CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1946	**Date: April 15, 2010**
	Change Request 6777

Transmittal 1934, dated March 19, 2010, is being rescinded and replaced by Transmittal 1946, dated April 15, 2010 to revise Chapter 1, section 75.3 to include information inadvertently omitted from Change Request 6782, Transmittal 1932, dated March 17, 2010. All other material remains the same.

SUBJECT: Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)

I. SUMMARY OF CHANGES: This CR provides claims processing and billing instructions that allow claims to be billed as if no OSC limitation exists on the claim.

EFFECTIVE DATE: October 1, 2002
IMPLEMENTATION DATE: July 6, 2010 (Analysis, Design and Coding)
October 4, 2010 (Testing and Implementation)

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	1/50.2.1/Inpatient Billing From Hospitals and SNFs
R	25/75.3/Form Locators 31-41

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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: 1946	Date: April 15, 2010	Change Request: 6777

Transmittal 1934, dated March 19, 2010, is being rescinded and replaced by Transmittal 1946, dated April 9, 2010 to revise Chapter 1, section 75.3 to include information inadvertently omitted from Change Request 6782, Transmittal 1932, dated March 17, 2010. All other material remains the same.

SUBJECT: Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)

Effective Date: October 1, 2002

Implementation Date: July 6, 2010 (Analysis, Design and Coding)
October 4, 2010 (Testing and Implementation)

I. GENERAL INFORMATION

A. Background: The Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) Prospective Payment Systems (PPSs) requires a single claim to be billed for an entire stay. Interim claims may be submitted to continually adjust all prior submitted claims for the stay until the beneficiary is discharged. In some instances, significantly long stays having numerous OSCs may exceed the amount of OSCs allowed to be billed on a claim.

NOTE: The below listed requirements are subject to change based on comments/estimates yet to be received from the analysis-only CR, CR 6596.

B. Policy: Title 42 of the Code of Federal Regulations (CFR), Part 412, Subpart N – Prospective Payment System for Hospital Inpatient Services of Inpatient Psychiatric Facilities, Subpart O – Prospective Payment System for Long-Term Care Hospitals, and Subpart P – Prospective Payment for Inpatient Rehabilitation Hospitals

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6777.1	Shared System Maintainers shall set a new payer-only condition code UU (Unified stay) when applicable.						X				
6777.2	FISS shall append payer-only condition code, UU, when receiving claims that meet all of the following criteria: • Type of Bill equals 11X; and • Provider Number is a Long-Term Care Hospital (XX2000 – XX2299) or Inpatient Psychiatric Facility (XX4XXX or 'S' or 'M' in 3rd position)						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	or Inpatient Rehabilitation Facility (XX3025-XX3099 or 'R' or 'T' in 3rd position) ; and • There are ten OSCs on the claim (this includes any OSC 70 spans that are appended systematically or manually during processing.) **NOTE:** Such claims will serve as the "base claim" for any subsequent adjustments.										
6777.3	For claims with payer-only condition code, UU, FISS shall send a list of all OSCs on the claim (which includes the associated HICN, Provider Number and Admission Date) to a FISS OSC repository only when the OSC threshold (10) is reached for the claim being processed. (By sending sets of ten OSCs to the repository, CMS is hoping to mitigate the risk associated with a provider needing to correct a previously billed OSC that has yet to be sent to the FISS OSC repository).						X				
6777.3.1	The FISS OSC repository should allow contractors the ability to view (not modify) the records within the repository.						X				
6777.3.2	FISS shall allow cancel TOBs to clear out the applicable OSCs already within the repository. (The provider will have to re-bill as appropriate to rebuild the OSC repository.)						X				
6777.4	For claims with payer-only condition code UU, FISS shall perform all normal billing edits except for frequency of billing edits that do not allow PPS hospitals to bill within 60 days of the prior bill (this is because of the potential for the OSC limitation to be reached sooner than 60 days.)						X				
6777.5	When receiving adjustments for the same stay (i.e., there is a match on the HICN, Provider Number and Admission Date), FISS shall append the payer-only condition code, UU.						X				
6777.6	For claims with payer-only condition code, UU, FISS shall refer to the FISS OSC repository to accumulate all non-covered periods (via the OSCs) submitted on the						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	previously submitted "unified" bill(s) (i.e., the "base claim" and all subsequent adjustments not including the bill in process.)										
6777.7	Based on the accumulation of unified claims described in 6777.6 above, FISS shall accurately modify the B-LOS and B-COV-DAYS fields on the claim being processed, before sending said fields onto the applicable Pricer.						X				NCH
6777.8	For all stored unified bills in the FISS OSC repository, FISS shall ensure that all the non-covered OSCs are accounted for within FISS to allow other interrupted stays to process.						X				NCH
6777.9	To ensure that the hospital only bills additional OSCs on subsequent claims for the stay, FISS shall Return to Provider (RTP) claims with a payer-only condition code, UU, that match OSC periods on the OSC repository for the same stay.						X				
6777.10	For claims with condition code, UU, CWF shall send a list of all OSCs on the claim (which includes the associated HICN, Provider Number and Admission Date) to the CWF OSC repository only when the OSC threshold (10) is reached for the claim. (By sending sets of ten OSCs to the repository, CMS is hoping to mitigate the risk associated with a provider needing to correct a previously billed OSC that has yet to be sent to the FISS OSC repository.)									X	
6777.10.1	The CWF OSC repository should allow contractors the ability to view (not modify) records within the repository.									X	
6777.10.2	CWF shall allow cancel TOBs to clear out the applicable OSCs already within the repository. (The provider will have to re-bill as appropriate to rebuild the OSC repository.)									X	
6777.11	When receiving a claim with condition code 'UU,' CWF shall perform all normal billing edits except any									X	NCH

