SHARP COMMUNITY MEDICAL GROUP/SHARP HEALTHCARE

Billing and Claim Payment Procedures

June 2021

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PREFACE

This billing guide is intended to serve as a useful guide to facilitate billing and understand claim payment The guidelines set forth in this manual are industry standard guidelines from Medicare, AMA and specialty associations. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Health Plan and the Department of Managed Health Care.

It is the responsibility of each provider or practitioner submitting claims to become familiar with billing, coverage and requirements. Sharp HealthCare will make every effort to ensure the information contained in this guide is accurate and current.

The edition date appears on each page. However, because regulations can change frequently, it is the responsibility of each provider or practitioner to keep abreast of billing and payment requirements.

PROVIDER FILE UPDATE

Are you **moving** your office? Locating to a **different suite** within the same building? Are you **retiring**? Did the phone company **change your area code**? In order to maintain accurate records and ensure you receive all information mailed to you, it is important you advise Sharp Health Care Provider Enrollment of any changes. ***To ensure the integrity of your address, we cannot accept the U.S. Post Office address change notices.*** If you change your business address and do not notify us, the U.S. Post Office will return your checks to us. ***Changes will NOT be accepted by FAX.*** All applications for change requests should be mailed to:

Sharp Community Medical Group
Provider Enrollment Department
8695 Spectrum Center Blvd, 4th Floor
San Diego, CA 92123

CLAIMS SCANNING

OPTICAL CHARACTER RECOGNITION (OCR)

Sharp Healthcare is using an Optical Character Recognition (OCR) system to capture claims information directly from the CMS-1500 claim form. OCR benefits include:

- Greater efficiency;
- Improved accuracy;
- More control over the data input, and
- Reduced data entry cost.

With the OCR system, it is important that claims be submitted with proper and legible coding. This is because the OCR output is largely dependent on the accuracy and legibility of the claim form submitted.

If you are not billing electronically, consider it! However, when you bill on paper, follow these tips when completing your CMS-1500 forms.

The print should be:

- Legible. Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended.
- Black Ink.
- Pica, Courier 10, or Courier 12 font type.
- CAPITAL letters.

The font must NOT have:

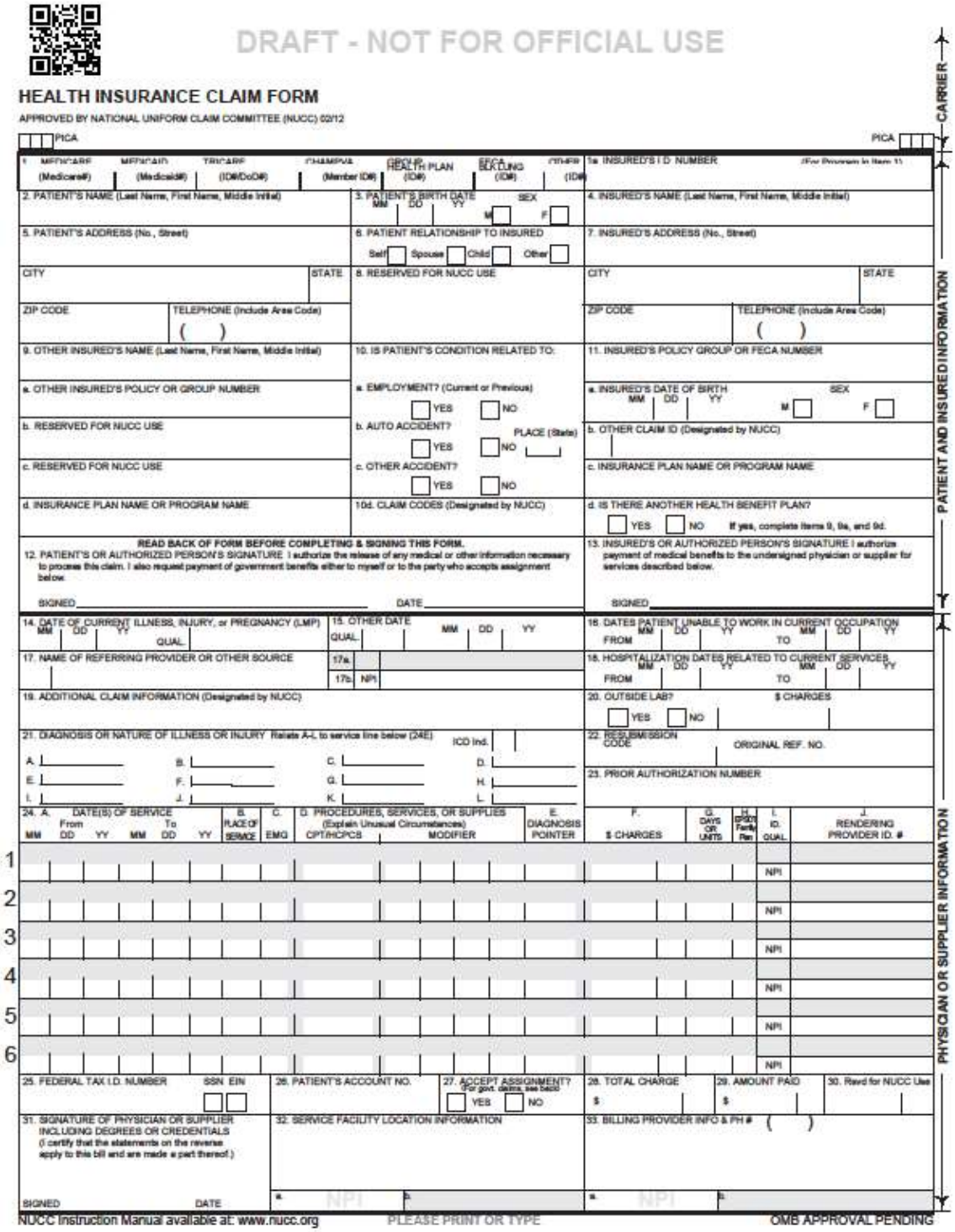
- Broken characters,
- Script,
- Stylized print,
- Italic print,
- Mini-font, or
- Proportional pitch (use only typefaces that have the same width for each character). Avoid Dot Matrix font.

Do NOT bill with:

- Liquid correction fluid changes.
- Data touching box edges or running outside of numbered boxes (instead, center claim information in each box). Exception: when using the 8-digit date format, information may be typed over the dotted lines shown in date fields, i.e., Item 24a.
- More than six service lines per claim (use a new form for additional services);
- Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier or ICD-9 CM codes are sufficient);
- Stickers or rubber stamps (such as “tracer”, “corrected billing,” provider name and address, etc);
- Special characters (i.e., hyphens, periods, parentheses, dollar signs and ditto marks).
- Handwritten claims,
- Attachments smaller than 8 ½ x 11.

The claim form must be:

- An original CMS-1500 or UB 1450 printed in red “drop out” ink with the printed information on back (photocopies are not acceptable);
- Size – 8 ½” x 11” with the printer pin-feed edges removed at the perforations;
- Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
- Thick enough (20-22lbs.) to keep information on the back from showing through;
- Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strike-overs, crossed out information or white out.



DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE OMB APPROVAL PENDING

PREPARING THE CMS-1500 CLAIM FORM

The CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program for claims from physicians and suppliers (except for ambulance services). It has also been adopted by the Office of Civilian Health and Medical Program for the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

Instructions require the reporting of 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers of service and suppliers have the option of entering either 6 or 8-digit dates in items 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 14, 16, 18, 19, 24a, he or she must enter 8-digit dates for **all** these fields. For instance, a provider or supplier will **not** be permitted to enter 8-digit dates for items 14, 16, 18, 19, and a 6-digit date for item 24a. The same applies to providers and suppliers who choose to submit 6-digit dates. Items 12 and 31 are exempt from this requirement.

Paper claims will be returned as unclean if they do not adhere to the date requirements. Electronic claims will be returned that do not include an 8-digit date (ccyymmdd) when a date is reported.

Items marked with **"R"** (Required) or **"C"** (Conditionally Required) will cause your claim to be rejected if they are missing, invalid, or incomplete. However, there are many other items on the claim form, which must be properly completed, or your claim will be developed, delayed or denied.

Back of CMS-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.
NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.
REFERS TO GOVERNMENT PROGRAMS ONLY
MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance, which is responsible to pay for the services for which the Medicare claim is made. See 42CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.
BLACK LUNG AND FECA CLAIMS
The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.
SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or TRICARE regulations.
For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.
For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.
No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).
NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.
NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instruction, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

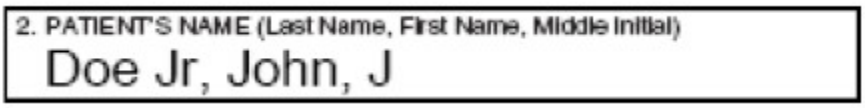
INSTRUCTIONS FOR FILLING OUT THE CMS-1500 CLAIM FORM

Carrier Block Instruction: Current version identified by the Quick Response (QR) code symbol and date approved by the NUCC at top left portion of claim form. In the 'carrier' section (upper right corner) enter name of payer, health plan, and payer address (9 digit zip without hyphen) as formatted above.

Item 1: Enter the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Group Health Plan claim is being filed, check the Group Health Plan box.

Item 1a: The patient's Insurance Identification Number. This information identifies the insured to the payer.

Item 2: Enter the patient's last name, first name, and middle initial, if any, as shown on the the patient's Health Insurance.



Item 3: Enter the patient's 8-digit birth date (MM DD CCYY) and sex.

Item 4: List the name of the insured here. (Last, First, MI)

Item 5: Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number. 9 digit zip code without hyphen.

Item 6: The patient's relationship to insured when item 4 is completed.

Item 7: Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word **SAME**. Complete this item only when items 4 and 11 are completed. 9 digit zip code without hyphen.

Item 8: This field is now 'Reserved for NUCC Use' and is not required. It was previously used to report "Patient Status'. "Patient Status" does not exist in 5010A1 so this field has been eliminated.

Item 9: Situational for 9, 9a and 9d. Enter the last name, first name, and middle initial of other

insured if patient is covered by more than one health insurance policy.

Item 9a: Enter the policy and/or group number of the insured.

NOTE: Item 9d must be completed if you enter a policy and/or group number in Item 9a.

Item 9b: Reserved for NUCC Use. Previously used to report "Other Insured's Date of Birth, Sex" which does not exist in 5010A1, so this field has been eliminated.

Item 9c: Reserved for NUCC Use. Previously used to report "Employer's Name or School Name" which does not exist in 5010A1, so this field has been eliminated

Item 9d: Enter the insurance plan name.

Item 10a-c: Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other applicable insurance coverage that may be primary.

Item 10d: Claim Codes (Designated by NUCC), used to identify additional information about the patient's condition or the claim. Refer to www.nucc.org under Code Sets for those code approved by NUCC for use on the 1500 Claim form.

Item 11: Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item 4 is completed, this field should also be completed.

Item 11a: Enter the insured's 8-digit birth date (MM DD CCYY) and sex if different from item 3.

Item 11b: Enter the 'Other Claim ID" and qualifier. Applicable qualifier and accompanying identifiers are designated by NUCC. (field title changed from 'Employer's Name or School Name')

Item 11c: Enter the 9-digit PAYER ID number of the primary insurer.

Item 11d: Complete. Answer yes or no. If yes complete 9, 9a and 9d.

Item 12: The patient or authorized representative must sign and enter either a 6- digit date (MM DD YY), 8-digit date (MM DD CCYY), or an alpha numeric date (e.g., January 1, 2013 unless the signature is on file). In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X). When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13: The signature in this item authorizes payment of mandated benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file as a separate authorization. It may state that the

authorization applies to all occasions of service until it is revoked.

Item 14: **Situational.** Enter either a 6-digit (MM DD YY) or 8-digit (MM DD CCYY) date of present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. For chiropractic services, enter either a 6-digit (MM DD YY) or 8-digit (MM DD CCYY) date of the initial exacerbation of the existing conditions.

Enter the applicable qualifier to identify which date is being reported.

- 431 Onset of Current Symptoms or Illness
- 484 Last Menstrual Period

Enter the qualifier to the right of the vertical, dotted line.

Item 15: Other Date. Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format. This identifies additional date information about the patient's condition or treatment.

Enter applicable qualifier to identify which date is being reported.

- 454 Initial Treatment
- 304 Latest Visit or Consultation
- 453 Acute Manifestation of a Chronic Condition
- 439 Accident
- 455 Last X-Ray
- 471 Prescription
- 090 Report Start (Assumed Care Date)
- 091 Report End (Relinquished Care Date)
- 444 First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

Item 16: If the patient is employed and is unable to work in current occupation, 'from-to' dates, enter either 6-digit (MM DD YY) or 8-digit (MM DD CCYY) dates when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17: Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Enter the applicable qualifier to identify which provider is being reported.

