CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2922	**Date: April 3, 2014**
	Change Request 8577

Transmittal 2874, dated February 6, 2014, is being rescinded and replaced by Transmittal 2922, dated April 3, 2014, to delete the note in §75.5, FL 67 that indicated that hospitals do not need to report diagnosis codes on nonpatient claims for laboratory services where the hospital functions as an independent laboratory. The sentence before the note, now the last sentence in the instruction for FL 67, governs reporting of diagnosis in such cases, and has for some time. The effective date and implementation date of Transmittal 2922 apply to the whole transmittal.

All other information remains the same.

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 25 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to publish an update to IOM Medicare Claims Processing Manual, Pub.100-04 Chapter 25, to reflect general manual changes.

EFFECTIVE DATE: April 18, 2014
IMPLEMENTATION DATE: April 18, 2014

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/Table of Contents
R	25/70/ Uniform Bill - Form CMS-1450
R	25/70.1/ Uniform Billing with Form CMS-1450
R	25/70.2/ Disposition of Copies of Completed Forms
R	25/75/ General Instructions for Completion of Form CMS-1450 for Billing
R	25/75.1/ Form Locators 1-15
R	25/75.3/ Form Locators 31-41
R	25/75.5/ Form Locators 43-81

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged 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.*

Business Requirements

Pub. 100-04	Transmittal: 2922	Date: April 3, 2014	Change Request: 8577

Transmittal 2874, dated February 6, 2014, is being rescinded and replaced by Transmittal 2922, dated April 3, 2014, to delete the note in §75.5, FL 67 that indicated that hospitals do not need to report diagnosis codes on nonpatient claims for laboratory services where the hospital functions as an independent laboratory. The sentence before the note, now the last sentence in the instruction for FL 67, governs reporting of diagnosis in such cases, and has for some time. The effective date and implementation date of Transmittal 2922 apply to the whole transmittal.

All other information remains the same.

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 25 Update

EFFECTIVE DATE: April 18, 2014

IMPLEMENTATION DATE: April 18, 2014

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to publish an update to IOM Medicare Claims Processing Manual, Pub.100-04 Chapter 25, to reflect general manual changes.

B. Policy: HIPAA Legislation Published in the Federal Register; 45 CFR Part 162

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8577.1	Contractors shall implement all requirements contained within the IOM Pub. 100-04 Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Matthew Klischer, matthew.klischer@cms.hhs.gov , Claudette Sikora, claudette.sikora@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Medicare Claims Processing Manual
Chapter 25 - Completing and Processing the Form CMS-1450 Data Set
(Rev.2922, Issued: 04-03-14)

Table of Contents

70.1 - Uniform Billing with Form CMS-1450

(Rev.2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

This form, also known as the UB-04, is a uniform institutional provider bill suitable for use in billing multiple third party payers. Because it serves many payers, a particular payer may not need some data elements. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form. *Medicare Administrative Contractors servicing both Part A and Part B lines of business (*A/B MACs *(A and HH))* responsible for receiving institutional claims also maintain lists of codes used by Medicare. All items on Form CMS-1450 are described. The A/B MAC *(A or HH)* must be able to capture all NUBC-approved input data described in section 75 for audit trail purposes and be able to pass coordination of benefits data to other payers with whom it has a coordination of benefits agreement.

70.2 - Disposition of Copies of Completed Forms

(Rev.2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

The provider retains the copy designated "Institution Copy" and submits the remaining copies of the completed Form CMS-1450 to its A/B MAC *(A or HH)*, managed care plan, or other insurer. Where it knows that a managed care plan will pay the bill, it sends the bill and any necessary supporting documentation directly to the managed care plan for coverage determination, payment, and/or denial action. It sends to the A/B MAC *(A or HH)* bills that it knows will be paid and processed by the A/B MAC *(A or HH).*

75 - General Instructions for Completion of Form CMS-1450 *for Billing*

(Rev.2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

This section contains Medicare requirements for use of codes maintained by the NUBC that are needed in completion of the Form CMS-1450 and compliant *Accredited Standards Committee (ASC)* X12 837 institutional claims. **Note that the internal claim record used for processing is not being expanded.** Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. The A/B MAC *(A or HH) does not* need *to* search paper files to annotate missing data unless it does not have an electronic history record. It *does not* need *to* obtain data that is not needed to process the claim.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the Form CMS-1450, this simply means that the A/B MAC *(A or HH)* accepts claims of up to 9 pages. The following layout describes the data specifications *Form CMS-1450*.