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	edits for frequency of billing that do not allow PPS hospitals to bill within 60 days of the prior bill (this is because of the potential for the OSC limitation to be reached sooner than 60 days.)										
6777.12	When receiving a claims with condition code UU, CWF shall unify all claims in history with the bill being processed using a match on the HICN, Provider Number and Admit date within a CWF OSC Repository: • If no match exists, store the claim as the "Base Claim" for subsequent adjustment bills and resume normal processing. • If a match exists, process the bill as normal but also accumulate all non-covered periods (via the OSCs) submitted on the previously submitted "unified" bills (i.e., the "base claim" and all subsequent adjustments not including the bill in process.)									X	NCH
6777.13	Based on the accumulation of unified claims described in 6777.12 above, CWF shall modify the beneficiary's benefit days to account for all non-covered periods submitted on the unified bills: • If benefit days are not expended, resume normal processing. • If benefit days are expended (zero), CWF shall initiate the current disposition to notify FISS and the provider of the benefits exhaust date. For example, if a claim in process has a non-covered period of 5 days, but there were 55 total non-covered days accumulated on the prior "unified" claims, then a total of 60 days should be subtracted from the B-LOS and B-COV-DAYS (for FISS) or the benefit days (for CWF.)									X	NCH
6777.14	For all unified bills being processed, CWF shall ensure									X	NCH

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	that all the non-covered OSCs are accounted for within CWF to allow interrupted stay claims to process.										
6777.15	For claims that have been manually processed due to the fact the number of OSC periods exceeded the limitation of ten, contractors shall work directly with hospitals to ensure such claims are appropriately processed.	X		X							
6777.15.1	Contractors shall ensure additional payment is not made for claims that had already been paid manually, perhaps through the use of certain Tape-to-Tape flags (e.g., S, T, U, W, etc.)	X		X							
6777.15. 2	Contractors shall override timely filing for such claims.	X		X							
6777.16	CWF shall do analysis to determine options that allow a claim to not set the spell of illness edits when the Dates of Service span a benefit period over 10 years.									X	NCH

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6777.17	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. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	article. In addition, the provider education article shall be included in the Contractors 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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6777.2 6777.5	In addition to provider-initiated adjustments, applicable claims should also include any alpha-adjustments.
6777.1 through 6777.16	Claims with a payer-only condition code UU may have admit dates prior to, and discharge dates on/after, October 1, 2002 (the start of LTCH PPS). Such claims shall be able to be processed through this method.
6777.3 6777.10	Any storing of OSCs should allow up to 999 OSCs for the stay.

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

V. CONTACTS

Pre-Implementation Contact(s):
Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986
Sarah Shirey-Losso at sarah.shireylosso@cms.hhs.gov or 410-786-0187
Valeri Ritter at valeri.ritter@cms.hhs.gov or 410-786-8652
Jason Kerr at Jason.kerr@cms.hhs.gov or 410-786-2123

Post-Implementation Contact(s):
Same as Pre-Implementation Contacts

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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.

ATTACHMENT

ATTACHMENT
EXAMPLE BILLING SCENARIO

NOTE: The following claims only show fields necessary to illustrate the billing sequence.

Claim A - 1st Claim (Has not reached OSC claim limitation yet)

Field	Value
Type of Bill	112
Statement Covers Period	1/1/08 – 6/1/08
Patient Status	30 (still patient)
OSC #1	76, 1/5/08 – 1/10/08
OSC #2	76, 2/5/08 – 2/10/08
OSC #3	76, 3/5/08 – 3/10/08
OSC #4	76, 4/5/08 – 4/10/08
OSC #5	76, 5/5/08 – 5/10/08

Claim B - Adjustment Claim **NOT BILLED** because max occurrences of OSCs is reached.

Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 3/10/09
Patient Status	30 (still patient)
OSC #1	76, 1/5/08 – 1/10/08
OSC #2	76, 2/5/08 – 2/10/08
OSC #3	76, 3/5/08 – 3/10/08
OSC #4	76, 4/5/08 – 4/10/08
OSC #5	76, 5/5/08 – 5/10/08
OSC #6	76, 6/5/08 – 6/10/08
OSC #7	76, 7/5/08 – 7/10/08
OSC #8	76, 8/5/08 – 8/10/08
OSC #9	76, 9/5/08 – 9/10/08
OSC #10	76, 10/5/08 – 10/10/08
OSC #11	***76, 11/5/08 – 11/10/08***
OSC #12	***76, 12/5/08 – 12/10/08***
OSC #13	***76, 1/5/09 – 1/10/09***
OSC #14	***76, 2/5/09 – 2/10/09***
OSC #15	***76, 3/5/09 – 3/10/09***

These are OSCs that cannot fit on the claim form.

Claim C- When OSCs extend beyond the limitation of nine (as shown above in Claim B), bill up to tenth OSC with the Statement Covers Through date being the same as the Through date for the tenth OSC.

Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 10/10/08
Patient Status	30 (still patient)
OSC #1	76, 1/5/08 – 1/10/08
OSC #2	76, 2/5/08 – 2/10/08
OSC #3	76, 3/5/08 – 3/10/08
OSC #4	76, 4/5/08 – 4/10/08

OSC #5	76, 5/5/08 – 5/10/08
OSC #6	76, 6/5/08 – 6/10/08
OSC #7	76, 7/5/08 – 7/10/08
OSC #8	76, 8/5/08 – 8/10/08
OSC #9	76, 9/5/08 – 9/10/08
OSC #10	76, 10/5/08 – 10/10/08

Condition Code (appended by FISS)	UU

Claim D- Once the Remittance Advice is received from Claim C, bill the subsequent "Unified Bill" with only the excess OSCs. Do not bill the OSCs previously billed on Claim C as the claims processing system has already stored those codes.

Field	**Value**
Type of Bill	117
Statement Covers Period	1/1/08 – 6/1/09
Patient Status	30 (still patient)
OSC #11	76, 11/5/08 – 11/10/08
OSC #12	76, 12/5/08 – 12/10/08
OSC #13	76, 1/5/09 – 1/10/09
OSC #14	76, 2/5/09 – 2/10/09
OSC #15	76, 3/5/09 – 3/10/09

These are the extra OSCs from Claim C. Notice that all prior OSCs, that were billed on a claim that reached the OSC threshold, are not carried onto subsequent "Unified Bills"

Condition Code (appended by FISS)	UU

Claim E- Bill the next "Unified Bill" with any new OSCs in addition to the OSCs billed on the prior claim as long as the OSC threshold was not met on the prior claim. (The claims processing system has yet to store OSC #11 through #15).

Field	**Value**
Type of Bill	117
Statement Covers Period	1/1/08 – 9/1/09
Patient Status	30 (still patient)
OSC #11	76, 11/5/08 – 11/10/08
OSC #12	76, 12/5/08 – 12/10/08
OSC #13	76, 1/5/09 – 1/10/09
OSC #14	76, 2/5/09 – 2/10/09
OSC #15	76, 3/5/09 – 3/10/09
OSC #16	76, 8/5/09 – 8/10/09

Because there were less than 10 OSCs on claim D, those OSCs must be carried over to Claim E. The claims processing system only sends ten OSCs to the repository at a time to allow the most possible time for the provider to correct any incorrect OSCs before they

Condition Code (appended by FISS)	UU

Claim F- Bill the next subsequent "Unified Bill" with any new OSCs (in addition to the OSCs billed on the prior claim as long as the OSC threshold was not met on the prior claim) as soon as the ten OSC limitation is reached despite being within the 60-day frequency of billing requirement (FISS bypasses the frequency of billing edit for claims that have a payer-only condition code UU).

Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 10/20/09
Patient Status	30 (still patient)
OSC #11	76, 11/5/08 – 11/10/08
OSC #12	76, 12/5/08 – 12/10/08
OSC #13	76, 1/5/09 – 1/10/09
OSC #14	76, 2/5/09 – 2/10/09
OSC #15	76, 3/5/09 – 3/10/09
OSC #16	76, 8/5/09 – 8/10/09
OSC #17	76, 9/3/09 – 9/6/09
OSC #18	76, 9/10/09 – 9/13/09
OSC #19	76, 9/20/09 – 9/23/09
OSC #20	76, 10/1/09 – 10/20/09

Condition Code (appended by FISS)	UU

Claim G – Bill the next subsequent "Unified Bill" with any new OSCs. Do not carry-over any OSCs billed on Claim F because it had reached the OSC limitation. **Note**: This claim was billed not because the OSC limitation was reached, but because they wanted to drop a bill at this time. Also, the provider does not realize that the patient exhausted benefits on 3/15/10.

