

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1496	Date: MAY 2, 2008
	Change Request 5950

SUBJECT: Medicare Shared Systems Modifications Necessary to Capture and Crossover Medicaid Drug Rebate Data Submitted on Form UB 04 Paper Claims and Direct Data Entry (DDE) Claims.

I. SUMMARY OF CHANGES: In order for Medicaid drug rebate information submitted to Medicare on the UB 04 to crossover to Medicaid, the contractors must be able to capture the NDC and quantity information appearing on the claim.

New / Revised Material

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

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	25/75.5 - Form Locators 43 - 81

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1496	Date: May 2, 2008	Change Request: 5950
-------------	-------------------	-------------------	----------------------

SUBJECT: Medicare Shared Systems Modifications Necessary to Capture and Crossover Medicaid Drug Rebate Data Submitted on Form UB 04 Paper Claims and Direct Data Entry (DDE) Claims.

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

I. GENERAL INFORMATION

- A. **Background:** The Deficit Reduction Act (DRA) of 2005 required State Medicaid agencies to provide for the collection of National Drug Codes (NDC) on all claims for certain physician-administered drugs for the purpose of billing manufacturers for Medicaid drug rebates. Prior to the DRA, physicians' offices, outpatient hospital departments, and clinics generally used Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicaid for drugs dispensed to Medicaid patients. However, because State Medicaid agencies are required to invoice manufacturers for rebates using NDCs for drugs for which the States have made payments, and they were not receiving NDCs on claims for these drugs, often States were not able to fulfill the rebate requirements for physician-administered drugs. The requirements for the collection of drug rebate data became effective beginning January 1, 2007. In addition, beginning January 1, 2008, in order for Federal financial participation (FFP) to be available for these drugs, State Medicaid agencies must be in compliance with the requirements. These requirements were implemented in a final rule published on July 17, 2007.

In order to accommodate the information needed to fulfill the rebate requirements on the UB04, the National Uniform Billing Committee (NUBC) designated the Revenue Description Field (Form Locator 43) for placement of rebate information. Medicare providers billing for dual eligible patients will be required to submit the NDCs for physician-administered drugs in the Revenue Description Field (Form Locator 43) on the UB-04 in order that this data can be crossed over to Medicaid for the billing of Medicaid rebates. Prior to these requirements, the Revenue Description Field area of the UB-04 has been used to describe the corresponding revenue code billed to Medicare. For this reason, there is currently no mechanism in place to allow for the capture and crossover of the drug rebate data which will be placed in this area, if submitted by providers on the UB-04. In addition to the NDC, the drug quantity must also be captured on all crossover claims for Medicaid billing, as provided for by the NUBC, as it is also necessary for States to bill manufacturers for Medicaid drug rebates (see BR section IV).

This change request is to implement modifications that would allow the capture and crossover of drug rebate data as submitted by Medicare providers. It is important to note the following items relative to this change request:

1. The requirements only apply when the Medicare provider is submitting claims for physician-administered drugs to Medicare for dual eligible (Medicare/Medicaid) beneficiaries;
2. Medicare will not edit, validate, nor process the drug rebate data received on a UB-04. The data would only be passed to Medicaid through the COB process.

- B. Policy:** Final policies regarding the collection of drug rebate data on Medicaid claims for physician-administered drugs are contained in the final rule (42 CFR Part 447, Section 520, July 17, 2007). Physicians’ offices, hospital outpatient departments and outpatient clinics who serve patients who are dually eligible for Medicaid and Medicare will include NDCs and corresponding quantity amounts on crossover claims for physician-administered drugs. Therefore, CMS is directing modifications to the Medicare Shared Systems to allow the capture of Medicaid drug rebate data in the form of NDC and corresponding quantity amount as submitted on the UB-04 paper claims and the crossover of that information only to State Medicaid agencies. A Change Request (CR) is not required to instruct providers on how to submit rebate information on the electronic formats. Each State Medicaid program instructs its providers thru billing instructions as how to bill. The Medicare COB system passes to Medicaid in loop 2400 drug rebate information for Medicaid to adjudicate (edit) on a crossover claim submitted electronically. The business requirements below describe the changes to Optical Character Recognition (OCR) and Medicare Shared Systems that are necessary to implement the new policies of the final rule. The purpose of the business requirements is to allow for the unedited crossover of Medicaid drug rebate data in the form of NDC and corresponding quantity amount as recorded by Medicare providers on the UB-04.