- DN Referring Provider
- DK Ordering Provider
- DQ Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

Referring physician is a physician who requests an item or service for the enrollee.

Ordering physician is a physician who orders non-physician services for the patient such as

diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and NPI. For example, a surgeon must complete items 17 – 17b when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the Performing physician's name and assigned NPI must appear in items 17 – 17b.

Item 17a: Other ID# number (non-NPI) of the referring, ordering, or supervising provider. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

- OB State License Number
- 1G Provider UPIN Number
- G2 Provider Commercial Number
- LU Location Number (This qualifier is used for Supervising Provider only)

Item 17b: Enter the NPI of the referring/ordering physician listed in item 17.When a claim involves multiple referring and/or ordering physicians', a separate CMS-1500 must be used for each ordering/referring physician.

Item 18: Enter either the 6-digit (MM DD YY) or 8-digit (MM DD CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization. Enter the admit and discharge date. If not discharged, leave the discharge date blank.

Item 19: Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.
Enter a concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise, an attachment must be submitted with the claim.
Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, enter all applicable modifiers
For each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

To avoid a delay in processing your claim be sure to enter pricing modifiers or procedure specific modifiers on the line next to procedure code, not in item 19.

Enter anesthesia start and stop time, to include total time in attendance and physical status.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter either the 6-digit (MM DD YY) or 8-digit (MM DD CCYY) assumed and/or relinquished

date for a global surgery claim when providers share post-operative care.

If the claim is a corrected claim enter this information here explaining what is corrected on the claim.

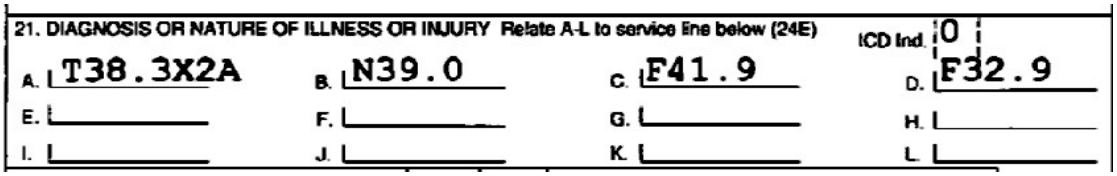
Item 20: Outside Lab? $Charges: These fields indicate that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs. Complete this field when billing for purchased services by enter an X in the 'Yes' box. A 'Yes' indicates that the reported service was provided by an entity other than the billing provider. A 'NO' mark or blank indicates that no purchased services are included on the claim.

If 'YES' is annotated, enter the purchase price under "$Charges" and complete Item number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.

Item 21: Enter the patient's diagnosis/condition. All physician specialties and non-physician practitioners (i.e., PA, NP CNS, CRNA) must use an ICD-10-CM or ICD-09-CM code number and code to the highest level of specificity. Enter up to 12 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis provided by the ordering physician.

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9 ICD-9-CM
0 ICD-10-CM



All claims must include ICD-10-CM or ICD-09-CM coding to highest level of specificity required or the claim will be rejected. This field allows for entry of a 1 character indicator and 12 diagnosis codes at a maximum of 7 characters in length.

All claims billed electronically must also contain a valid ICD-10-CM or ICD-09-CM code.

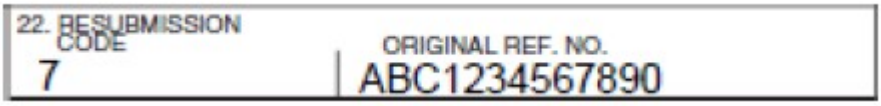
Please be advised that effective on and after 10/1/15 all claims with dates of service on or after 10/1/15 must be submitted with an ICD10 code and will be rejected if an ICD9 code is submitted. A referral that is approved with a ICD9 code prior to 10/1/15 and the service was provided on 10/1/15 and after, the claim must be coded with an ICD10.

If billing for transgender patients, please indicate the applicable transgender ICD-10 code (F64.x) as secondary information on claims for all services, including mental health and primary care services.

Item 22: Resubmission and/or Original Reference Number. List the original reference number for

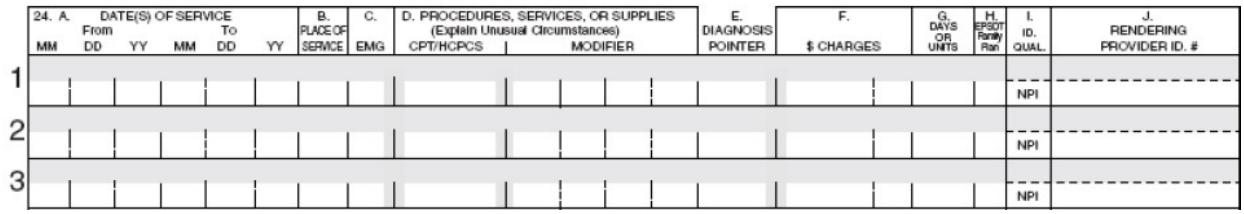
resubmitted claims. This item is used to indicate a previously submitted claim or encounter. When resubmitting a claim, enter the appropriate bill frequency code left justified in the left hand side of the field:

7 Replacement of prior claim
8 Void/cancel of prior claim



Item 23: Enter the authorization number provided by group or Heath Plan if provided. If billing for laboratory tests submit a single claim for CLIA-covered laboratory test and report the CLIA number of the billing laboratory that is performing the testing in item 23 on the CMS-1500 form.

Item 24 a-j:



Item 24a: Enter the 6-digit (MM DD YY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G.

Item 24b: Enter the appropriate place of service code(s) from the list provided in Appendix C. Identify the location, using the 2 character place of service code, for each item used or service performed.

For example, when a service is rendered to a hospital inpatient, use the "inpatient hospital" code of **21**.

Item 24c: Leave Blank. Not required.

Item 24d: Enter the CPT or HCPCS code(s) and modifier(s) (if applicable from the appropriate code set in effect on the date of service. Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

HCPCS consists of valid *Physician's Current Procedural Terminology (CPT)* procedure codes and modifiers (Level 1) published by the American Medical Association (AMA), supplemented by alpha-numeric codes and modifiers developed by CMS (Level II), or carrier specific codes and modifiers (Level III). Use of HCPCS codes on claims is mandatory. HCPCS Codes are updated annually. Billing with codes that are deleted will result in a rejection as an unclean claim. In addition using other coding systems in the submission of claims will result in rejection of the claim as unclean. ***Please add modifier KX to any procedure that is gender specific for transgender, ambiguous genitalia, and hermaphrodite patients.***

Item 24e: Enter the diagnosis code reference number or letter as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, enter the primary diagnosis reference number or letter for each service; either a 1, or a 2, or a 3, or a 4, or the applicable letter reference number. Add other applicable references, since lines may have more than one diagnosis reference number.

Item 24f: Enter the charge amount for each listed service.

Item 24g: Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

Item 24h: Leave blank. Not required.

Item 24i: The shaded area is to be used to identify a non-NPI identification number. Use the following:

OB	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number
ZZ	Provider Taxonomy (for the 1500 Claim form ZZ will remain as the qualifier)

The non-shaded area is to be used for a NPI only.

Item 24j: Enter the rendering provider NPI ID in the non-shaded area. In the shaded area enter the other ID number as referenced by the qualifier used (if reporting).

Complete a separate claim when more than one provider or suppliers within a group have rendered service to same patient.

Item 24 a-j: Shaded areas

The shaded areas of Item 24 can be used to provide supplemental information such as:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Contract Rate

The following qualifiers are to be used when reporting these services:

ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
CTR	Contract Rate

When entering supplemental information for NDC, add in the following order:

Qualifier,NDC Code, one space, unit/basis of measurement qualifier,quantity.

Quantity of Measurement qualifiers:

F2	International Unit	ME	Milligram	UN	Unit
GR	Gram	ML	Milliliter		

The following describes how to submit NDC information:

Before you can fill out the claim to bill for a drug, you will need to know the following information:

- Amount of drug to be billed
- HCPCS/CPT code
- HCPCS/CPT code description
- Number of HCPCS/CPT units
- NDC (11-digit billing format)
- NDC description
- NDC unit of measure

Consider the following example for Ciprofloxacin IV 1200 MG (1 day supply):

Amount of drug to be billed:	1200 MG
HCPCS/CPT code:	J0744
HCPCS/CPT code description:	Ciprofloxacin for intravenous infusion, 200 MG
Number of HCPCS/CPT units	6
NDC (11-digit billing format):	00409-4765-86
NDC description:	Ciprofloxacin IV SOLN 200 MG/20 ML
NDC unit of measure	ML

How do I calculate the NDC units?

Billing the correct number of NDC units for the corresponding HCPCS/CPT codes on your claims is essential.

To calculate the units manually there are several steps you will need to take. Using the example above for Ciprofloxacin:

- The amount of the drug to be billed is 1200 MG, which is equal to 6 HCPCS/CPT units.
- The NDC unit of measure for a liquid, solution or suspension is ML; therefore, the amount billed must be converted from MG to ML.
- According to the NDC description for NDC 00409-4765-86, there are 200 MG of ciprofloxacin in 20 ML of solution (200 MG/20 ML).
- Take the amount to be billed (1200 MG) divided by the number of MG in the NDC description (200 MG). *1200 ÷ 200 = 6*
- Multiply the result (6) by the number of ML in the NDC description (20 ML) to arrive at the correct number of NDC units to be billed on the claim (120). *6 x 20 ML = 120*

When submitting NDCs on my claim, what other information will I need to include?

When submitting NDCs on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500) claims, you must also include the following related information in order for your claim to be accepted and reviewed for possible benefits at the NDC level:

- The applicable HCPCS or CPT code
- Number of HCPCS/CPT units
- NDC qualifier (N4)
- NDC unit of measure (UN, ML, GR, F2)
- Number of NDC units (up to three decimal places)

Note: As a reminder, you also must include your billable charge.

How should the NDC be entered on the claim?

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 configuration. See the examples below:

Label Configuration	Add leading zero, Remove hyphens
4-4-2 (**xxxx**-xxxx-xx)	**0xxxx**xxxxxx
5-**3**-2 (xxxxx-**xxx**-xx)	xxxxx**0xxx**xx
5-4-**1** (xxxxx-xxxx-**x**)	xxxxxxxxx**0x**

Where do I enter NDC data on electronic claim (ANSI 5010 837P) transactions?

Here are general guidelines for including NDC data in an electronic claim:

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (**UN**, **ML**, **GR**, or **F2**)	2410	CTP05

Note: The total charge amount for each line of service also must be included for the Monetary Amount in Loop ID, Segment SV102.

Where do I enter NDC data on a paper claim (CMS-1500)?

In the **shaded portion** of line-item field 24A-24G, enter NDC qualifier **N4** (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units).

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400409476586 ML120													N		12345678901
01	01	13	01	01	13	11		J0744		1	17.94	6	N	NPI	123456789

Can you give some billing examples?

Example #1
HCPCS code J9400 provides a good billing example. A patient receives Ziv-Alfibercept ZALTRAP 400 MG. Zaltrap is available as 200 MG per 8 ML (25 MG per ML) solution, single-use vial, NDC 00024-5841-01.

For this sample scenario:

- The NDC is 00024-5841-01 (the qualifier is N4)
- The unit of measure is ML
- The quantity (number of J-code units administered) is 400
- The quantity (number of NDC units administered) is 16

On the CMS-1500, the data would be entered as follows: **N400024584101 ML16**

Example #2 (Billing with a single dose vial)
The HCPCS code description for J0692 is "Injection, cefepime HCl, 500 MG." A patient receives Cefepime 500 MG. Cefepime is available as a 1 gram reconstitutable single-use vial (i.e., sterile powder in a vial, not premixed). You can use NDC 60505-0834-04.

For this sample scenario:

- The NDC is 60505-0834-04 (the qualifier is N4)
- The unit of measure is UN
- The quantity (number of NDC units administered) is 1*
- The quantity (number of J-code units administered) is 2*

On the CMS-1500, the data would be entered as follows: **N460505083404 UN1**

*Please note: You can bill for the entire vial size of the single-use vial, even though the actual dose administered is less than the entire package size. Multi-use vials are not subject to payment for drug waste.

How do I determine if the NDC is valid for the date of service?

When billing with NDCs on professional/ancillary electronic (837P) or paper (CMS-1500) claims, it is important to ensure that the NDC used is valid for the date of service. This is because NDCs can expire or change. An NDC's inactive status is determined based on a drug's market availability in nationally recognized drug information databases.