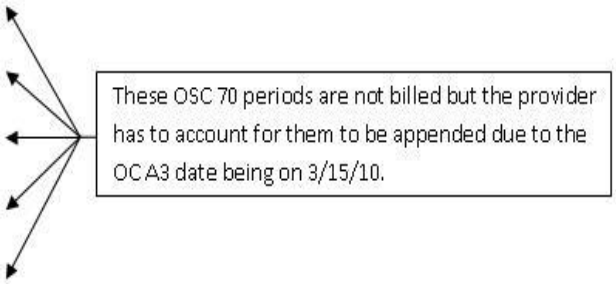
Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 8/3/10
Patient Status	30 (still patient)
OSC #21	76, 3/1/10 – 3/3/10
OSC #22	76, 4/1/10 – 4/3/10
OSC #23	76, 5/1/10 – 5/3/09
OSC #24	76, 6/1/10 – 6/3/10
OSC #25	76, 7/1/10 – 7/3/10
OSC #26	76, 8/1/10 – 8/3/10

Condition Code (appended by FISS)	UU

When Claim G is processed, the system applies Occurrence Code A3 on 3/15/10. Because there are non-covered spans on Claim G, the contractor manually appends multiple OSC 70 spans within the existing OSCs spans, as appropriate. However, the Claim G had to be Returned-To-Provider (RTPed) because, with the addition of multiple OSCs, there are more than ten OSCs assigned to the claim.

Claim H – Once Claim G is RTPed for exceeding the OSC threshold, the provider bills Claim H. Claim H is the same claim as Claim G except that OSC #26 was removed to allow the OSC 70 spans to fit and the Statement Covers Through Date was changed to a 7/31/10 (a day prior to the first extra OSC billed on Claim G—OSC #26).

Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 7/31/10
Patient Status	30 (still patient)
OSC #21	76, 3/1/10 – 3/3/10
	70, 3/15/10 – 3/31/10
OSC #22	76, 4/1/10 – 4/3/10
	70,4/4/10 – 4/30/10
OSC #23	76, 5/1/10 – 5/3/09
	70, 5/4/10 – 5/31/10
OSC #24	76, 6/1/10 – 6/3/10
	70, 6/4/10 – 6/30/10
OSC #25	76, 7/1/10 – 7/3/10
	70, 7/4/10 – 7/31/10



Condition Code (appended by FISS)	UU

Claim I - Bill the next subsequent "Unified Bill" to encompass the entire stay, along with any new OSCs since the OSC limitation was reached on Claim H. Also, notice that even though an OSC 70 period spans Claim H onto Claim I, a remaining OSC 70 period has to be accounted for on Claim I as a new OSC 70. Lastly, the provider determines the cost outlier threshold is reached on 12/7/10, so Occurrence Code (OC) 47 is appended for 12/7/10 and Occurrence Code A3 is appended for 12/6/10 (which is why the last OSC 70 span ends on 12/6/10).

Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 12/31/10
Patient Status	01 (discharged – home)
Occurrence Code	A3, 12/6/10
Occurrence Code	47, 12/7/10
	70, 8/1/10 – 8/30/10
OSC #26	76, 9/1/10 – 9/3/10
	70, 9/4/10 – 9/26/10
OSC #27	76, 10/1/10 – 10/3/10
	70, 10/4/10 – 10/28/10
OSC #28	76, 10/30/10 – 11/3/10
	70, 11/4/10 – 11/15/10
OSC #29	76, 12/1/10 – 12/3/10
	70, 12/4/10 – 12/6/10

Condition Code (appended by FISS)	UU

Claim J: Bill the FINAL "Unified Bill" to encompass the entire stay, along with any new OSCs.

Field	Value
Type of Bill	117
Statement Covers Period	1/1/08 – 3/1/11
Patient Status	01 (discharged – home)
Occurrence Code	A3, 12/6/10
Occurrence Code	47, 12/7/10
	70, 8/1/10 – 8/30/10
OSC #26	76, 9/1/10 – 9/3/10
	70, 9/4/10 – 9/26/10
OSC #27	76, 10/1/10 – 10/3/10
	70, 10/4/10 – 10/28/10
OSC #28	76, 10/30/10 – 11/3/10
	70, 11/4/10 – 11/15/10
OSC #29	76, 12/1/10 – 12/3/10
	70, 12/4/10 – 12/6/10
OSC #30	76, 1/5/11 – 1/22/11

Condition Code (appended by FISS)	UU

NOTE: This bill will pay as if all 38 OSCs were billed on this final discharge bill (30 non-covered periods and 8 non-utilization periods).

