present at time of inpatient admission. *CMS will pay the complicating condition/major complicating condition (CC/MCC) DRG for those selected Hospital Acquired Conditions (HACs) that are coded as "Y" for the POA Indicator*
N	Diagnosis was not present at time of inpatient admission. *CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.*

Continued on next page

U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. *CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.*
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. *CMS will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.*

ICD-10-CM POA Exempt Codes

For a list of the 2013 ICD-10-CM POA Exempt Codes go to the Downloads section at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html

Air and Ground Transportation Indicators

Value	Description
C1	Inter-facility transport (to a higher level of care) determined necessary by the originating facility based upon the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.
C2	Patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
C3	Secondary code where a response was made to a major incident or mechanism of injury. All such responses are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified.
C4	Indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

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Ground Only

Value	Description
C5	Indicates situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter.
C6	Indicates situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.
C7	Indicates circumstances where IV medications were required en route. The patient's condition should also be reported on the claim with a code selected from the list.

Air Only

All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

Value	Description
D1	Long Distance: patient's condition requires rapid transportation over a long distance.
D2	Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
D3	Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.
D4	Pick up point not accessible by ground transportation.

Ambulance Modifiers

Modifiers	Ambulance Origination/Destination Modifiers
AM	Non-emergency Medically Necessary Stretcher Transport Required
D	Diagnostic or therapeutic site other than "p" or "h" when these are used as origin codes
E	Residential, domiciliary custodial facility
G	Hospital based dialysis facility
H	Hospital
HH	Ambulance transport from hospital to hospital
I	Site of transfer (e.g. airport or helicopter pad)
J	Free standing ESRD facility
N	Skilled Nursing Facility

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P	Physician’s office
PI	PET tumor initial treatment strategy
PS	PET tumor subsequent treatment strategy
QL	Patient pronounced dead after ambulance was called
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
R	Residence
RH	Ambulance transport from Patients home to hospital
S	Scene of accident or acute event
X	Destination code only-Intermediate stop at physician’s office on the way to the hospital