Additionally, an NDC is considered to be obsolete two years after its inactive date. It is a good idea to conduct a periodic check of records or automated systems where NDCs may be stored in your office for billing purposes. To help ensure that correct reimbursement is applied, the 11-digit NDC on your claim should correspond to the active NDC on the medication's outer packaging. Inactive products will continue to be reimbursed until they become obsolete.

Item 25: Enter the Federal Tax I.D. (Employer Tax Identification number) or Social Security Number of the provider of service or supplier. Federal Tax I.D. number is required.

Item 26: Enter the patient's account number assigned by the provider of service's or supplier's accounting system. This field is optional but is reported on the provider remittance advice.

Item 27: Check the appropriate item to indicate whether the provider of service or supplier accepts assignment under the terms of the payer's program.

Item 28: Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29: Not required.

NOTE: *We recommend this be left blank, as it is often misunderstood and can cause incorrect payments.*

Item 30: Leave blank. Reserved for NUCC use. (Was previously used to report 'Balance Due')

Item 31: Enter the name of the provider of service or supplier and either the the 6-digit (MM DD YY) or 8-digit (MM DD CCYY) date, or alphanumeric date (e.g., January 1, 2008) the form was signed.

NOTE: *The name entered in box 31 of the CMS - 1500 claim form means that the provider has certified the services*

shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by provider or were furnished incident to his/her professional service by an employee under provider's immediate personal supervision, except as otherwise expressly permitted. Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by the 1500 claim form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Item 32: Enter the name, address, and zip code (9 digit zip without hyphen) of the location where the services were rendered (such as a hospital, clinic, laboratory, or facility other than the patient's home or physician's office). Providers of service (namely physicians) must identify the supplier's name, address, and zip code, and NPI when billing for purchased diagnostic tests. When more than one supplier is used, a separate CMS-1500 should be used to bill for each supplier.

This item is completed whether the supplier personnel performs the work at the physicians office or at another location.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a: Add the NPI of the provider entered in box 32 if different from the billing provider NPI.

Item 32b: Enter the 2 digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

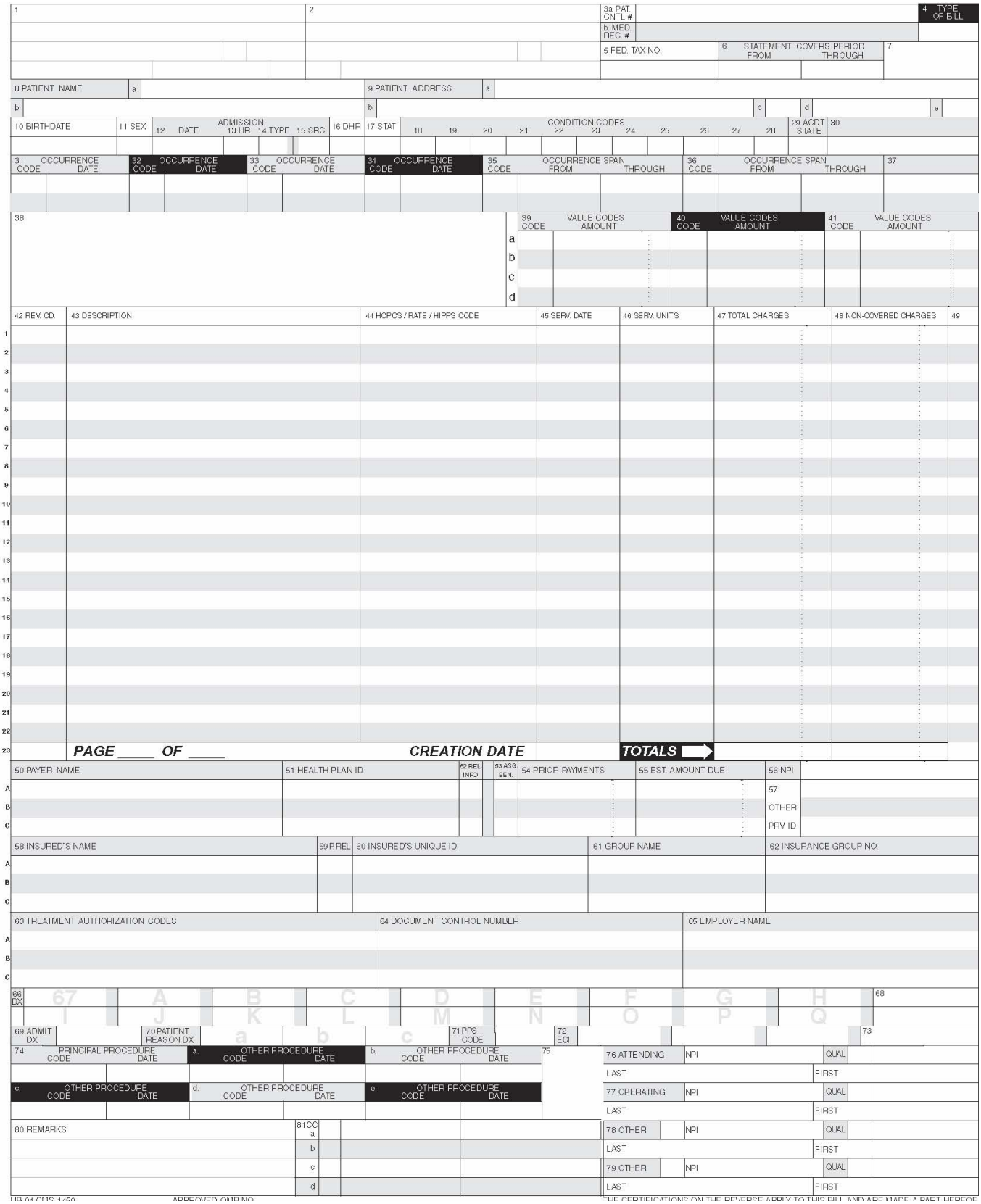
The NUCC defines the following qualifiers used in 5010A1:

OB State License Number
G2 Provider Commercial Number
LU Location Number

Item 33: Enter the providers or supplier's billing name, address, zip code, and telephone number. This information identifies the provider that is requesting to be paid for the services rendered and should always be completed. (9 digit zip code without a hyphen)

Item 33a: Add the NPI in box 33A

Item 33b: Same as 32b above.


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE _____ OF _____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO.
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57
OTHER
PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
a b c
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
80 REMARKS
81CC a b c d
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
UB-04 CMS-1450 APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

COMPLETION OF FORM -1450 FOR INPATIENT AND OUTPATIENT BILLING

This form, also known as the UB-04, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on Form 1450 are described.

This section details only the data elements which are required for billing.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is your name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Phone and/or Fax numbers are desirable.

FL 2. (Untitled) Pay-to name, address and Secondary Identification Fields - Situational
Required when the pay-to name and address information is different than the Billing Provider information in FL1. If used, the minimum entry is the provider name, address, city, State, and Zip code.

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. Sharp will ignore the leading zero. 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.

Code Structure

2nd Digit-Type of Facility
1 – Hospital
2 – Skilled Nursing
3 – Home Health
4 - Religious Non-Medical (Hospital)
5 – Reserved for national assignment (discontinued effective 10/1/05)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

3rd Digit-Bill Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).
4 - Other - Part B - (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services to non-patients, and referenced diagnostic services).
5 – Intermediate Care – Level I
6 – Intermediate Care – Level II
7 – Reserved for national assignment (discontinued effective 10/1/05)
8 - Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9 - Reserved for National Assignment

3rd Digit-Classification (Clinics Only)
1 - Rural Health Clinic (RHC)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free Standing Provider-Based Federally Qualified Health Center (FQHC)
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center
7 - Federally Qualified Health Center (FQHC)
8 – Licensed Freestanding Emergency medical Facility (Effective 7/1/2012)
9 - OTHER

3rd Digit-Classification (Special Facilities Only)

1 – Hospice (Non Hospital Based)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6- Residential Facility (Not used for Medicare)
7-8 – Reserved for National Assignment
9 – Special Facility-Other (Not Used for Medicare)

4th Digit-Frequency - Definition

1 - Admit Through Discharge Claim	Use this code for bill encompassing an entire inpatient confinement or course of outpatient treatment for which you expect payment from the payer.
2 - Interim-First Claim	Use this code for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment.
3 - Interim-Continuing Claim	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4 - Interim-Last Claim	Use this code for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The "Through" date of

	this bill (FL 6) is the discharge for this treatment.
5 – Late Charge	Not valid. Use 7 and correct the previously submitted bill.
7 - Replacement of Prior Claim	Use to correct a previously submitted bill. Apply this code to the corrected or "new" bill.
8 – Void/Cancel of a Prior Claim	Used to indicate that this claim eliminates and cancels a previously submitted claim.
9 – Final Claim for a Home Health PPS Episode	Used to indicate the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

FL 5. Federal Tax Number – Required. Enter your provider of service Federal Tax I.D. number (Employer Identification Number). Format is NN-NNNNNNN.

FL 6. Statement Covers Period (From-Through)
Required. Enter the beginning and ending dates of the period included on this bill in numeric fields (MM-DD-YY).

FL 7. Not Used.

FL 8a. Patient's ID -Not required. Use when different from the subscriber/insured's ID

FL 8b. Patient's Name - Required. The provider enters the patient's last name, first name, and, if any, middle initial

FL 9a.- 9d. Patient Address -Required. 9a. Patient Address, 9b. City name, 9c. State, 9d.Zip Code, 9e. Country code

FL 10. Patient Birth Date
Required. MM/DD/CCYY

FL 11. Patient's Sex
Required. The provider enters an "**M**" for male, an "**F**" for female, or "U" for unknown

FL 12. Admission/Start of Care Date

Required. Enter the date the patient was admitted for inpatient care (MM-DD-YY).

FL 13. Admission Hour
Not required. Entered in military time using two numeric characters.

FL 14. Type of Admission/Visit.
Required on inpatient bills only. Enter the code indicating the priority of this admission.

Code Structure:

1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	Newborn	Use of this code necessitates the use of a Special Source of Admission Codes Fl 15.
5	Trauma Center	Visits to a trauma center hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving trauma activation.
6-8	Reserved for National Assignment	
9	Information Not Available	.

FL 15. Source of Admission
Required. Enter the code indicating the source of this admission or outpatient registration.

1	Nonhealthcare Facility Point of Origin (Physician Referral)	Inpatient: The patient was admitted to this facility Outpatient: The patient presents to this facility for outpatient services. This includes patients coming from home or the workplace and patients receiving care at home (such as home health services).
2	Clinic Referral	Inpatient: The patient was admitted to this facility Outpatient: The patient presented to this facility for outpatient services.
3		Reserved for National Assignment.
4	Transfer from a Hospital (different facility)	Inpatient: The patient was admitted to this facility as a transfer from an acute care facility where they were inpatient or outpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.
5	Transfer from a SNF, ICF or ALF	Inpatient: The patient was admitted to this facility as a transfer from a SNF, ICF or ALF where he or she was a resident.

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF, ICF or ALF where he or she is a resident.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facilityas a transfer from another type of health care facility not defined elsewhere in this code list.. Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.
7		Reserved for National Assignment.
8	Court/Law Enforcement	Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. This includes transfers from incarceration facilities.
9	Information Not Available	Inpatient: The means by which the patient was admitted to this hospital is not known. Outpatient: The means by which the patient was admitted is not known. *Effective April 1, 2010, this point of origin code is acceptable on any TOB.*
A		Reserved for National Assignment.
B		Reserved for National Assignment.
C		Reserved for National Assignment.
D	Transfer from One Distinct Unit of hospital to Another Distinct Unit of same hospital resulting in a separate claim to the payer	The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. For outpatients: patient received outpatient services in this facility as a transfer from within this hospital resulting in separate claim to payer.
E	Transfer from Ambulatory Surgery Center	Inpatient: Patient was admitted to this facility as a transfer from an ambulatory surgery center. Outpatient: Patient presented to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center
F	Transfer from Hospice Facility	Inpatient: Patient admitted as a transfer from a hospice facility. Outpatient: Patient presented to this facility for outpatient or referenced diagnostic services from a hospice
G-Z		Reserved for National Assignment

Coding Structure: Newborn

1-4 Discontinued

5 Born Inside This Hospital

6 Born Outside of this Hospital

7-9 Reserved for National Assignment

FL 16. Discharge Hour
Not Required. Enter in military time.

