

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3709	Date: February 3, 2017
	Change Request 9964

SUBJECT: Internet Only Manual (IOM) Chapter 25 Revision

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to publish an update to IOM, Medicare Claims Processing Manual, Pub.100-04 Chapter 25, with revision deleting the outdated Type of Bill codes list.

EFFECTIVE DATE: April 4, 2017

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

IMPLEMENTATION DATE: April 4, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	25/75.1 - Form Locator 4

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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IMPLEMENTATION DATE: April 4, 2017

I. GENERAL INFORMATION

A. Background: N/A

B. Policy: The purpose of this Change Request (CR) is to publish an update to IOM, Medicare Claims Processing Manual, Pub.100-04 Chapter 25, with revision deleting the outdated Type of Bill codes list. The Type of Bills codes are described in Chapter 1.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
9964.1	Contractors shall be aware of the IOM Chapter 25 changes.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E M A C	C E D I		
		A	B	H H H				
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Matt Klischer, 410-786-7488 or Matthew.Klischer@cms.hhs.gov , Katrina Mills, 410-786-3968 or Katrina.Mills@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 0

75.1 - Form Locators 1-15

(Rev. 3709, Issued: 02-03-17; Effective: 04-04-17; Implementation: 04-04-17)

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

Required. The minimum entry is the provider name, city, State, and nine-digit ZIP Code. Phone and/or Fax numbers are desirable.

FL 2 - Billing Provider's Designated Pay-to Name, address, and Secondary Identification Fields

Not Required. If submitted, the data will be ignored.

FL 3a - Patient Control Number

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

FL 3b - Medical/Health Record Number

Situational. The number assigned to the patient's medical/health record by the provider (not FL3a).

FL 4 - Type of Bill

Required. This four-digit alphanumeric code gives three specific pieces of information after a leading zero. CMS will ignore the leading zero. CMS will continue to process three specific pieces of information. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Code Structure

2nd Digit-Type of Facility (CMS will process this as the 1st digit)

3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Clinics Only) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Special Facilities Only) (CMS will process this as the 2nd digit)

4th Digit-Frequency - Definition (CMS will process this as the 3rd digit)

FL 5 - Federal Tax Number

Required. The format is NN-NNNNNNN.

FL 6 - Statement Covers Period (From-Through)

Required. The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY).

FL 7

Not Used.

FL 8 - Patient's Name and Identifier

Required. The provider enters the patient's last name, first name, and, if any, middle initial, along with patient identifier (if different than the subscriber/insured's identifier).

FL 9 - Patient's Address

Required. The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP Code.

FL 10 - Patient's Birth Date

Required. The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.

FL 11 - Patient's Sex

Required. The provider enters an "M" (male) or an "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.

FL 12 - Admission/Start of Care Date

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

FL 13 - Admission Hour

Not Required. If submitted, the data will be ignored.

FL 14 - Priority (Type) of Admission or Visit

Required.

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FL 15 - Point of Origin for Admission or Visit

Required except for Bill Type 014X. The provider enters the code indicating the source of the referral for this admission or visit.

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