FORM CMS-1450 LAYOUT SUMMARY

FL	Description	Line	Type	Size	Buffer Space
FL01	[Billing Provider Name]	1	AN	25	
FL01	[Billing Provider Street Address]	2	AN	25	
FL01	[Billing Provider City, State, Zip]	3	AN	25	
FL01	[Billing Provider Telephone, Fax, Country Code]	4	AN	25	
FL02	[Billing Provider's Designated Pay-to Name]	1	AN	25	
FL02	[Billing Provider's Designated Pay-to Address]	2	AN	25	
FL02	[Billing Provider's Designated Pay-to City, State]	3	AN	25	
FL02	[Billing Provider's Designated Pay-to ID]	4	AN	25	
FL03a	Patient Control Number		AN	24	
FL03b	Medical/Health Record Number		AN	24	
FL04	Type of Bill	1	AN	4	1
FL05	Federal Tax Number	1	AN	4	
FL05	Federal Tax Number	2	AN	10	
FL06	Statement Covers Period - From/Through	1	N/N	6/6	1/1
FL07	Unlabeled	1	AN	7	
FL07	Unlabeled	2	AN	8	
FL08	Patient Name *and Identifier (ID)*	1a	AN	19	
FL08	Patient Name	2b	AN	29	
FL09	Patient Address - Street	1a	AN	40	1
FL09	Patient Address - City	2b	AN	30	2
FL09	Patient Address - State	2c	AN	2	1
FL09	Patient Address - ZIP	2d	AN	9	1
FL09	Patient Address - Country Code	2e	AN	3	
FL10	Patient Birthdate	1	N	8	1
FL11	Patient Sex	1	AN	1	2

FL	Description	Line	Type	Size	Buffer Space
FL12	Admission/Start of Care Date	1	N	6	
FL13	Admission Hour	1	AN	2	1
FL14	Priority (Type) of Admission or Visit	1	AN	1	2
FL15	Point of Origin for Admission or Visit	1	AN	1	2
FL16	Discharge Hour	1	AN	2	1
FL17	Patient Discharge Status	1	AN	2	1
FL18	Condition Code		AN	2	1
FL19	Condition Code		AN	2	1
FL20	Condition Code		AN	2	1
FL21	Condition Code		AN	2	1
FL22	Condition Code		AN	2	1
FL23	Condition Code		AN	2	1
FL24	Condition Code		AN	2	1
FL25	Condition Code		AN	2	1
FL26	Condition Code		AN	2	1
FL27	Condition Code		AN	2	1
FL28	Condition Code		AN	2	1
FL29	Accident State		AN	2	1
FL30	Unlabeled	1	AN	12	
FL30	Unlabeled	2	AN	13	
FL31	Occurrence Code/Date	a	AN/N	2/6	1/1
FL31	Occurrence Code/Date	b	AN/N	2/6	1/1
FL32	Occurrence Code/Date	a	AN/N	2/6	1/1
FL32	Occurrence Code/Date	b	AN/N	2/6	1/1
FL33	Occurrence Code/Date	a	AN/N	2/6	1/1
FL33	Occurrence Code/Date	b	AN/N	2/6	1/1
FL34	Occurrence Code/Date	a	AN/N	2/6	1/1
FL34	Occurrence Code/Date	b	AN/N	2/6	1/1
FL35	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	1/1/1
FL35	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	1/1/1