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

50.2.1 – Inpatient Billing From Hospitals and SNFs

(Rev. 1946; Issued: 04-15-10; Effective Date: 10-01-02; Implementation Date: 07-06-10 for Analysis, Design and Coding and 10-04-10 for Testing and Implementation)

Non PPS Hospitals and SNFs

Inpatient services in TEFRA hospitals (i.e., hospitals excluded from inpatient prospective payment system (PPS), cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in one of these hospitals ceases to need a hospital level of care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill.

SNF providers shall follow the billing instructions provided in Chapter 6 (SNF Inpatient Part A Billing), Section 40.8 (Billing in Benefits Exhaust and No-Payment Situations) for proper billing in benefits exhaust and no-payment situations.

PPS Hospitals

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and inpatient psychiatric facilities (IPFs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, IRF, IPF and a LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or

- For subsequent discharge bills, bill type 117 with a patient status other than 30. (See Chapter 25 for a list of valid patient discharge status codes)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds); or
- The beneficiary is discharged.

Effective December 3, 2007, when a beneficiary's Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no pay bill (TOB 110) with a patient status code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

***NOTE**: For stays that necessitate the reporting of more than ten OSCs (i.e., more OSCs than the claim formats allow), Long Term Care Hospitals, Inpatient Psychiatric Facilities, and Inpatient Rehabilitation Facilities shall refer to instructions provided in Chapter 32, section 74.3 of this Manual.*

Medicare Claims Processing Manual
Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

75.3 - Form Locators 31-41
(Rev. 1946; Issued: 04-15-10; Effective Date: 10-01-02; Implementation Date: 07-06-10 for Analysis, Design and Coding and 10-04-10 for Testing and Implementation)

FLs 31, 32, 33, and 34 - Occurrence Codes and Dates

Situational. Required when there is a condition code that applies to this claim.

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION
Due to the varied nature of Occurrence and Occurrence Span Codes, provisions have been made to allow the use of both type codes within each. The Occurrence Span Code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as 10 Occurrence Codes to be utilized. With respect to Occurrence Codes, complete field 31a - 34a (line level) before the "b" fields. Occurrence and Occurrence Span codes are mutually exclusive. An example of Occurrence Code use: A Medicare beneficiary was confined in hospital from January 1, 2005 to January 10, 2005, however, his Medicare Part A benefits were exhausted as of January 8, 2005, and he was not entitled to Part B benefits. Therefore, Form Locator 31 should contain code A3 and the date 010805.

The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved. Occurrence and occurrence span codes are mutually exclusive. When FLs 36 A and B are fully used with occurrence span codes, FLs 34a and 34b and 35a and 35b may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field. Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

Code Structure (Only codes affecting Medicare payment/processing are shown.)

Code	Title	Definition
01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage.

Code	Title	Definition
		Provide the date of accident/injury
02	No-Fault Insurance Involved - Including Auto Accident/Other	Date of an accident, including auto or other, where the 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.
04	Accident/Employment Related	Date of an accident that relates to the patient's employment.
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	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08		Reserved for assignment by the NUBC
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.
11	Onset of Symptoms/Illness	(Outpatient claims only.) Date that the patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual (CDI)	(HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.

Code	Title	Definition
13-15		Reserved for assignment by the NUBC
16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).
17	Date Outpatient Occupational Therapy Plan Established or Reviewed	The date the occupational therapy plan was established or last reviewed.
18	Date of Retirement Patient/Beneficiary	Date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision.
21	UR Notice Received	(Part A SNF claims only.) Date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary.
22	Date Active Care Ended	Date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period. For FI or A/B MAC Use Only. Providers Do Not Report.	Code is not required if code "21" is used.
24	Date Insurance Denied	Date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.

Code	Title	Definition
26	Date SNF Bed Available	The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	The date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
28	Date CORF Plan Established or Last Reviewed	The date a plan of treatment was established or last reviewed for CORF care.
29	Date OPT Plan Established or Last Reviewed	The date a plan was established or last reviewed for OPT.
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	The date a plan was established or last reviewed for outpatient speech pathology.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date the hospital notified the beneficiary that the beneficiary does not (or no longer) requires inpatient care and that coverage has ended.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) that may not be reasonable or necessary under Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	The first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.
34	Date of Election of Extended Care Services	The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
35	Date Treatment Started for Physical Therapy	The date the provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge for a Covered	The date of discharge for a hospital stay in which the patient received a covered

Code	Title	Definition
	Transplant Procedure(s)	transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. **NOTE:** When the patient received a covered and a non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant	The date of discharge for an inpatient hospital stay during which the patient received a non-covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs.
38	Date treatment started for Home IV Therapy	Date the patient was first treated at home for IV therapy (Home IV providers - bill type 85X).
39	Date discharged on a continuous course of IV therapy	Date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers- bill type 85X).
40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test was performed as a part of a PAT program. This code may be used only if a date of admission was scheduled prior to the administration of the test(s).
42	Date of Discharge	(Hospice claims only.) The date on which a beneficiary terminated their election to receive hospice benefits from the facility rendering the bill. The frequency digit should be 1 or 4.
43	Scheduled Date of Cancelled Surgery	The date for which outpatient surgery was scheduled.
44	Date Treatment Started for Occupational Therapy	The date the provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	The date the provider initiated services for speech therapy.