FL17. Patient Discharge Status
Required. Enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care. See Code 61 for hospitals with approved swing beds.
04	Discharged/transferred to a Facility that provides custodial or supportive care or an Intermediate Care Facility (ICF)
05	Discharged/transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care (effective 2/23/05).
07	Left against medical advice or discontinued care
08	Reserved for National Assignment
*09	Admitted as an inpatient to this hospital (For Medicare Outpatient claims only for services that begin greater than three days prior to an admission)
10-19	Reserved for National Assignment
20	Expired
21	Discharged/Transferred to Court/Law Enforcement
22-29	Reserved for National Assignment
30	Still patient
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)

Code	Structure
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a federal health care facility, (effective 10/1/03). Usage Note: Discharges and transferred to a government operated health care facility such as Department of Defense hospital, a Veteran's Administration (VA) hospital or a VA nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
44-49	Reserved for National Assignment
50	Hospice – home
51	Hospice - medical facility
52-60	Reserved for National Assignment
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital
64	Discharged/transferred to a nursing facility certified under Medi-Cal but not Certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH), (effective 1/1/06)
67-68	Reserved for National Assignment
69	Discharged/transferred to a Designated Disaster Alternative Care Site (effective 10/1/13)
70	Discharged/Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List
71-80	Reserved for National Assignment
81	Discharged to Home or Self-Care with a planned Acute Care Hospital Inpatient Readmission
82	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
83	Discharged/Transferred to Skilled Nursing Facility with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
84	Discharged/Transferred to a Facility that provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
85	Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
86	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission
87	Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
88	Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
89	Discharged/Transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Rehabilitation distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
91	Discharged/Transferred to a Medicare certified long-term care hospital with a planned acute care

	hospital inpatient readmission
92	Discharged/Transferred to a nursing facility certified under Medi-Cal but not certified under Medicare with a planned acute care hospital inpatient readmission
93	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/Transferred to a critical access hospital with a planned acute care hospital inpatient readmission
95	Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.

FL 18., 19, 20, 21, 22,23,24,25,26,27, and 28 – Condition Codes

Code	Title	Definition
02	Condition is Employment Related	Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment.
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan and the hospital expects to receive payment from the plan.
05	Lien Has Been Files	The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 18 months of Entitlement Covered by Employer Group Health Insurance	Medicare may be a secondary insurer if the patient is also covered by an employer group health insurance during the patient's first 18 months of end stage renal disease entitlement.
07	Treatment of Non-terminal Condition for Hospice Patient	The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	The beneficiary would not provide information concerning other insurance coverage. The F1 develops to determine proper payment.
09	Neither Patient Nor Spouse is Employed	In response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other

		employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no Large Group Health Plan (LGHP)	In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. The CMS will assign as needed for F1 use. Providers will not report.
15	Clean Claim Delayed in CMS's Processing System(Medicare Payer Only Code)	The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to CPE/CPT standards.
16	SNF Transition Exemption (Medicare Payer Only Code)	An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
17	Patient is Homeless	The patient is homeless.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child Retains Mother's Name	A patient (who is a dependent child entitled to benefits) that does not have this/her father's last name.
20	Beneficiary Requested Billing	Provider realizes services are at a noncovered level or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)
21	Billing for Denial Notice	The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
22	Patient on Multiple Drug Regimen	Patient receiving multiple IV drugs while on Home IV therapy
23	Home Care Giver Available	Home care giver available to assist self admin of IV drugs
24	Home IV Patient also receiving HHA services	Patient under care of HHA while receiving home IV therapy services
25	Patient is a Non-US Resident	Patient not a resident of United States
26	VA Eligible Patient Choose to Receive Services In a Medicare Certified Facility	Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	In response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers that patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees: or (2) the EGHP is a multi or

		multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part time employees: or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time-Day)	Patient declares that they are enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that they are enrolled in cooperative/work study program.
33	Patient is a Student (Full-Time-Night)	Patient declares that they are enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that they are enrolled as a part-time student.
	Accommodations	
35	Reserved for National Assignment	Reserved for National Assignment
36	General Care Patient in a Special Unit	(Not sued by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available. Accommodation charges for this period are at the prevalent semi-private rate.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) The patient was assigned to ward accommodations at their own request.
38	Semi-private Room Not Available	(Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private accommodations were not available.
	Note: *If revenue charge codes indicate a ward accommodation was assigned and neither code 37 nor code 38 applies, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, Medicare pays semi-private costs.*	
39	Private Room Medically Necessary	(Not used by hospitals under PPS.) The patient needed a private room for medical reasons.
40	Same Day Transfer	The patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization	The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).

42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Post Discharge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. (Note: For Medicare, the change in patient status from inpatient to outpatient is made prior to discharge or release *while the patient is still a patient of the hospital*.)
45	Ambiguous Gender Category	Code indicates claim is for a patient with ambiguous gender characteristics (e.g., transgendered or hermaphrodite).
46	Non-Availability Statement on File	A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.
47	Transfer from Another Home Health Agency	Code identifies when a patient is admitted to a home health agency as a transfer from another home health agency.
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49	Product replacement within product lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication the product is not functioning properly.
50	Product replacement for known recall of a product	Manufacturer or FDA has identified the product for recall and therefore replacement
51	Attestation of Unrelated Outpatient Nondiagnostic Services	For use on outpatient claims only. Facility attests that outpatient nondiagnostic service rendered within 3 calendar days of the inpatient admission are not related to the inpatient stay.
52	Out of Hospice Service Area	Used when a patient is discharged for moving out of the hospice service area, including patients admitted to a hospital without contractual arrangements with the hospice.
53	Initial Placement of a medical device provided as part of a clinical trial or a free sample	Used on outpatient claims where a device credit was received upon initial medical device placement in a clinical trial or as a free sample.
54	No Skilled Home Health Visits in Billing Period. Policy Exception Documented at the Home Health Agency (effective July 1, 2016)	Report when the home health claim is submitted without any skilled visits due to a circumstance that is allowed by the payer and indicates that the policy exception is documented at the home health agency.
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30

		days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	The patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Managed care Organization Enrollee	Code indicates that patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
59	Non-primary ESRD Facility	Code indicates that ESRD beneficiary received non
60	Operating Cost Day Outlier	Day Outlier obsolete after FY 1997. (Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. The FI indicates the cost outlier portion paid value code 17.
61	Operating Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI indicates the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not report by providers.) Bill was paid under PIP. The F1 records this from its system.
63	Payer Only Code	Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment
64	Other Than Clean Claim	(Not reported by providers.) The claim is not "clean." The F1 records this from its system.
65	Non-PPS Bill	(Not reported by providers.) Bill is not a PPS Bill. The F1 records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Coast Outlier Payment	The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	The beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	The beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/DGME/N&A Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health.
70	Self Administered Anemia Management Drug	Code indicates the billing is for a home dialysis patient who self administers an anemia management drug such as erythropoietin alpha (EPO) or darbepoetin alpha.
71	Full Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal

		dialysis facility.
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis services at home.
75	Home 100-percent	Not used for Medicare.
76	Back-up In-Facility Dialysis	The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by Managed Care Plan	The bill is for a newly covered service under Medicare for which a managed care plan does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off-Site	Physical therapy, occupational therapy, or speech pathology services were provided off-site.
80	Home Dialysis-Nursing Facility	Home dialysis furnished in a SNF or Nursing facility.
81	C-section or inductions performed at less than 39 weeks gestation for medical necessity	
82	C-section or inductions performed at less than 39 weeks gestation electively	
83	C-sections or inductions performed at 39 weeks gestation or greater	
84	Dialysis for Acute Kidney Injury (AKI)	Dialysis facilities (TOB 072X) enter this code
85	Delayed Recertification of Hospice Terminal illness	Use when hospice termination is untimely (recertification)
86	Additional Hemodialysis Treatments with Medical Justification	Use when patients exhibits a medical condition that necessitates hemodialysis frequency greater than patient plan of care and all treatments are necessary/reasonable
87	ESRD Self Care Retraining	Reports special dialysis services retraining where patient or caregiver had previously completed dialysis training.
88-97	Reserved for Assignment by NUBC	
Additional codes see UB Editor		

FL 29 – Accident State Required if claim is related to an auto accident and the accident occurred in country or location that has a state, province or subcountry code.

FL 31, 32,33 and 34 - . Occurrence Codes and Dates-

Situational. – Required when there is a condition code that applies to this claim. Report in alphanumeric sequence.

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.

FL 37. (Untitled) internal Claim Numbers (ICN)/Document Control Number (DCN)
Required. Enter the claim number assigned to the original bill here. Utilize on adjustment requests (Bill Type, FL 4 = XX7). When requesting an adjustment to a previously processed claim, insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN should be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer B and C should be shown on lines B and C respectively, in FL 37.

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 – Not required.

FL42. Revenue Code
Required. Enter the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. Enter the appropriate numeric revenue code on the adjacent line in FL 43 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which noncovered charges, in FL 48, if any, are summed.

To assist in bill review, list revenue codes in ascending numeric sequence and do not repeat on the same bill to the extent possible. To limit the number of line items on each bill, sum revenue codes at the "zero" level to the extent possible.

Provide detail level coding for all charge codes with CPT/HCPC codes assigned when billing outpatient services; including supplies, laboratory, radiology, therapy, surgery and emergency procedures and visits.

002X Health Insurance Prospective Payment System (HIPPS)

Subcategory	*Standard Abbreviation*
0 - Reserved	
1 - Reserved	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HH PPS (effective 10/1/00)
4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (effective 1/1/02

010X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

Subcategory	Standard Abbreviations
0 - All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1 - All-Inclusive Room and Board	ALL INCL R&B

011X Room & Board - Private (Medical or General)

BILLING PROCEDURES

Subcategory	Standard Abbreviations
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
8 - Rehabilitation	REHAB/PVT
9 - Other	OTHER/PVT

12X Room & Board - Semi-private Two Bed (Medical or General)

Routine service charges incurred for accommodations with two beds.

13X Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2 - OB	OB/3&4BED
3 - Pediatric	PEDS/3&4BED
4 - Psychiatric	PSYCH/3&4BED
5 - Hospice	HOSPICE/3&4BED

6 - Detoxification	DETOX/3&4BED
7 – Oncology	ONCOLOGY/3&4BED
8 - Rehabilitation	REHAB/3&4 BED
9 – Other	OTHER/3&4BED

14X Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 – OB	OB/DLX
3 – Pediatric	PEDS/DLX
4 – Psychiatric	PSYCH/DLX
5 – Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX
7 - Oncology	ONCOLOGY/DLX
8 - Rehabilitation	REHAB/DLX
9 - Other	OTHER/DLX

15X Room & Board Ward (Medical or General)

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
8 - Rehabilitation	REHAB/WARD
9 - Other	OTHER/WARD

16X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are

currently separating this charge for billing.

Subcategory	Standard Abbreviation
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/Other

17X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Subcategories 1-4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under state regulations or other statutes supersede the following guidelines. For example, some states may have fewer than four levels of care or may have multiple levels within a category such as intensive care.

Level I - Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).

Level II - Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (Continuing Care).

Level III - Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).

Level IV - Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).

Subcategory	Standard Abbreviation
0 - Classification	NURSERY
1 - Newborn-Level I	NURSERY/LEVEL I
2 - Newborn-Level II	NURSERY/LEVEL II
3 -Newborn-Level III	NURSERY/LEVEL III
4-Newborn-Level IV	NURSERY/LEVEL IV
9 - Other	NURSERY/OTHER

18X Leave of Absence

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider. NOTE: Charges are billable for codes 2 - 5.

Subcategory	Standard Abbreviation
0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - Reserved	
2 - Patient Convenience charges billable	LOA/PT CONV CHGS BILLABLE
3 - Therapeutic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

20X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are to be identified.

0 - General Classification	INTENSIVE CARE or (ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU/PEDS
4 - Psychiatric	ICU/PSTAY
6 - Post ICU	POST ICU
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Intensive Care	ICU/OTHER

21X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

Subcategory	Standard Abbreviation
0 - General Classification	CORONARY CARE or (CCU)
1 - Myocardial Infarction	CORONARY CARE or (CCU)
2 - Pulmonary Care	CCU/PULMONARY
3 - Heart Transplant	CCU/TRANSPLANT
4 - Post-CCU	POST CCU
9 - Other Coronary Care	CCU/OTHER

ANCILLARY REVENUE CODES (25X - 99X)

25X Pharmacy

Code indicates charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist

Subcategory	Standard Abbreviations
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Nongeneric Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME

4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 - Experimental Drugs	DRUGS/EXPERIMT
7 – Nonprescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

26X IV Therapy

Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating of the per diem.

27X Medical/Surgical Supplies (Also see 62X, an extension of 27X)

Code indicates charges for supply items required for patient care.