II. BUSINESS REQUIREMENTS TABLE

Use “*Shall*” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5950.1	Contractors shall accept drug rebate data in the form of NDC and corresponding quantity amounts when submitted on a UB-04 paper claim in the first Revenue Description Field (Form Locator 43) into the shared system claim remarks field.	X		X		X					
5950.1.1	Contractors shall accept an NDC in the first Revenue Description Field (Form Locator 43) as 13 position entries (positions 01 through position 13) beginning with qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999).	X		X		X					
5950.1.2	Contractors shall accept the drug quantity qualifier (UN (units), F2 (international units), GR (gram) or ML (milliliter)) along with the drug quantity in the first Revenue Description Field (Form Locator 43) immediately following the last digit of the NDC.	X		X		X					
5950.1.2.1	Contractors shall ensure that immediately following the Unit of Measurement Qualifier, the unit quantity accommodates a floating decimal for fractional units limited to 3 digits (to the right of the decimal).	X		X		X					
5950.1.2.2	Contractors shall leave blank any unused spaces.	X		X		X					
5950.1.2.3	Contractors shall ensure that all data elements are left justified to allow for the largest quantity possible. (Note: the Revenue Description Field on the UB-04 is 24 characters in length).	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5950.2	Contractors that utilize OCR shall modify their OCR Scanner System to read the NDC code and corresponding quantity amount located in the first Revenue Description Field (Form Locator 43) as defined by NUBC billing instructions. (See attached billing instructions.)	X		X		X					
5950.3	Contractors shall modify their OCR Scanner Systems to move the first NDC code and quantity data to the shared systems claim remark field.	X		X		X					
5950.4	For the DDE Screen System, the contractor shall modify DDE to accept drug rebate information as described in 5950.1, 5950.1.1, 5950.1.2, and 5950.1.2.1 into the shared system claim remarks field.						X				
5950.5	The contractor shall crossover drug rebate information only to State Medicaid agencies in loop 2300 Billing Note NTE02 (NTE01 = ADD).						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5950.6	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R I E R	R H H I S S	Shared-System Maintainers				OTH ER
							F I S S	M C S	V M S	C W F	

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:																								
5950.5	<p>The instructions are summarized as follows: Using the Revenue Description Field (Form Locator 43) on the UB-04:</p> <ul style="list-style-type: none"> • Report the N4 qualifier in the first two (2) positions, left-justified. • Followed immediately by the 11 character National Drug Code number in the 5-4-2 format (no hyphens). • Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. <p>The Unit of Measurement Qualifier codes are as follows: F2 -International Unit GR-Gram ML-Milliliter UN- Unit</p> <ul style="list-style-type: none"> • Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal). • Any spaces unused for the quantity are left blank. <p>The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td>N</td><td>4</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>0</td><td>1</td><td>U</td><td>N</td><td>1</td><td>2</td><td>3</td><td>4</td><td>.</td><td>5</td><td>6</td><td>7</td><td></td> </tr> </table>	N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	
N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7			

B. For all other recommendations and supporting information, use this space:

N/A

V. CONTACTS

Pre-Implementation Contact(s): Joe Fine, 410-786-2128, joseph.fine@cms.hhs.gov

Post-Implementation Contact(s): Joe Fine, 410-786-2128, joseph.fine@cms.hhs.gov

VI. FUNDING

A. For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC):

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

75.5 - Form Locators 43-81

(Rev. 1496, Issued: 05-02-08; Effective Date: 10-01-08; Implementation Date: 10-06-08)

FL 43 - Revenue Description

Not Required. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. “Other” code categories are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also see FL 80, Remarks.)

When required to submit drug rebate data for Medicaid rebates, submit N4 followed by the 11 digit NDC code in positions 01-13 (e.g., N499999999999). Report the NDC quantity qualifier followed by the quantity beginning in position 14. The Description Field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

FL 44 - HCPCS/Rates/HIPPS Rate Codes

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

Health Insurance Prospective Payment System (HIPPS) Rate Codes

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the “Grouper” software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a casemix group and assigns the correct RUG code. The AIs were developed by CMS.

The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and

accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HCPCS Modifiers (Level I and Level II)

The UB-04 accommodates up to four modifiers, two characters each. See AMA publication CPT 200x (x= to current year) Current Procedural Terminology Appendix A - HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

Claims for home health (HH), inpatient skilled nursing facility (SNF), swing bed providers and inpatient rehabilitation facilities (IRF) enter the HIPPS code here where applicable. RHC/FQHC encounters billed on TOBs 071x or 073x do not require HCPCS coding. The complete list of HIPPS codes for use on SNF, swing bed, IRF and HH claims can be accessed at the following Web site:

http://new.cms.hhs.gov/PropMedicareFeeSvcPmtGen/02_HIPPSCodes.asp

FL 45 - Service Date

Required Outpatient. Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.

Inpatient claims for skilled nursing facilities and swing bed providers enter the assessment reference date (ARD) here where applicable.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times,

once for each service date. Assessment Date – used for billing SNF PPS (Bill Type 021X).