Code	Title	Definition
46	Date Treatment Started for Cardiac Rehabilitation	The date the provider initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	Code indicates that this is the first day after the day the cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular, coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making a cost outlier payment.
48-49	Payer Codes	For use by third party payers only. The CMS assigns for FI or A/B MAC use. Providers do not report these codes.
51	*Date of Last Kt/V Reading*	*For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. Effective 7/1/2010.*
52-69		*Reserved for assignment by the NUBC*
A1	Birth Date-Insured A	The birth-date of the insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy	The first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer A.
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as “Split Bill Date”). Effective 10/1/03.
A5-AZ		Reserved for assignment by the NUBC
B1	Birth Date-Insured B	The birth-date of the individual in whose name the insurance is carried.

Code	Title	Definition
B2	Effective Date-Insured B Policy	The first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer B.
B4-BZ		Reserved for assignment by the NUBC
C1	Birth Date-Insured C	The birth-date of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	The first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer C.
C4-CZ		Reserved for assignment by the NUBC
D0-DQ		Reserved for assignment by the NUBC
DR		Reserved for Disaster Related Code
DS-DZ		Reserved for assignment by the NUBC
E0		Reserved for assignment by the NUBC
E1	Birth Date-Insured D	Discontinued 3/1/07.
E2	Effective Date-Insured D Policy	Discontinued 3/1/07.
E3	Benefits Exhausted	Discontinued 3/1/07.
E4-EZ		Reserved for assignment by the NUBC
F0		Reserved for assignment by the NUBC
F1	Birth Date-Insured E	Discontinued 3/1/07.
F2	Effective Date-Insured E Policy	Discontinued 3/1/07.
F3	Benefits Exhausted	Discontinued 3/1/07.

Code	Title	Definition
F4-FZ		Reserved for assignment by the NUBC
G0		Reserved for assignment by the NUBC
G1	Birth Date-Insured F	Discontinued 3/1/07.
G2	Effective Date-Insured F Policy	Discontinued 3/1/07.
G3	Benefits Exhausted	Discontinued 3/1/07.
G4-LZ		Reserved for assignment by the NUBC
M0-ZZ		See instructions in FLs 35 and 36 – Occurrence Span Codes and Dates

FLs 35 and 36 - Occurrence Span Code and Dates

Required For Inpatient.

The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

Code Structure

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
71	Hospital Prior Stay Dates	(Part A claims only.) The 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 actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.

Code	Title	Definition
74	Non-covered Level of Care/Leave of Absence Dates	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, but not valid for HHA under PPS.
75	SNF Level of Care Dates	The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (condition code "60"). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care.
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or A/B MAC or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability Period	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified

Code	Title	Definition
		or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
80	Prior Same-SNF Stay Dates for Payment Ban Purposes	The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.
M0	QIO/UR Stay Dates	If condition code “C3”, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Inpatient Respite Dates	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay
M5-MQ		Reserved for assignment by the NUBC
MR		Reserved for Disaster Related Occurrence Span Code
MS-ZZ		Reserved for assignment by the NUBC

Special Billing Procedures When more than Ten Occurrence Span Codes (OSCs) Apply to a Single Stay

The Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) Prospective Payment Systems (PPSs) requires a single claim to be billed for an entire stay. Interim claims may be submitted to continually adjust all prior submitted claims for the stay until the beneficiary is discharged. In some instances, significantly long stays having numerous OSCs may exceed the amount of OSCs allowed to be billed on a claim.

When a provider paid under the LTCH, IPF or IRF PPSs encounters a situation in which ten or more OSCs are to be billed on the CMS-1450 or electronic equivalent, the provider must bill for the entire stay up to the Through date of the 10th OSC for the stay (the Through date for the Statement Covers Period equals the Through date of the tenth OSC). As the stay continues, the provider must only bill the 11th through the 20th OSC for the stay, if applicable. Once the twentieth OSC is applied to the claim, the provider must only bill the 21st through the 30th OSC for the stay, if applicable. The Shared System Maintainers (SSMs) retain the history of all OSCs billed for the stay to ensure proper processing (i.e., as if no OSC limitation exists on the claim).

For a detailed billing example that outlines possible billing scenarios, please go to http://www.cms.hhs.gov/Transmittals/01_Overview.asp and refer to CR 6777 located on the 2010 Transmittals page.

FL 37 - (Untitled)

Not used. Data entered will be ignored.

FL 38 - Responsible Party Name and Address

Not Required. For claims that involve payers of higher priority than Medicare.