BILLING PROCEDURES

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTROC LENS
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

28X Oncology

Code indicates charges for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

29X Durable Medical Equipment (DME) (Other Than Renal)

Code indicates charge for medical equipment that can withstand repeated use (excluding renal equipment).

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

31X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

33X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategory	Standard Abbreviation
0 - General Classification	RX X-RAY
1 - Chemotherapy - Injected	CHEMOTHER/INJ
2 - Chemotherapy - Oral	CHEMOTHER/ORAL

3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy - IV	CHEMOTHERP-IV
9 - Other	RX X-RAY/OTHER

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

35X Computed Tomographic (CT) Scan

Charges for CT scans of the head and other parts of the body.

36X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-other than kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

37X Anesthesia

Charges for anesthesia services in the hospital.

38X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED

2 - Whole Blood	BLOOD/WHOLE
3 - Plasma	BLOOD/PLASMA
4 - Platelets	BLOOD/PALTELETES
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives(Cryopricipitates)	BLOOD/DERIVATIVES
9 - Other Blood	BLOOD/OTHER

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration	BLOOD/ADMIN.
9 - Other Blood Storage & Processing	BLOOD/OTHER STOR

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviations
0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 - Other Respiratory Services	OTHER RESPIR SVS

42X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Subcategory	Standard Abbreviations
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

43X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic

interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	Standard Abbreviations
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviations
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

45X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Subcategory	Standard Abbreviations
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical Screening Services	*ER/EMTALA*
2 - ER Beyond EMTALA Screening	*ER/BEYOND EMTALA*
6 - Urgent Care	*URGENT CARE*

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 762, "Treatment or Observation Room."

Usage Notes

[a] General Classification code 450 should not be used in conjunction with any subcategory. The sum of codes 451 and 452 is equivalent to code 450.

[b] Stand alone usage of code 451 is acceptable when no services beyond an initial screening/assessment are rendered.

[c] Stand alone usage of code 452 is not acceptable.

46X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	Standard Abbreviations
0 - General Classification	PULMONARY FUNC
9 - Other Pulmonary Function	OTHER PULMON FUNC

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviations
0 - General Classification	AUDIOLOGY
1 - Diagnostic	AUDIOLOGY/DX
2 - Treatment	AUDIOLOGY/RX
9 - Other Audiology	OTHER AUDIOL

48X Cardiology

Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviations
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
3 - Echocardiology	ECHOCARDIOLOGY
9 - Other Cardiology	OTHER CARDIOL

49X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviations
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 760, "Treatment or Observation Room."

50X Outpatient Services

Not valid for this payer.

51X Clinic

Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

52X #Visits Free-Standing Clinic

This code indicates charges for an outpatient visit at a freestanding clinic. Generally this code is used to bill for services rendered by RHCs and FQHCs. RHCs and FQHCs report their visits using RC 0521, 0522, 0524, 0525, 0527 or 0528 in FL 42. Report the revenue code that most accurately reflects the service rendered. Outpatient mental health treatment subject to the limitation continues to be reported with RC 0900.

Subcategory

0 - General Classification

1 – Clinic visit by member to RHC/FQHC

2 – Home visit by RHC/FQHC practitioner

3 – Family practice clinic

4 – Visit by RHC/FQHC practitioner to a member in a covered part A stay at SNF

5 – Visit by RHC/FQHC practitioner to member in a SNF or NF or ICF MR or other residential facility

6 – Urgent care clinic

7 - Visit nurse service to a member's home in a home health shortage area

9 – Other freestanding clinic

55X Skilled Nursing Visits

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviations
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

56X Home Health - Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting their social problems, rendered on any basis.

Subcategory	Standard Abbreviations
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

57X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of a patient.

Subcategory	Standard Abbreviations
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

58X Other Visits (Home Health)

Code indicates charges by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified by their own revenue codes.

Subcategory	Standard Abbreviations
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

61X Magnetic Resonance Technology (MRT)
Code indicates charges for magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA).

Subcategory	Standard Abbreviations
0 - General Classification	MRI
1 – MRI – Brain/Brain Stem	
2 – MRI – Spinal cord/spine	
4 – MRI - Other	
5 – MRA – Head and neck	
6 – MRA – Lower extremities	
8 – MRA – Other	
9 – Other MRT	

62X # Days Medical/surgical Supplies Extension of 027X

This code category indicates charges for supply items required for patient care. This category is an extension of 027X and is used for reporting an additional breakdown of supply charges when needed.

Subcategory

1 – Supplies incident to radiology
2 – Supplies incident to other diagnostic services
3 – Surgical dressings
4 - FDA investigational devices

63X Pharmacy-Extension of 25X

This code indicates charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist. The category is an extension of 025X for reporting additional breakdown where needed.

Subcategory	Standard Abbreviations
0 - RESERVED (use 0250 for general classification)	
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythropoietin (EPO) less than 10,000 units	DRUG/EPO/<</ins> 10,000 units
5 - EPO 10,000 or more units	DRUG/EPO/>10,000 units
6 - Drugs Requiring Detailed Coding*	DRUGS/DETAIL CODE
7 - Self-administrable Drugs	DRUGS/SELFADMIN

NOTE: *Revenue code 636 relates to HCPCS code, so HCPCS is the recommended code to be used in FL 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).

064X # Units Home IV Therapy Services

This code indicates a charges for IV drug therapy services performed in the patient's residence

0 – General

1 – Nonroutine nursing, central line

2 – IV site care, central line (this revenue code is related to the HCPCS code)

3 – IV start/care, peripheral line

4 – Non-routine nursing, peripheral line

5 – Training patient/care giver, central line

6 – Training, disabled patient, central line

7 – Training, patient/caregiver, peripheral

8 – Training, disabled patient, peripheral

9 – Other IV therapy services

065X Hospice Services

Code indicates charges for hospice care services for a terminally ill patient if he/she elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	Standard Abbreviations
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care	HOSPICE/CTNS HOME
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Respite Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (non respite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYSICIAN
9 - Other Hospice	HOSPICE/OTHER

66X Respite Care (HHA only)

Charges for hours of care under the respite care benefit for service of a homemaker or home health aide, personal care services, and nursing care provided by a licensed professional nurse.

Subcategory	Standard Abbreviations
0 – General Classification	RESPITE CARE
1 - Hourly Charge/Skilled Nursing	RESPITE/SKILLED NURSE
2 - Hourly Charge/Home Health Aide/ Homemaker	RESPITE/HMEAID/HMEMKE
9 - Other Respite Care	RESPITE/CARE

68X Trauma Response

This code indicates charges for trauma team activation

Subcategory
0 – Not used
1 – Level I
2 – Level II
3 – Level III
4 – Level IV
9 – Other trauma response (may be used for states and local authorities with levels beyond IV)

69X Reserved

70X Cast Room

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service, if necessary.

Subcategory	Standard Abbreviations
0 - General Classification	CAST ROOM

71X Recovery Room

This code allows the room charge for patient recovery after surgery.

Subcategory	Standard Abbreviations
0 - General Classification	RECOVERY ROOM

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

Subcategory	Standard Abbreviations
0 - General Classification	DELIVROOM/LABOR
1 – Labor	LABOR
2 – Delivery	DELIVERY ROOM
3 – Circumcision	CIRCUMCISION
4 – Birthing Center	BIRTHING CENTER
9 – Other labor room/delivery	OTHER/DELIV-LABOR

73X Electrocardiogram (EKG/ECG)

Charges for operation of specialized equipment to record electromotive variations in heart muscle for diagnosis of heart ailments.

Subcategory	Standard Abbreviations
0 - General Classification	EKG/ECG
1 – Holter Monitor	
2 - Telemetry	
9 – Other EKG/ECG	

74X Electroencephalogram (EEG)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviations
0 - General Classification	EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	Standard Abbreviations
0 - General Classification	GASTR-INTS SVS

76X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 762 should be used for observation services.

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. The reason for observation must be stated in the orders for observation.

Subcategory	Standard Abbreviations
0 - General Classification	TREATMENT/OBSERVATION RM
1 - Treatment Room	TREATMENT RM
2 – Observation Room	OBSERVATION RM

77X Preventative Care Services

This code indicates charges for preventative care services established by payers, (e.g., vaccination).

Subcategory
0 – General
1 – Vaccine administration

79X Extra-Corporeal Shock Wave Therapy (formerly named Lithotripsy)

Charges for the use of extra-corporeal shock wave therapy (ESWT)

Subcategory
0 - General Classification

80X Inpatient Renal Dialysis (# Sessions)

A waste removal process, performed in an inpatient setting, uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviations
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

81X Acquisition of Body Components

The acquisition and storage of various organs, body tissue, bone marrow and other body components used for transplantation.

Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation.

Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory	*Standard Abbreviations*
0 - General Classification	*ORGAN ACQUISIT*
1 - Living Donor	*LIVING/DONOR*

2 – Cadaver Donor	*CADAVER/DONOR*
3 - Unknown Donor	*UNKNOWN/DONOR*
*4 -Unsuccessful Organ Search Donor Bank Charge**	*UNSUCCESSFUL SEARCH*
9 - Other Organ Acquisition	*ORGAN/DONOR*

*NOTE: *Revenue code 814 is used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation*

82X Hemodialysis - Outpatient or Home Dialysis

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

Subcategory	Standard Abbreviations
0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance/100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

83X Peritoneal Dialysis - Outpatient or Home

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory

0 - General Classification
1 – Peritoneal/composite or other rate
2 - Home Supplies
3 - Home Equipment
4 - Maintenance/100%
5 - Support Services
9 - Other outpatient peritoneal dialysis

84X Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting,

which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviations
0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance/100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 - Other CAPD Dialysis Outpatient	CAPD/HOME/OTHER

85X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home

A continuous cycling dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviations
0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance/100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 - Other CCPD Dialysis Outpatient	CCPD/HOME/OTHER

86X Magnetoencephalography (MEG)

Charges for operation of specialized medical equipment to measure the magnetic fields generated by brain activity.

Subcategory
0 – General Classification
1 – MEG

87X Reserved for Assignment by the NUBC

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviations
0 - General Classification	DIALY/MISC
1 - Ultrafiltration	DIALY/ULTRAFILT
2 - Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
9 - Other Miscellaneous Dialysis	DIALY/MISC/OTHER

89X Reserved for National Assignment

90X Behavioral Health Treatments/Services
Indicates charges for prevention, intervention, and treatment services in the areas of mental health, substance abuse, developmental disabilities, and sexuality. Behavioral health services are individualized, holistic, and culturally component. They may include on-going care, support, and nontraditional services.

Subcategory	Standard Abbreviations
0 - General Classification	PSTAY TREATMENT
1 - Electroshock Treatment	ELECTRO SHOCK
2 - Milieu Therapy	MILIEU THERAPY
3 - Play Therapy	PLAY THERAPY
4 - Activity Therapy	ACTIVITY THERAPY
5 – Intensive outpatient service-psychiatric	
6 – Intensive outpatient – chemical dependency	
7 – Community behavioral health program	

91X Behavioral Health Treatments/Service-Extension of 090X
Code indicates charges for prevention, intervention, and treatment services in the areas of mental health, substance abuse, developmental disabilities, and sexuality. Behavioral health services are individualized, holistic, and culturally component. They may include on-going care, support, and nontraditional services.

Rationale: This breakdown provides additional identification of services as necessary.

Subcategory	Standard Abbreviations
0 - General Classification	PSYCH/SERVICES
1 - Rehabilitation	PSYCH/REHAB
2 - Partial Hospitalization* - Less Intensive	PSYCH/PARTIAL HOSP
3 - Partial Hospitalization* - Intensive	PSYCH/PARTIAL INTENSIVE
4 - Individual Therapy	PSYCH/INDIV RX
5 - Group Therapy	PSYCH/GROUP RX
6 - Family Therapy	PSYCH/FAMILY RX
7 - Bio Feedback	PSYCH/BIOFEED
8 - Testing	PSYCH/TESTING
9 - Other	PSYCH/OTHER

NOTE: *Medicare does not recognize codes 912 and 913 services under its partial hospitalization program.

92X Other Diagnostic Services

Code indicates charges for various diagnostic services specific to common screenings for disease, illness, or medical condition.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy test	ALLERGY TEST
5 - Pregnancy test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

93X Medical Rehabilitation Day Program

Medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy and speech therapy.

The subcategories of 93X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported for in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable therapy revenue codes as normal.

Subcategory	Standard Abbreviations
1 - Half Day	HALF DAY
2 - Full Day	FULL DAY

94X Other Therapeutic Services (Also see 95X an extension of 94X.)