FL 46 - Units of Service

Required. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable for the following:

- Accommodations - 0100s - 0150s, 0200s, 0210s (days)
- Blood pints - 0380s (pints)
- DME - 0290s (rental months)
- Emergency room - 0450, 0452, and 0459 (HCPCS code definition for visit or procedure)
- Clinic - 0510s and 0520s (HCPCS code definition for visit or procedure)
- Dialysis treatments - 0800s (sessions or days)
- Orthotic/prosthetic devices - 0274 (items)
- Outpatient therapy visits - 0410, 0420, 0430, 0440, 0480, 0910, and 0943 (Units are equal to the number of times the procedure/service being reported was performed.)
- Outpatient clinical diagnostic laboratory tests - 030X-031X (tests)
- Radiology - 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS code definition of tests or services)
- Oxygen - 0600s (rental months, feet, or pounds)
- Drugs and Biologicals- 0636 (including hemophilia clotting factors)

The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.

For RHCs or FQHCs, a “visit” is defined as a face-to-face encounter between a clinic/center patient, and one of the certified RHC or FQHC health professionals. Encounters with more than one health professional, and encounters with the same health professional which take place on the same day and at a single location constitute a single “visit,” except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

EXAMPLE 1

A known diabetic visits the provider on the morning on May 1 and sees the physician assistant. The physician assistant believes an adjustment in current medication is required, but wishes to have the clinic’s physician, who will be present in the afternoon,

check the determination. The patient returns in the afternoon and sees the physician, who revises the prescribed medication. The physician recommends that the patient return the following week, on May 8, for a fasting blood sugar analysis to check the response to the change in medication. In this situation, the provider bills the Medicare program for one visit. Also, it includes a line item charge for laboratory services for May 1.

EXAMPLE 2

A patient visits the provider on July 1 complaining of a sore throat, and sees the physician assistant. The physician assistant examines the patient, takes a throat culture and requests that the patient return on July 8 for a follow-up visit to the physician assistant. In this situation, the provider bills the Medicare program for two visits. Also, it includes an entry for laboratory.

FL 47 - Total Charges - Not Applicable for Electronic Billers

Required. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is “0001” which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The FI determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where “gross” billing is used, the FI adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the carrier to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.

FL 48 - Noncovered Charges

Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49 - (Untitled)

Not used. Data entered will be ignored.

Note: the “PAGE ____ OF ____” and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A, B, and C - Payer Identification

Required. If Medicare is the primary payer, the provider must enter “Medicare” on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate. Conditional payments for Medicare Secondary Payer (MSP) situations will not be made based on a Home Health Agency Request for Anticipated Payment (RAP). A = Primary Payer, B = Secondary Payer, and C = Tertiary Payer. For example: If “Medicare” is entered in Form Locator 50A, this indicates that the provider has determined based on the responses from the patient or the patient’s representative or from the insurance enrollment card information that Medicare is the primary payer. In the UB-04, there are a number of value codes to indicate various reasons and amounts associated with insurance or other payers that are primary to Medicare (e.g., Form Locators 39-41, Codes 12, 13, 14, 15, 16, 41, 42, and 43). These value codes are analogous to “Payer Codes” (A, B, D, E, F, H, I, and G respectively). When applicable, use these value codes so they are consistent with the associated payer codes (both are required).

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID

Report the national health plan identifier when one is established;
otherwise report the “number” Medicare has assigned.

FLs 52A, B, and C - Release of Information Certification Indicator

Required. A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

NOTE: The back of Form CMS-1450 contains a certification that all necessary release statements are on file.

FL 53A, B, and C - Assignment of Benefits Certification Indicator

Not used. Data entered will be ignored.

FLs 54A, B, and C - Prior Payments

Situational. For all services other than inpatient hospital or SNF the provider must enter the sum of any amounts collected from the patient toward deductibles (cash and blood) and/or coinsurance on the patient (fourth/last line) of this column. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as non-covered by Medicare. Thus, for example, if total inpatient hospital charges were \$350.00 including \$50.00 for a deductible pint of blood, the hospital would apportion \$300.00 to the Part A deductible and \$50.00 to the blood deductible. Blood is treated the same way in both Part A and Part B.

FL 55A, B, and C - Estimated Amount Due From Patient

Not required.

FL 56 – Billing Provider National Provider ID (NPI)

Required May 23, 2008. However, the CMS may require the NPI sooner than May 23, 2008.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)

Situational. Use this field to report other provider identifiers as assigned by a health plan (as indicated in FL50 lines 1-3) prior to May 23, 2007.

FLs 58A, B, and C - Insured’s Name

Required. On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider must enter the patient’s name as shown on the HI card or other Medicare notice. All additional entries across line A (FLs 59-66) pertain to the person named in Item 58A. The instructions that follow explain when to complete these items.