FLs 39, 40, and 41 - Value Codes and Amounts

Required. Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second). **Note that codes 80-83** (Covered days, Non-Covered Days, Co-insurance Days, and Lifetime Reserve Days) **are only available for use on the UB-04.**

Code	Title	Definition
01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital Has No Semi-Private Rooms	Entering this code requires $0.00 amount.
03		Reserved for assignment by the NUBC
04	Inpatient Professional Component Charges Which Are Combined Billed	The sum of the inpatient professional component charges that are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. **(Used only by some all-inclusive rate hospitals.)**
05	Professional Component Included in Charges and Also Billed Separately to Carrier	(Applies to Part B bills only.) Indicates that the charges shown are included in billed charges FL 47, but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the carrier processes the bill for physician's services. These charges are also deducted when computing interim payment. The hospital uses this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.
06	Medicare Part A and Part B Blood Deductible	The product of the number of un-replaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each un-replaced pint furnished. If all deductible pints have been replaced, this code is not to be used. When the hospital gives a discount for un-replaced deductible blood, it shows charges after the discount is applied.
07		Reserved for assignment by the NUBC

Code	Title	Definition
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. The provider may not use this code on Part B bills. For Part B coinsurance use value codes A2, B2 and C2.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing Period	The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. The provider uses this code only on bills spanning 2 calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. The provider uses this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. It may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have

Code	Title	Definition
		been payable had it filed a proper claim.
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
15	Worker's Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
16	PHS, Other Federal Agency	That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. **NOTE:** A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).
17	Operating Outlier Amount	(Not reported by providers.) The FI or A/B MAC reports the amount of operating outlier payment made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.
18	Operating Disproportionate Share Amount	(Not reported by providers.) The FI or A/B MAC reports the operating disproportionate share amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital DSH adjustment in this entry.

Code	Title	Definition
19	Operating Indirect Medical Education Amount	(Not reported by providers.) The FI or A/B MAC reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.
20	Payer Code	(For internal use by third party payers only.)
21	Catastrophic	Medicaid-eligibility requirements to be determined at State level.
22	Surplus	Medicaid-eligibility requirements to be determined at State level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at State level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at State level.
25	Offset to the Patient-Payment Amount – Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount – Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount – Vision and Eye Services	Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount – Dental Services	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount – Chiropractic Services	Chiropractic Services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
31	Patient Liability Amount	The FI or A/B MAC approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance	If more than one patient is transported in a single ambulance trip, report the total number of patients

Code	Title	Definition
	Transport	transported.
33	Offset to the Patient-Payment Amount – Podiatric Services	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount – Other Medical Services	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount – Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36		Reserved for assignment by the NUBC
37	Units of Blood Furnished	The total number of units of whole blood or packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete units rounded upwards, e.g., 1 1/4 units is shown as 2. This entry serves as a basis for counting units towards the blood deductible.
38	Blood Deductible Units	The number of unreplaced deductible units of blood furnished for which the patient is responsible. If all deductible units furnished have been replaced, no entry is made.
39	Units of Blood Replaced	The total number of units of blood that were donated on the patient's behalf. Where one unit is donated, one unit is considered replaced. If arrangements have been made for replacement, units are shown as replaced. Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced units), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by Managed Care Plan	(For inpatient service only.) Inpatient charges covered by the Managed Care Plan. (The hospital uses this code when the bill includes inpatient charges for newly

Code	Title	Definition
		covered services that are not paid by the Managed Care Plan. It must also report condition codes 04 and 78.)
41	Black Lung (BL)	That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
42	Veterans Affairs (VA)	That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill.
43	Disabled Beneficiary Under Age 65 With LGHP	That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
44	Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received	That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due.
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.
46	Number of Grace Days	If condition code “C3” or “C4”, indicating that the QIO has denied all or a portion of this billing period, the 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 one numeric digit.

Code	Title	Definition
47	Any Liability Insurance	That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer's payment.
48	Hemoglobin Reading	The most recent hemoglobin 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.
49	Hematocrit Reading	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.
50	Physical Therapy Visits	The number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	The number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	The number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.
54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law.
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse – Home Visit Hours (HHA only)	The number of hours of skilled nursing provided during the billing period. The provider counts only hours

Code	Title	Definition
		spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.)
57	Home Health Aide – Home Visit Hours (HHA only)	The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (The number is rounded to the nearest whole hour.)

NOTE: Codes 50-57 represent the number of visits or hours of service provided. Entries for the number of visits are right justified from the dollars/cents delimiter as follows:

					1	3		

The FI or A/B MAC accepts zero or blanks in the cents position, converting blanks to zero for CWF.

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. (See note following code 59 for an example.)
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. (See note following this code for an example.)