Code indicates charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
6 - Complex Medical	RTN COMPLX MED

Equipment Routine	EQUIP-ROUT
7 - Complex Medical Equipment Ancillary	COMPLX MED EQUIP-*ANC*
8 - Pulmonary Rehabilitation	
9 - Other Therapeutic Services	ADDITIONAL RX SVS

95X Other Therapeutic Services-Extension of 94X

Charges for other therapeutic services not otherwise categorized. Check plan benefits to determine coverage.

Subcategory	*Standard Abbreviations*
0 - Reserved	
1 - Athletic Training	*ATHLETIC TRAINING*
2 - Kinesiotherapy	*KINESIOTHERAPY*

96X Professional Fees – Medical Professional must bill on a CMS 1500.

97X Professional Fees (extension of 096X) – must bill on a CMS 1500.

98X Professional Fees - Extension of 96X & 97X – must bill on a CMS 1500.

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviations
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

100X Behavioral Health Accommodations

This code indicates routine charges incurred for accommodations at specified behavioral health facilities

0 – General

1 - Residential-psychiatric

2 – Residential-chemical dependency

3 - Supervised living

4 – Halfway house

5 – Group Home

210X Alternative Therapy Services

Indicates charges for therapies not elsewhere classified under other therapeutic service revenue codes.

0 – General

1 – Acupuncture

2 – Acupressure

3 – Massage

4 – Reflexology

5 – Biofeedback

6 – Hypnosis

9 – Other alternative therapy service

310X Adult Care

Code represents charges for personal, medical, psychosocial, and/or therapeutic services in a special community setting for adults needing supervision or assistance with activities of daily living (ADL)

1 – Adult day care, social – hourly

2 – Adult day care, social – hourly

3 – Adult day care, medical and social – daily

4 – Adult day care, social – daily

5 – Adult foster care – daily

9 – Other adult care

FL 43. Revenue Description
Not Required. Enter 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 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS/Rates (FL 44) or as described in Remarks, FL *).

FL 44. HCPCS/Rates
Required. Code the HCPCS code applicable to ancillary services for outpatient claims, the HIPPS rate code (consisting of the RUG-IV code obtained from the MDS grouper, and a two-digit modifier indicating the assessment type attributable to the RUG-IV code for SNFs, and the HHRGs for home health), or the daily accommodation rate for inpatient bills (can be determined by dividing the total charge by the number of days.

FL 45. Service Date – Required on all outpatient claims.

FL 46. Units of Service
Required. Enter the number of digits or units of service on the line adjacent to revenue code and description where appropriate, e.g., number of covered days in a particular type of accommodation, pints of blood.

The following revenue codes (FL 42) require the number of covered days, visits, treatment, tests, or units based on CPT/HCPCS code definition, etc., to be reported:

Accommodation (days): 010X-015X, 020X-021X
Blood (pints): 038X
Clinic: 051X, 052X (HCPCS code definition for visit or procedure)
Dialysis treatments (sessions or days): 080X
DME (rental months): 029X
Emergency room - 0450, 0452, and 0459 (HCPCS code definition for visit or procedure)
Drugs and biologicals (including hemophilia clotting factors): 0636
Orthotic/prosthetic devices (items): 0274
Outpatient clinical diagnostic laboratory (tests): 030X-031X
Outpatient therapy: 0410, 0420, 0430, 0440, 0480, 090X, 091X, and 0943 (the number of times the procedure/service being reported was performed)
Oxygen (rental months, feet, or pounds): 060X
Radiology (HCPCS code definition of tests or services): 032X, 0333, 034X, 035X, 040X, 061X

Enter up to seven numeric digits. Show charges for noncovered services as noncovered

FL 47. Total Charges – Not Applicable for Electronic Billers

Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of *revenue codes requiring HCPCS procedure codes, enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 is* "0001" which represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to 9 **numeric** digits (0000000.00).

FL 48. Non-Covered Charges
Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49. (Untitled) – Reserved for Assignment by NUBC

FL 50A, B, and C. Payer Name
Required. Enter the primary payer on line A. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If payer is the secondary or tertiary payer, identify the primary payer on line A and enter payer information on line B or C as appropriate. (See §§262, 263, 264, and 289 to determine when Medicare is not the primary payer.)

FL 51A (Required), B (Situational), and C.(Situational) Health Plan ID
Required. Report the HIPAA national plan identifier when it is mandated for use. Until that point, report the legacy or proprietary number as defined in trading partner agreements.

FLs 52A, B, and C. Release of Information Certification Indicator
Required. A "Y" code indicates you have on file a signed statement permitting you 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 Condition or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersedes the HIPAA Privacy Rule by requiring a signature be collected.

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

FL 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments – Not required.

FL 55A, B, and C. Estimated Amount Due From Patient
Not Required.

FL 56. National Provider ID (NPI)

Required

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

Situational. Use this field to report an identification number other than the NPI as necessary for the receiver to identify the provider.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B or C) that corresponds to the line on which payer information is shown in FLs 50-54, enter the patient's name as shown on his/her ID card. All additional entries across line A (FLs 59-65) pertain to the person named in Item 58A. The instructions which follow explain when to complete these items.

Enter the name of the individual in whose name the insurance is carried under if there are payer(s) of higher priority.

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, enter the code indicating the relationship of the patient to the identified insured, if this information is readily available. Effective October 16, 2003.

Code	Title	Definition
01	Spouse	Self-explanatory
18	Self	Self-explanatory
19	Child	Self-explanatory
20	Employee	Self-explanatory
21	Unknown	Patient's relationship to the insured is unknown
39	Organ Donor	
40	Cadaver Donor	Use this code where the bill is submitted for procedures performed on a cadaver donor where they are paid by the receiving patient's insurance coverage.
53	Life Partner	.
G8	Other Relationship	

FLs 60A, B, C. Insured Unique ID (Certificate/Social Security Number/HI Claim/Identification Number(HICN) Required. On the same lettered line (A, B, or C) that corresponds to the line on which payer information is shown in FLs 50-54, enter the patient's ID#. Show the number as it appears on the patient's insurance card.

FL 61A, B, C. Insurance Group Name – Required. Enter group name if applicable.

FL 62A, B, C. Insurance Group Number – Situational (required if known). Enter group # if applicable.

FL 63. Treatment Authorization Code – 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.

FL 64. Document Control Number (DCN)

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

FL 65. Employer Name – Required. Enter name of the employer that provides (or may provide) health care coverage for the insured individual identified in FL 58 on lines A, B, and C.

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

Required. The qualifier that denotes the version of International Classification of Diseases (CD) 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 principal diagnosis is the condition established after study to be chiefly responsible for this admission.

Please be advised that effective on and after 10/1/15 all claims with dates of service on or after 10/1/15 must be submitted with an ICD-10 code and will be rejected if a ICD-9 code is submitted. A referral that is approved with a ICD-9 code prior to 10/1/15 and the service was provided on 10/1/15 and after, the claim must be coded with an ICD-10.

Inpatient- Required. Enter the ICD-10-CM code for the principal diagnosis. The code must be the full ICD-10-CM diagnosis code.

POA – Present on Admission indicator applies to diagnosis codes for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis code. (Situational) Report only once per diagnosis.

N Indicating no

Y Indicating yes

U Indicating unknown (per the NUBC: No information in the record)

W Indicating not Applicable (per the NUBC: clinically undetermined)

When the code is exempt from POA reporting, leave this field blank.

Outpatient-Required. Report the full ICD-10-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. Report the diagnosis to your highest degree of certainty.

FLs 67 A – 67Q. Other Diagnoses Codes
Inpatient--Required. Enter the full ICD-10-CM codes for up to seventeen additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

Outpatient--Required. Enter the full ICD-10-CM codes in FLs 67A -67Q for up to seventeen other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

**More than 8 and up to 99 can be submitted in an electronic claim.

**Present on Admission Indicator (gray shaded) with fields 67, 67A-Q. for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding diagnosis code.

Value	Definition	Coding Guidelines Explanation
Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	No information in the record	Documentation is insufficient to determine if condition is present on admission
W	Clinically undetermined	Provider is unable to clinically determine whether condition was present on admission or not
[blank]	Unreported/not used	Exempt from POA reporting

FL 68. Reserved for assignment by NUBC

FL 69. Admitting Diagnosis

Required. For inpatient hospital claims and Medicare Part B only claims (TOBs 012X and 022X in FL4), the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. Required on all inpatient claims except for 028X, 065X, 066X, and 086X.

FL. 70A -C – Patient's Reason for Visit

Situational. Patient's Reason for Visit is required for all unscheduled outpatient visits for outpatient bills.

FL 71 – Prospective Payment System (PPS) Code – Inpatient Only – Report the PPS code assigned to the claim to identify the MS-DRG based on the grouper software as named in the contract with the primary payer.

FL 72 – External Cause of Injury (ECI) Codes – enter up to three full ICD-10 codes

FL 73 – Reserved for assignment by NUBC

FL 74 – Principal Procedure Code and Date

Situational. Required on inpatient claims when the principal procedures must be reported.

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 for assignment by NUBC.

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

Situational. Required when claim/encounter contains any services other than nonscheduled transportation services. 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 Identifier (including NPI). Provides 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

FL 78-79 - Other Provider Names and Identifiers. Provides the name and identification number of the provider that corresponds to the indicated provider type on this claim.

Secondary Identifier Qualifiers:

0B – State License Number

1G – Provider UPIN Number

G2 – Provider Commercial Number

LU – Location number

FL 80 – Remarks This field is used to capture additional information necessary to adjudicate the claim in the judgment of the provider.

FL 81a-81d Code-Code Used to report overflow or additional codes related to field locators or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

REQUIRED DATA FOR 837 INCOMING PROFESSIONAL CLAIMS/ENCOUNTERS SUBMISSION:

Please ensure the following technical requirements are met before submitting your EDI test files.

Tab	Loop	Pos	Seg	Field	Description	Required Data:
2	2010AA	015	NM1	NM1 08	Identification Code Qualifier	"XX"
2	2010AA	015	NM1	NM1 09	Identification Code	NPI of Billing Provider
2	2010AA	035	REF	REF 01	Reference Identification Qualifier	"EI" required if NPI submitted (1)
2	2010AA	035	REF	REF 02	Reference Identification	Tax ID
2	2010AA	035	REF	REF 01	Reference Identification Qualifier	"0B" if state license known
2	2010AA	035	REF	REF 02	Reference Identification	State license
2	2010BA 2010CA	015	NM1	NM1 08	Identification Code Qualifier	MI
2	2010BA 2010CA	015	NM1	NM1 09	Identification Code	HMO Member # for insured/patient
2	2300	180	REF	REF 01	Reference ID Qualifier	"9F" if claim involved a referral/authorization
2	2300	180	REF	REF 02	Reference Identification	Assigned Referral Number if claim involved a referral/authorization
2	2300	195	CR1	CR1 03 to CR1 06	Ambulance Transport Information	Required if claim involved ambulance transport
2	2310A	015	NM1	NM1 08	Identification Code Qualifier	"XX"
2	2310A	015	NM1	NM1 09	Identification Code	NPI of Referring Provider (2)
2	2310A	035	REF	REF 01	Reference ID Qualifier	"EI" requested
2	2310A	035	REF	REF 02	Reference Identification	Tax ID
2	2310B	015	NM1	NM1 08	Identification Code Qualifier	"XX"

2	2310B	015	NM 1	NM1 09	Identification Code	NPI of Rendering Provider (3)
2	2310B	035	REF	REF 01	Reference ID Qualifier	EI" required if NPI submitted (4)
2	2310B	035	REF	REF 02	Reference Identification	Tax ID
2	2310B	035	REF	REF 01	Reference ID Qualifier	"0B" if state license known
2	2310B	035	REF	REF 02	Reference Identification	State license
2	2310D	015	NM 1	NM1 08	Identification Code Qualifier	"XX"
2	2310D	015	NM 1	NM1 09	Identification Code	NPI of Facility
2	2310A	035	REF	REF 02	Reference Identification	Tax ID

(1) Tax ID is required on 2010A Billing Provider if an NPI is submitted as the primary identifier. Claims submitted without a Tax ID for the Billing Provider are non-HIPAA compliant and will be rejected.

(2) Use the Referring Provider's individual's NPI, not a group NPI.

(3) Only one Rendering Provider/NPI will be accepted per Claim, do not override on the line level.

(4) Tax ID is required on 2310B if Rendering Provider is an employee of the submitting Medical Group

Required Data for 837 Incoming Institutional Claims/Encounters Submission:

Please ensure the following technical requirements are met before submitting your EDI test files.