The provider must enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and it is requesting payment because:

- Another payer paid some of the charges and Medicare is secondarily liable for the remainder;
- Another payer denied the claim; or
- The provider is requesting conditional payment. If that person is the patient, the provider enters “Patient.” Payers of higher priority than Medicare include:
 - EGHPs for employed beneficiaries and spouses age 65 or over;
 - EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period of up to 12 months;
 - LGHPs for disabled beneficiaries;
 - An auto-medical, no-fault, or liability insurer; or
 - WC including BL.

FL 59A, B, and C - Patient’s Relationship to Insured

Required. If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Effective October 16, 2003

Code	Title
01	Spouse

Code	Title
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

FLs 60A, B, and C – Insured’s Unique ID (Certificate/Social Security Number/HI Claim/Identification Number (HICN))

Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient’s HICN, i.e., if Medicare is the primary payer, it enters this information in FL 60A. It shows the number as it appears on the patient’s HI Card, Certificate of Award, Medicare Summary Notice, or as reported by the Social Security Office.

If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP for the patient or the patient’s spouse or during the first year of ESRD entitlement), it shows the involved claim number for that coverage on the appropriate line.

FL 61A, B, and C - Insurance Group Name

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C - Insurance Group Number

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63 - Treatment Authorization Code

Situational. Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever QIO review is performed for outpatient

preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

FL 64 – Document Control Number (DCN)

Situational. The control number assigned to the original bill by the health plan or the health plan’s fiscal agent as part of their internal control.

FL 65 - Employer Name

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

FL 66 – Diagnosis and Procedure code Qualifier (ICD Version Indicator)

Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision. **Medicare does not accept ICD-10 codes. Medicare only processes ICD-9 codes.**

FL 67 - Principal Diagnosis Code

Required. The hospital enters the ICD code for the principal diagnosis. The code **must** be the full ICD diagnosis code, including all five digits where applicable. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of “V” codes. Where the proper code has fewer than five digits, the hospital may not fill with zeros. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a DRG and cause the hospital to be incorrectly paid under PPS. The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported (7862). If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis (4660). When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).

Examples include:

- Routine general medical examination (V700);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V709); and
- Examination of ears and hearing (V721).

NOTE: Diagnosis codes are not required on nonpatient claims for laboratory services where the hospital functions as an independent laboratory.

FLs 67A-67Q - Other Diagnosis Codes

Inpatient Required. The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may **not** duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. If the principal diagnosis is duplicated, the FI will remove the duplicate diagnosis before the record is processed by GROUPER for IPPS claims. The MCE identifies situations where the principal diagnosis is duplicated for IPPS claims.

Outpatient - Required. The hospital enters the full ICD codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

NOTE: Medicare will ignore data submitted in 67I – 67Q.

FL 68

Not used. Data entered will be ignored.

FL 69 - Admitting Diagnosis

Required. For inpatient hospital claims subject to QIO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. This definition is not the same as that for SNF admissions.

FL70A – 70C - Patient's Reason for Visit

Situational. Patient's Reason for Visit is required for all un-scheduled outpatient visits for outpatient bills.

FL71 – Prospective Payment System (PPS) Code

Not used. Data entered will be ignored.

FL72 - External Cause of Injury (ECI) Codes

Not used. Data entered will be ignored.

FL 73

Not used. Data entered will be ignored.

FL 74 - Principal Procedure Code and Date

Situational. Required on inpatient claims when a procedure was performed. Not used on outpatient claims.

FL 74A – 74E - Other Procedure Codes and Dates

Situational. Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.

FL 75

Not used. Data entered will be ignored.

FL 76 - Attending Provider Name and Identifiers (including NPI)

Situational. Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter.

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FL 77 - Operating Provider Name and Identifiers (including NPI)

Situational. Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FLs 78 and 79 - Other Provider Name and Identifiers (including NPI)

Situational. The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

Provider Type Qualifier Codes/Definition/Situational Usage Notes:

DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.

ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send.

82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FL 80 - Remarks

Situational. For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's FI may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)

FL 81 - Code-Code Field

Situational. To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

Code List Qualifiers:

01-A0 Reserved for National Assignment

A1 National Uniform Billing Committee Condition Codes – not used for Medicare

A2 National Uniform Billing Committee Occurrence Codes – not used for Medicare

A3 National Uniform Billing Committee Occurrence Span Codes – not used for Medicare

A4 National Uniform Billing Committee Value Codes – not used for Medicare

A5 - B0 Reserved for National Assignment

B3 Health Care Provider Taxonomy Code

Code Source: ASC X12 External Code Source 682 (National Uniform Claim Committee)

B4-ZZ Reserved for National Assignment

80 – Reserved