NOTE: Codes 58 and 59 are not money amounts. They represent arterial blood gas or oxygen saturation levels. Round to two decimals or to the nearest whole percent. For example, a reading of 56.5 is shown as:

						5	7

A reading of 100 percent is shown as:

					1	0	0

Code	Title	Definition
60	HHA Branch MSA	The MSA in which HHA branch is located. (The HHA reports the MSA when its branch location is different than the HHA's main location – It reports the MSA number in dollar portion of the form locator, right justified to the left of the dollar/cents delimiter.)
61	Place of Residence Where Service is Furnished (HHA and Hospice)	MSA number or Core Based Statistical Area (CBSA) number (or rural State code) of the place of residence where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter. For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.
62	HH Visits – Part A (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
63	HH Visits – Part B (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
64	HH Reimbursement – Part A (Internal Payer Use Only)	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
65	HH Reimbursement – Part B	The dollar amounts determined to be associated with the HH visits identified in a

Code	Title	Definition
	(Internal Payer Use Only)	value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
66	Medicare Spend-down Amount	The dollar amount that was used to meet the recipient's spend-down liability for this claim.
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. The provider counts only the hours spent in the home, excluding travel time. It reports in whole hours, right justifying to the left of the dollar/cent delimiter. (Rounded to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Indicates the number of units of EPO administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0		

Code	Title	Definition
69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of ESRD Networks	(For third party payer use only.) The FI or A/B MAC reports the amount the Medicare payment was reduced to help fund ESRD

Code	Title	Definition
		networks.
72	Flat Rate Surgery Charge	(For third party payer use only.) The standard charge for outpatient surgery where the provider has such a charging structure.
73-75	Payer Codes	(For use by third party payers only.)
76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0

Code	Title	Definition
77	Medicare New Technology Add-On Payment	Code indicates the amount of Medicare additional payment for new technology.
78-79	Payer Codes	Codes reserved for internal use only by third party payers. The CMS assigns as needed. Providers do not report payer codes.
80	Covered days	The number of days covered by the primary payer as qualified by the payer.
81	Non-Covered Days	Days of care not covered by the primary payer.
82	Co-insurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness.

Code	Title	Definition
83	Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
84-99		Reserved for assignment by the NUBC
A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.
A4	Covered Self-Administrable Drugs – Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. For use with Revenue Code 0637. See The Medicare Benefit Policy Manual).
A5	Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code

Code	Title	Definition
		0637.
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05)
A9	Patient Height	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05)
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
AC-B0		Reserved for assignment by the NUBC
B1	Deductible Payer B	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use

Code	Title	Definition
		Value Codes 8-11.
B3	Estimated Responsibility Payer B	Amount the provider estimates will be paid by the indicated payer.
B4-B6		Reserved for assignment by the NUBC
B7	Co-payment Payer B	The amount the provider assumes will be applied toward the patient's co-payment amount involving the indicated payer.
B8-B9		Reserved for assignment by the NUBC
BA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer B	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated
BC-C0		Reserved for assignment by the NUBC
C1	Deductible Payer C	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer. (**Note:** Medicare blood deductibles should be reported under Value Code 6.)
C2	Coinsurance Payer C	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.
C3	Estimated Responsibility Payer C	Amount the provider estimates will be paid by the indicated payer.
C4-C6		Reserved for assignment by the NUBC
C7	Co-payment Payer C	The amount the provider assumes is applied to the patient's co-payment amount involving the indicated payer.
C8-C9		Reserved for assignment by the NUBC

Code	Title	Definition
CA	Regulatory Surcharges, Assessments, Allowances or HealthCare Related Taxes Payer C	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
CC-CZ		Reserved for assignment by the NUBC
D0-D2		Reserved for assignment by the NUBC
D3	Patient Estimated Responsibility	The amount estimated by the provider to be paid by the indicated patient
D4	Clinical Trial Number Assigned by NLM/NIH.	8-digit, numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of "99999999" if the trial does not have an 8-digit www.clinicaltrials.gov registry number. Effective 10/1/07.
D5	*Last Kt/V Reading*	*Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service. Effective 7/1/2010.*
D6-DQ		*Reserved for assignment by the NUBC*
DS-DZ		Reserved for assignment by the NUBC
FC	Patient Paid Amount	The amount the provider has received from the patient toward payment of this bill.
FD	Credit Received from the Manufacturer for a Replaced Medical Device	The amount the provider has received from a medical device manufacturer as credit for a replaced device.

Code	Title	Definition
E0-G7		Reserved for assignment by the NUBC
G8	Facility Where Inpatient Hospice Service is Delivered	MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. Report the dollar portion of the form locator right justified to the left of the dollar/cents delimiter. Effective 1/1/08.
G9-Y0		Reserved for assignment by the NUBC
Y1	Part A Demonstration Payment	This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
Y2	Part B Demonstration Payment	This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be

Code	Title	Definition
		applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ		Reserved for assignment by the NUBC