Table	Loop	Pos	Seg	Field	Description	Required Data:
2	2010AA	015	NM1	NM108	Identification Code Qualifier	XX
2	2010AA	015	NM1	NM109	Identification Code	NPI of Billing Provider
2	2010AA	035	REF	REF01	Reference Identification Qualifier	EI required if NPI submitted (1)
2	2010AA	035	REF	REF02	Reference Identification	Tax ID
2	2010BA / 2010CA	015	NM1	NM108	Identification Code Qualifier	MI
2	2010BA / 2010CA	015	NM1	NM109	Identification Code	HMO Member # for insured/patient
2	2300	180	REF	REF01	Reference Identification Qualifier	9F if claim involved a referral/authorization
2	2300	180	REF	REF02	Reference Identification	Assigned Referral Number

						if claim involved a referral/authorization
2	2310D	015	NM1	NM108	Identification Code Qualifier	XX
2	2310D	015	NM1	NM109	Identification Code	NPI of Referring Physician (2)
2	2310D	035	REF	REF01	Reference Identification Qualifier	0B state license if known
2	2310D	035	REF	REF02	Reference Identification	State license
2	2310E	015	NM1	NM108	Identification Code Qualifier	XX
2	2310E	015	NM1	NM109	Identification Code	NPI of service facility (3)
2	2310E	035	REF	REF02	Reference Identification	Tax ID

(1) Tax ID is required on 2010A Billing Provider if an NPI is submitted as the primary identifier. Claims submitted without a Tax ID for the Billing Provider are non-HIPAA compliant and will be rejected.

(2) Use the Referring Provider's individual's NPI, not a group NPI.

(3) NPI and Tax ID of Service Facility is required

REPORTS & RECONCILIATION FOR EXTERNAL EDI SUBMITTERS

External submitters (Trading Partners) send encrypted EDI files to a folder on our FTP server. Each Trading Partner has a dedicated folder with a unique user ID and password and the FTP folder is further protected by defining the only IP addresses it will accept files from, even if the user ID and password are correct.

The files will remain in the FTP folder until a regularly scheduled job searches the folders for specific file names, downloads the files, and decrypts them.

A job to log, load and process the files runs every hour, and the following reports are created, encrypted and uploaded to the appropriate FTP folder at 7:00 p.m. each evening.

1. A **TA1 response file** denoting *receipt* of the file is created during the initial logging of the file, but only if the Trading Partner has requested one. This is entirely dependent on the Trading Partners decision.
2. A **997 response file** denoting *acceptance or rejection* of the file is created during the initial logging of the file, but only if the Trading Partner desires one. By default, all Trading Partners are setup to create the 997 response file but the trading partner can set a switch in the EDI file to turn off creation of the 997 response file. This is entirely dependent on the Trading Partners decision.
3. An **AB1455 Report file** is created at the end of the Log, Load & Process Job. It acknowledges *receipt* of each individual claim on the EDI file. California State Law requires it sent to Trading Partners within two working days, but our process has it created immediately after the files are processed.
4. **Error Reports:**
    a. After the claims are processed, edit errors are worked by the claims staff and claims that cannot be accepted into our system are rejected. The Trading Partner is notified with an **835 remittance** response with rejected claims.
    b. After all edit errors have been worked, the file is closed. An **EDTS edit report** listing claims that failed edits, with specifics is created.
5. **835 Remittance Response Files** are created after the claims go through the adjudication process in the Claims System. When claims are finalized, the response file is created and the results of the adjudication of each claim is sent to the Trading Partner.

In all, six separate reports are available to allow Trading Partners who submit electronically to not only confirm receipt of the file, but to confirm the rejection, acceptance, processing and adjudication of each individual claim. Reports 1 & 2 are optional, at the discretion of the Trading Partner; reports 3, 4a, 4b & 5 are generated for Trading Partners who submit electronically, without exception.

The files will be encrypted with your PGP public-key and placed in the Sharp FTP folder at 7:00 p.m. each evening. They will be available to you at that time. Samples of each report follow.

ZZZZ181.997
- 997 Response file confirming receipt and acceptance/rejection of 837 files.

```
ISA*00*          *00*          *ZZ*SHARP-66       *ZZ*953967887      *071010*09?
GS*HC*953967887*SRS66*20071010*0913*9261*X*004010X098A1~
ST*997*9264~
AK1*HC*123~
```

AK2*837*0001~
AK5*A~
AK9*A*1*1*1~
AK1*HC*124~
AK2*837*0002~
AK5*A~
AK9*A*1*1*1~
SE*10*9264~
GE*1*9261~
IEA*1*000008537~
[End of file]

ZZZZ71762.TA1
- TA1 Response file confirming receipt and acceptance/rejection of 837 files.

TA1*000000001*071031*0852*A*000~

ZZZZ_1057SHP_71235.835
- 835 Remittance Response file (EOB)

ISA*00* *00* *ZZ*SHARP-66 *ZZ*953967887 *071025*10?
GS*HC*SHP66*953967887*20071025*1005*14237*X*004010X098A1~
ST*835*26194~
BPR*I*142.51*C*CHK**********20071024~
TRN*1*682795*1770519730~
REF*EV*476~
DTM*405*20071025~
N1*PR*SHARP HEALTH PLAN HMO~
N3*4305 UNIVERSITY AVE., SUITE 200~
N4*SAN DIEGO*CA*92105~
N1*PE*ANALYTIC PATHOLOGY MEDICAL GROUP*FI*1865431033~
N3*RAND MEDICAL BILLING*PO BOX 10076~
N4*VAN NUYS*CA*914100076~
LX*1~
CLP*1580811058*1*225*104.14*0*HM*6630468***E~
NM1*QC*1*BRANDYWINE*LINDA****MI*90428151W 01~
DTM*050*20070910~
SVC*HC:88189*225*104.14**1~
DTM*472*20070815~
CAS*CO*A2*120.86~
REF*LU*1~

ZZZZ_AB1455_ZZZZ_SHARP_00015_071019.TXT
- List of all claims received on an 837 file.

Printed: 10/22/2007 Sharp AB1455 Response Report Page 1
Trading Partner: ZZZZ MCA 837I PROF ZZZZ
For EDI Run: 206622

This is a response report meeting the requirements of California AB1455. It is not meant for any purpose other than confirming receipt of medical claims on an electronic file. Do not use this information to resubmit any claims on this file.

This form acknowledges electronic claims within two working days of their receipt by Sharp HealthCare. This acknowledgement only serves to notify you that the claims were received. It does not guarantee claim payment. For questions regarding this receipt please call Sharp HealthCare. All clean claims for Sharp HealthCare members will be processed within 45 working days (60 calendar days) of receipt for commercial members. Senior claims will be processed within 60 calendar days for contracted providers and 30 calendar days for non contracted providers. For all acknowledged claims, please allow 60 calendar days for processing before inquiring about claim status.

Received Claims:

Member Name	Claim #	Account#	Service Dt	Billed Amt	Received Dt
Referring Physician					
WALTERS MARLENE	2839628	80162342	05/29/2007	40.00	10/22/2007
ARMAND WHITNEY					

ZZZZ_EDTS_ZZZZ_SHARP_00015_071019.TXT
- List of all rejected claims on an 837 file.

Printed: 10/24/2007 837I Provider Edit Report Page 1
Trading Partner: ZZZZ MCA 837I PROF RAND
For EDI Run: 206623

Total Claims Received For EDI Run: 114

Member Name	DOB	Sex	Account#	Member#	CPT	MOD	Charge $	Service Dt
Referring Physician								
Field Rejected: REG_B_PAT.DOB								
Rejection Reason: Missing/incomplete/invalid patient birth date								
LARCH ALDO	20080425	F	6160496952	040011086	88305	26	150	20070922
MICHELLE BUICK					88311	26		

[End of file]

ICD-10-CM DIAGNOSTIC CODES

The *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)*. This coding system can be used for any setting in which medical services are rendered. The use of diagnostic coding is required for all Medicare claims submitted by physicians. The *ICD-10-CM* books are updated each year, effective October 1, with a grace period until January 1. Changes to the codes must be made by this date, or the service will be rejected.

The official ICD-10-CM can be found at:
https://www.cdc.gov/nchs/icd/icd10cm.htm

ICD-10-CM coding books are available at other publishing companies and technical bookstores.

CODING REQUIREMENTS

The physician can assist the staff by documenting diagnosis and symptoms in more detail. It is most important for providers to use the most recent version of the ICD-10-CM coding book and to code to the highest level of specificity. Furthermore, make sure that the diagnosis on the claim that which was valid at the time the procedure was performed. Code to the highest degree of specificity and code consistent with the age and sex of the beneficiary. You can reference more than one diagnosis indicator per line of service (see item 24E).

CPT PROCEDURE CODE DEFINITION

The format of the CPT manual includes descriptions of procedures which are not listed in their entirety for all procedures. The partial description is indented under the main entry and constitutes what is always followed by a semicolon on the main entry. The main entry then encompasses the portion of the description preceding the semicolon, which applies to and is a part of all indented entries which follow with their codes.

Example:

70120 Radiologic examination, mastoids; **less than three views per side**
70130 Complete, minimum of three views per side

The common portion of the description is "radiologic examination, mastoids." This description is considered part of both codes. The distinguishing part of each of these codes is that which follows the semicolon.

In addition, a code description may define a correct coding relationship where one code is a part of another based on the language used in the descriptor. Some examples of this type of correct coding by code definition are:

1. ***"Partial" and "complete" CPT codes are billed***. The partial procedure is bundled into the ***complete*** procedure.
2. "***Partial" and "total" CPT codes are billed.*** The partial procedure is bundled into the ***total*** procedure.
3. "***Unilateral" and "bilateral" CPT codes are billed***. The unilateral procedure is bundled into the bilateral ***billed***. The single procedure is bundled into the ***multiple*** procedures.

CODING SERVICES SUPPLEMENTAL TO A PRINCIPAL PROCEDURE (ADD-ON CODES)

The CPT coding system identifies certain codes, which are to be submitted in addition to other codes. Generally, these are identified with the statement "***list separately in addition to code for primary procedure***." The basis for these CPT codes is to enable providers to separately identify a service that is performed in certain situations as an additional service.

Incidental services that are necessary to accomplish the primary procedure (e.g. lysis of adhesions in the course of an open cholecystectomy) are not separately billed.

Supplemental codes frequently specify codes or ranges of codes with which they are to be used. It would be inappropriate to use these codes other than those specified. When CPT codes are not identified as supplemental codes, they are not to be billed. Those supplemental codes that are part of a more comprehensive procedure but do not described a separately identifiable service are not appropriate.

CLAIMS EDITING SYSTEM

The clinical editing system in use is based on multiple coding support including:

- CPT-4, HCPCS, and ICD-10-CM
- CCI
- AMA and CMS guidelines and industry standards
- Medical policy and literature research
- Input from academic affiliations
- Specialty society recommendations

Every decision is fully supported with a variety of clinical documentation to ensure complete understanding of the system and communication to the provider community. The edits are based on the information provided on the claim. If the claim information is incomplete or invalid, the claim edits will be accurate but may not be the outcome the provider expected.

Most edits are reviewed by coding staff before claims are processed. Please make sure additional documentation to justify coding is included on the claim, such as modifiers and information in box 19 of the CMS 1500 or box 84 of the UB04. Any clinical or operative reports should be attached to validate procedures billed with modifier 59, emergency services and unlisted procedures. The additional information will provide the claims examiner with the necessary information to process the claim correctly.

GLOBAL SURGICAL PACKAGE

The CPT codes that represent a readily identifiable surgical procedure include, on a procedure by procedure basis, a variety of services. In defining the specific services included in a given CPT surgical code, the following services are always included in addition to the operation per se:

- local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
- immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- writing orders
- evaluating the patient in the post anesthesia recovery area;
- typical postoperative care.

Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service.

MODIFIERS AND PAYMENT RULES

SPLIT GLOBAL, PROFESSIONAL (26) & TECHNICAL COMPONENT (TC)

Only certain services include a technical and professional component. Many Fee Schedules includes separate allowances for these services.
Certain procedures are a combination of a physician component (professional) and a technical component.
When the physician component is reported separately, the service may be identified by adding modifier "26" to the usual procedure number.

Note: Modifier-26 should not be used if there is a specific code, which already describes only the physician component of a given service. For example, it would be inappropriate to use modifier -26 in conjunction with procedure code 93010 (electrocardiogram, routine ECG with at least 12 leads; **interpretation and report only**) because it is 100% professional.

Under certain circumstances, a charge may be made for the technical components alone. Adding modifier "TC" to the usual procedure number identifies the technical component charge.

Modifier-TC should not be used if there is a specific code, which describes a procedure that is 100% technical (having no professional component).