FL	Description	Line	Type	Size	Buffer Space
FL36	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	1/1/1
FL36	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	1/1/1
FL37	Unlabeled	a	AN	8	
FL37	Unlabeled	b	AN	8	
FL38	Responsible Party Name/Address	1	AN	40	2
FL38	Responsible Party Name/Address	2	AN	40	2
FL38	Responsible Party Name/Address	3	AN	40	2
FL38	Responsible Party Name/Address	4	AN	40	2
FL38	Responsible Party Name/Address	5	AN	40	2
FL39	Value Code	a	AN	2	1
FL39	Value Code Amount	a	N	9	1
FL39	Value Code	b	AN	2	1
FL39	Value Code Amount	b	N	9	1
FL39	Value Code	c	AN	2	1
FL39	Value Code Amount	c	N	9	1
FL39	Value Code	d	AN	2	1
FL39	Value Code Amount	d	N	9	1
FL40	Value Code	a	AN	2	1
FL40	Value Code Amount	a	N	9	1
FL40	Value Code	b	AN	2	1
FL40	Value Code Amount	b	N	9	1
FL40	Value Code	c	AN	2	1
FL40	Value Code Amount	c	N	9	1
FL40	Value Code	d	AN	2	1
FL40	Value Code Amount	d	N	9	1
FL41	Value Code	a	AN	2	1
FL41	Value Code Amount	a	N	9	1
FL41	Value Code	b	AN	2	1
FL41	Value Code Amount	b	N	9	1
FL41	Value Code	c	AN	2	1
FL41	Value Code Amount	c	N	9	1
FL41	Value Code	d	AN	2	1
FL41	Value Code Amount	d	N	9	1
FL42	Revenue Codes	1-23	N	4	
FL43	Revenue Code Description/IDE	1-	AN	24	

FL	Description	Line	Type	Size	Buffer Space
	Number/Medicaid Drug rebate	23			
FL44	HCPCS/Accommodation Rates/HIPPS Rate Codes	1-23	N	14	
FL45	Service Dates	1-23	N	6	
FL46	Service Units	1-23	N	7	
FL47	Total Charges	1-23	N	9	
FL48	Non-Covered Charges	1-23	N	9	
FL49	Unlabeled	1-23	AN	2	
FL50	Payer Identification - Primary	A	AN	23	
FL50	Payer Identification - Secondary	B	AN	23	
FL50	Payer Identification - Tertiary	C	AN	23	
FL51	Health Plan *Identification Number*	A	AN	15	
FL51	Health Plan *Identification Number*	B	AN	15	
FL51	Health Plan *Identification Number*	C	AN	15	
FL52	Release of Information - Primary	A	AN	1	1
FL52	Release of Information - Secondary	B	AN	1	1
FL52	Release of Information - Tertiary	C	AN	1	1
FL53	Assignment of Benefits - Primary	A	AN	1	1
FL53	Assignment of Benefits - Secondary	B	AN	1	1
FL53	Assignment of Benefits - Tertiary	C	AN	1	1
FL54	Prior Payments - Primary	A	N	10	1
FL54	Prior Payments - Secondary	B	N	10	1
FL54	Prior Payments - Tertiary	C	N	10	1
FL55	Estimated Amount Due - Primary	A	N	10	1
FL55	Estimated Amount Due - Secondary	B	N	10	1
FL55	Estimated Amount Due - Tertiary	C	N	10	1
FL56	N*ational* P*rovider* I*dentifier (NPI)* – Billing Provider	1	AN	15	
FL57	Other Provider ID	A	AN	15	
FL57	Other Provider ID	B	AN	15	

FL	Description	Line	Type	Size	Buffer Space
FL57	Other Provider ID	C	AN	15	
FL58	Insured’s Name - Primary	A	AN	25	1
FL58	Insured's Name - Secondary	B	AN	25	1
FL58	Insured's Name -Tertiary	C	AN	25	1
FL59	Patient’s Relationship - Primary	A	AN	2	1
FL59	Patient's Relationship - Secondary	B	AN	2	1
FL59	Patient's Relationship - Tertiary	C	AN	2	1
FL60	Insured's Unique ID - Primary	A	AN	20	
FL60	Insured's Unique ID - Secondary	B	AN	20	
FL60	Insured's Unique ID - Tertiary	C	AN	20	
FL61	Insurance Group Name - Primary	A	AN	14	1
FL61	Insurance Group Name - Secondary	B	AN	14	1
FL61	Insurance Group Name -Tertiary	C	AN	14	1
FL62	Insurance Group *Number* - Primary	A	AN	17	1
FL62	Insurance Group *Number* - Secondary	B	AN	17	1
FL62	Insurance Group *Number* - Tertiary	C	AN	17	1
FL63	Treatment Authorization Code - Primary	A	AN	30	1
FL63	Treatment Authorization Code - Secondary	B	AN	30	1
FL63	Treatment Authorization Code - Tertiary	C	AN	30	1
FL64	Document Control Number (DCN)	A	AN	26	
FL64	DCN	B	AN	26	
FL64	DCN	C	AN	26	
FL65	Employer Name (of the insured) - Primary	A	AN	25	
FL65	Employer Name (of the insured) - Secondary	B	AN	25	
FL65	Employer Name (of the insured) - Tertiary	C	AN	25	
FL66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)		AN	1	
FL67	Principal Diagnosis Code and Present on Admission (POA) Indicator		AN	8	
FL67A	Other Diagnosis and POA Indicator		AN	8	
FL67B	Other Diagnosis and POA Indicator		AN	8	

FL	Description	Line	Type	Size	Buffer Space
FL67C	Other Diagnosis and POA Indicator		AN	8	
FL67D	Other Diagnosis and POA Indicator		AN	8	
FL67E	Other Diagnosis and POA Indicator		AN	8	
FL67F	Other Diagnosis and POA Indicator		AN	8	
FL67G	Other Diagnosis and POA Indicator		AN	8	
FL67H	Other Diagnosis and POA Indicator		AN	8	
FL67I	Other Diagnosis and POA Indicator		AN	8	
FL67J	Other Diagnosis and POA Indicator		AN	8	
FL67K	Other Diagnosis and POA Indicator		AN	8	
FL67L	Other Diagnosis and POA Indicator		AN	8	
FL67M	Other Diagnosis and POA Indicator		AN	8	
FL67N	Other Diagnosis and POA Indicator		AN	8	
FL67O	Other Diagnosis and POA Indicator		AN	8	
FL67P	Other Diagnosis and POA Indicator		AN	8	
FL67Q	Other Diagnosis and POA Indicator		AN	8	
FL68	Unlabeled	1	AN	8	
FL68	Unlabeled	2	AN	9	
L69	Admitting Diagnosis Code		AN	7	
FL70a	Patient Reason for Visit Code		AN	7	
FL70b	Patient Reason for Visit Code		AN	7	
FL70c	Patient Reason for Visit *Code*		AN	7	
FL71	Prospective Payment System (PPS) Code		AN	3	2
FL72a	External Cause of Injury *(ECI)* Code and POA Indicator		AN	8	
FL72b	ECI Code and POA Indicator		AN	8	
FL72c	ECI Code and POA Indicator		AN	8	
FL73	Unlabeled		AN	9	
FL74	Principal Procedure Code/Date		N/N	7/6	1/1
FL74a	Other Procedure Code/Date		N/N	7/6	1/1
FL74b	Other Procedure Code/Date		N/N	7/6	1/1
FL74c	Other Procedure Code/Date		N/N	7/6	1/1
FL74d	Other Procedure Code/Date		N/N	7/6	1/1
FL74e	Other Procedure Code/Date		N/N	7/6	1/1

FL	Description	Line	Type	Size	Buffer Space
FL75	Unlabeled	1	AN	3	1
FL75	Unlabeled	2	AN	4	1
FL75	Unlabeled	3	AN	4	1
FL75	Unlabeled	4	AN	4	1
FL76	Attending Provider - ID*s*	1	AN	11/2/9	
FL76	Attending Provider – Last *Name*/First *Name*	2	AN	16/12	
FL77	Operating Physician - ID*s*	1	AN	11/2/9	
FL77	Operating Physician - Last *Name*/First *Name*	2	AN	16/12	
FL78	Other Provider - ID*s*	1	AN	2/11/2/9	
FL78	Other Provider - Last *Name*/First *Name*	2	AN	16/12	
FL79	Other Provider - ID*s*	1	AN	2/11/2/9	
FL79	Other Provider - Last/First	2	AN	16/12	
FL80	Remarks	1	AN	21	
FL80	Remarks	2	AN	26	
FL80	Remarks	3	AN	26	
FL80	Remarks	4	AN	26	
FL81	Code-Code - QUAL*IFIER*/CODE/VALUE	a	AN/AN/AN	2/10/12	
FL81	Code-Code - QUAL*IFIER*/CODE/VALUE	b	AN/AN/AN	2/10/12	
FL81	Code-Code - QUAL*IFIER*/CODE/VALUE	c	AN/AN/AN	2/10/12	
FL81	Code-Code - QUAL*IFIER*/CODE/VALUE	d	AN/AN/AN	2/10/12	

75.1 - Form Locators 1-15

(Rev.2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

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

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

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

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

FL 3a - Patient Control Number

Required. The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment

may be shown if the provider assigns one and needs it for association and reference purposes.

FL 3b – Medical/Health Record Number

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

FL 4 - Type of Bill

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

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

Code Structure

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

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

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

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

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

Bill Type Codes

The following lists "Type of Bill," FL4 codes. For a definition of each facility type, see the Medicare State Operations Manual.

Bill Type Code	
011X	Hospital Inpatient (Part A)
012X	Hospital Inpatient Part B
013X	Hospital Outpatient
014X	Hospital Other Part B
018X	Hospital Swing Bed
021X	SNF Inpatient
022X	SNF Inpatient Part B
023X	SNF Outpatient
028X	SNF Swing Bed

032X Home Health
033X Home Health
034X Home Health (Part B Only)
041X Religious Nonmedical Health Care Institutions
071X Clinical Rural Health
072X Clinic ESRD
073X Clinic – Freestanding (Effective April 1, 2010)
074X Clinic OPT
075X Clinic CORF
076X Community Mental Health Centers
077X Federally Qualified Health Centers (Effective April 1, 2010)
081X Nonhospital based hospice
082X Hospital based hospice
083X Hospital Outpatient (*Ambulatory Surgery Center*)
085X Critical Access Hospital

FL 5 - Federal Tax Number

Required. The format is NN-NNNNNNN.

FL 6 - Statement Covers Period (From-Through)

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

FL 7

Not Used.

FL 8 - Patient's Name *and Identifier*

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

FL 9 - Patient's Address

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

FL 10 - Patient's Birth Date

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

FL 11 - Patient's Sex

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

FL 12 - Admission/Start of Care Date

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

FL 13 - Admission Hour

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

FL 14 – Priority (Type) of Admission or Visit

Required.

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

FL 15 – Point of Origin for Admission or Visit

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

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

75.3 - Form Locators 31-41

(Rev.2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

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.

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

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.

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

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 *claim*, 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).

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

75.5 - Form Locators 43-81

(Rev.2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

FL 43 - Revenue Description/IDE Number/Medicaid Drug Rebate

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 *durable medical equipment (*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 *Healthcare Common Procedure Coding System (*HCPCS*)* coding.

When required to submit drug rebate data for Medicaid rebates, submit N4 followed by the 11 digit *National Drug Code (*NDC*)* in positions 01-13 (e.g., N499999999999). Report the NDC quantity qualifier followed by the quantity beginning in position 14. The Description Field on *Form CMS-1450* 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.

HCPCS used for Medicare claims are available from Medicare contractors.

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 case mix 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 is 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 Rate Codes used for Medicare claims are available from Medicare contractors.

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.

HIPPS Modifiers/Assessment Type Indicators used for Medicare claims are available from Medicare contractors.

HCPCS Modifiers (Level I and Level II)

Form CMS-1450 accommodates up to four modifiers, two characters each. See AMA publication CPT 20xx (xx= 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.

HCPCS modifiers used for Medicare claims are available from Medicare contractors.

FL 45 - Service Date

Required Outpatient. 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.

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, 077X (effective April 1, 2010), 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.

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.

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.

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 A/B MAC *(A or HH)* 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 A/B MAC *(A or HH)* 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 (Required), B (Situational), and C (Situational) - Payer Identification

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.

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. Required when the indicated payer has paid an amount to the provider towards this bill.

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

Not required.

FL 56 – Billing Provider National Provider ID (NPI)

Required on or after May 23, 2008.

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

Not used. Data entered will be ignored.

FLs 58A, B, and C - Insured's Name

Required. The name of the individual under whose name the insurance benefit is carried.

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.

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

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

The unique number assigned by the health plan to the insured.

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 Worker's Compensation (WC) or an Employer Group Health Plan (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 *Quality Improvement Organization (*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 (of the Insured)

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.

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 *for*

ICD-9 or all seven digits for ICD-10. 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 ICD-9-CM is applicable*. Where the proper code has fewer than five digits (ICD-9-CM) *or seven digits (ICD-10-CM),* 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 *Diagnosis Related Group (*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. 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. 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.

FLs 67A-67Q - Other Diagnosis Codes

Situational. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.

FL 68 – Reserved

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.

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 – Reserved

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 – Reserved

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 A/B MAC *(A or HH)* 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.

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