Note: It would be inappropriate to use modifier -TC in conjunction with procedure code 93005 (electrocardiogram, routine ECG with at least 12 leads; **tracing only without interpretation and report**) because it is 100% technical.

MODIFIER 22 – Unusual Procedural Services

When the service provided is greater than that which usually required for the listed procedure, it may be identified by adding a modifier 22. Include a report with the claim and document the amount of addition time or circumstances that justify the use of modifier 22.

MODIFIER 25: Significant, Separately Identifiable Evaluation Management (E & M) Service by the Same Physician on the Same Day of the Procedure or Other Service

A provider may need to indicate that on the day a procedure or service was performed the patient's condition required a significant, separately identifiable E & M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E & M service may be prompted by the symptom or condition for which the procedure and/ or service was provided. As such, different diagnoses are not required for reporting of the E & M services on the same day. (This modifier is not used to report an E&M service that resulted in a decision to perform major surgery). The patient's records must contain information to support the use of modifier 25.

A 50% reduction in reimbursement will apply for an E/M service (99201-99205 or 99212-99215 with modifier 25) if billed for the same person on the same date of service as a Preventative Medicine Service. Reason: some elements of the practice expense for a preventative visit service is duplicated in the reimbursement for the E/M code.

Visits by the same physician on the same day as a surgical procedure with 000 or 010 days postoperative or endoscopy procedures that are related to the standard preoperative evaluation or recovery from the procedure are included in the global reimbursement for the procedure. However, if a significant separately identifiable service is performed and is clearly documented in the patient's records, payment can be made for the visit when billed with modifier 25.

The documentation for the E/M must include important, weighty, notable, distinct correlation, with signs and symptoms to make a diagnostic classification or demonstrate a distinct problem.

The E & M service should be able to stand alone for the new problem found and treated on the same day that a minor surgery or procedure with a global period of zero to ten days. Remember, documenting an evaluation of a problem that does not include documentation that supports what was done about the problem, or the management portion of the service, will be considered incomplete and will be denied.

Bill the surgical procedure code(s) above the E&M code with modifier -25 for adjudication accuracy.

In order to pay claims timely and accurately supporting documentation must be attached to all claims billed with a modifier 25. For further detail and claim examples of appropriate and inappropriate use of modifier 25 use please refer to : https://med.noridianmedicare.com/web/jeb/topics/modifiers/25

Correct Claim Example

- A patient was in a motor vehicle accident and was seen to close a wound (CPT 12032)
- Physician checked for any neurological injury (CPT 99213)
- CPT 12032 has a 10-day global period, modifier 25 is appended to CPT 99213
- Per NCCI edits, CPT 12032 and 99213 is listed with an indicator 1 with rationale edit saying CPT manual or CMS manual coding instructions

Documentation in the patient's medical record must support the use of this modifier. Supporting documentation is not required with the submitted claim.

Date of Service	Treatment	CPT/Modifier
05/02/17	Layer closure of wound of scalp	12032
05/02/17	E/M visit to verify neurological injury	99213-25

MODIFIER 50: Bilateral Procedure

Procedures performed on both sides of the body or body area during the same operative session and on the same day are called bilateral procedures. Procedures which are usually performed as bilateral procedures or the code descriptor specifically states that the procedure is bilateral, should not be reported with bilateral modifiers. Use of modifier 50 indicates that a procedure is bilateral, indicating that the procedure is performed twice during the same operative session. When billing for bilateral services the quantity in the units field should always be one. Bilateral procedures are reimbursed at 150% of the contracted allowable.

MODIFIER 51: Multiple Procedures

When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s). The payment for procedures billed with a modifier 51 will be reduced to 50% of the contracted allowable.

MODIFIER 52: Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52 signifying that the service is reduced. Procedures with modifier 52 appended will be reduced 50% of the allowable amount. Note: For hospital outpatient reporting of previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifier'73' and '74'.

MODIFIER 53: Discontinued Procedure

Under certain circumstances such as a serious risk to the patient's well-being, a surgical or diagnostic procedure is terminated at the physician or other health care professional's direction. Under these circumstances the procedure provided should be identified by its usual procedure code and the addition of modifier 53 (discontinued procedure) signifying that the procedure was started but discontinued. This provides a means of reporting the discontinued procedure leaving the identification of the basic service intact. Modifier 53 should be used with surgical codes or medical diagnostic codes, and not with the following: evaluation and management services, elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite, or when a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure. Allowance will be 25% of the allowable amount for the primary unmodified procedure. Multiple procedure reductions will still apply.

MODIFIER 59: Distinct Procedural Service

Under certain circumstances, the provider may need to indicate that a procedure or service was distinct or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encounters or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Document in Box 19 of the CMS 1500 the explanation for the use of modifier 59 or Box 84 of the UB92. Include medical records such as operative reports if the documentation can support the use of modifier 59.

MODIFIER 80: Assistant Surgeon

Surgical assistant services are identified by adding the modifier 80 to the procedure. Procedures with a modifer 80 appended will be paid at 16% of the allowable amount.

MODIFIER 81: Assistant Surgeon

Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. Procedures with a modifier 81 appended will be paid at 10% of the allowed amount.

ELIGIBILITY RELATED CALIFORNIA HEALTH AND SAFETY CODE 1371.8

In order for your claim to be valid for payment under California Health and Safety code § 1371.8, member eligibility and authorization must be confirmed or obtained no more than 2 business days prior to the date the authorized service is to be provided. The provider must retain proof of such authorization in order to qualify for payment should it later be determined that the member was not enrolled or eligibility for payment for the authorized service on the date the service was provider.

BALANCE BILLING

Balance billing members is prohibited by the Department of Managed Health Care (DMHC) for both contracted and non contracted providers. All contracted providers have language in their contracts that prohibits balance billing of members. Providers must complete a provider dispute resolution form (PDR) and explain the reason why the provider believes additional payment is due. Providers who balance bill members may have their practices considered an unfair billing pattern subject to fines by the DMHC.

DUPLICATE BILLING

Approximately, 5 percent of all claims filed are denied as duplicate claims. This is an unnecessary waste of funds and is a problem area targeted for reduction.

Whenever possible, Sharp Healthcare will work with providers to eliminate the submission of duplicate claims. Providers submitting the greatest percentage of duplicate claims will be identified and contacted to learn about various alternatives to duplicate filing.

There are several reasons you may receive a denial as a duplicate of a claim either already in process, or previously paid.

••Claims denied as not reasonable or medically indicated **cannot be resubmitted** with a corrected or changed diagnosis code. Any corrections must be submitted in writing to the Provider Dispute Resolution Department.

•••Automated “re-billing” systems that are set to re-bill every 30 or 45 days account for a large number of these problems. Often we receive the same claim several times before someone checks to see what the problem is. Many times the payment from the original claim has gone to the deductible, or the service was denied for medical necessity, eligibility, or other reason. Make sure if you are using an automated system that it accurately posts these types of settlements and provides you with the necessary reports or mechanisms to pursue other avenues of appeal or collection.

••If a procedure is performed more than once on a given day, utilize ICD-9-CM codes, modifiers, and documentation to identify different sites, sessions or specimens.

Use the Sharp IDX Outreach product to determine if the claim has been received and payment has been made or the claim settled in some way, before sending in a duplicate.

TRACER CLAIMS

Sharp does not recommend submitting claims stamped ,"Tracer". Since claims must be acknowledged within 2 or 15 working days depending on type of submission, there is no reason to continue this process.

MULTIPLE PAGE CLAIMS

Sometimes more than one claim form is required for one patient. When this occurs do not total each claim, total the last page of the CMS 1500 or UB04. Attach multiple pages together so they can be processed as one claim.

PROOF OF TIMELY FILING TIPS

Claims must be submitted within the time period specified in AB1455 or your contract. The timeframe can not be less than 90 days. If you believe a claim was filed within the contracted period you can attach evidence to the provider dispute unit. The following table will assist you with acceptable forms of proof.

Forms of Acceptable Proof:	Items to Verify Acceptable Proof:
ELECTRONIC	
Edit report of acceptance by Sharp	-Proof must be a copy of the edit report -Submission dates must be included and fall within the filing limits from the date of service (DOS)
For EDI claims that could not be processed by Sharp	Sharp letter must indicate that the original submission fell within the filing limits
PAPER CLAIMS	
Dated Request for Additional Information form from Sharp	Ensure dates are within the filing limitations from DOS to Sharp letter date Confirm that the response to Sharp' request also falls within the filing limits
Claim Denial letter or EOB from Sharp	Verify member information and dates of service Ensure EOB/Denial Letter date is within the filing limit
Denial letter from other insurance carrier, dates and printed on letterhead	Letter must have valid letterhead Letter must be dated Claim to Sharp must be made within the filing limits, starting from the date of the letter
Dated EOB from other insurance carrier	EOB must have date within the filing limits Claim to Sharp must be made within the filing limits, starting from the date of the EOB
Proof of member billing	Must include complete billing history Follow-up attempts must be made within the timely filing limits
15 Day Acknowledgement Letter	Provide the acknowledgement notice as proof of time submission

AB1455 TIME LIMITS AND MEASUREMENTS

ITEM	DESCRIPTION
AUTOMATIC PAYMENT OF INTEREST	Interest is due within 5 working days of the payment of the claim without the need for any reminder or request by the provider.
INTEREST LESS THAN $2.00	In the event that the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, the interest for that claim may be paid, along with interest on other such claims, within 10 calendar days of the close of the calendar month in which the claim was paid.
INPATIENT SERVICE CLAIMS	A payer shall accept separately billable claims for inpatient services on at least a bi-weekly basis. (Cannot require the facility to wait until discharge to submit the full claim.)
CLAIM FILING DEADLINE	A payer cannot impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service. In the event that the payer is not primary under coordination of benefits, a deadline shall not be imposed for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.
CLAIM FORWARDING	Claims involving Emergency Services shall be forwarded to the appropriate payer within 10 working days of receipt of the claim. Claims not involving Emergency Services: • If the provider that filed the claim is contracted with the plan's capitated provider, the plan has 10 working days of the receipt of the claim to: ✓ Send the claimant a notice of denial, with instructions to bill the capitated provider, or ✓ Forward the claim to the appropriate capitated provider In all other cases, the plan has 10 working days of the receipt of the claim incorrectly sent to the plan to forward the claim to the appropriate payer.
OVERPAYMENTS	A payer's written request for reimbursement to the provider for an overpayment of a claim must be made within 365 days of the date of payment. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider. If the provider contests the notice of reimbursement of the

ITEM	DESCRIPTION
	overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment, shall send a written notice stating the basis upon which the provider believes that the claim was not overpaid. If the provider does not contest the notice of reimbursement, the provider shall reimburse the payer within 30 working days of the receipt by the provider of the notice of overpayment of a claim.
ACKNOWLEDGEMENT OF CLAIMS	Acknowledgement of claims shall be provided within: • 2 working days of the receipt of an electronic claim • 15 working days of the receipt of a paper claim
TIME FOR REIMBURSEMENT	A payer shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim, unless the complete claim or portion thereof is contested or denied. (see contesting or denying claims) If an HMO also maintains a PPO or POS line of business, the plan shall reimburse all claims relating to or arising out of non-HMO lines of business within 30 working days. If a specialized health care service plan contracts with an HMO, they shall reimburse complete claims received for HMO services within 30 working days.
TIME FOR CONTESTING OR DENYING CLAIMS	A payer may contest or deny a claim, or portion thereof, by notifying the provider in writing that the claim is contested or denied within 45 working days after the date of receipt of the claim by the payer. If an HMO also maintains a PPO or POS line of business, the plan shall contest or deny claims relating to or arising out of non-HMO lines of business within 30 working days. If a specialized health care service plan contracts with an HMO, they shall contest or deny claims received for HMO services within 30 working days.
CONTRACT MODIFICATIONS (to the Information for Contracting Providers and to the Fee Schedules and Other Required Information)	A payer shall provide a minimum of 45 days prior written notice before instituting any changes, amendments or modifications in the disclosures made pursuant to the information in Information for Contracting Providers and Fee Schedules and Other Required Information. (section m)

ITEM	DESCRIPTION
REQUIRED REPORTS	Within 60 days of the close of each calendar quarter, the plan shall disclose to the Department of Managed Health Care in a single combined document: • Any emerging patterns of claims payment deficiencies • Whether any of its claims processing organizations or capitated providers failed to timely and accurately reimburse 95% of its claims (including the payment of interest and penalties), and • The corrective action that has been undertaken over the preceding two quarters. The first report from the plan shall be due within 45 days after the close of the calendar quarter that ends 120 days after the effective date of these regulations. Within 15 days of the close of each calendar year, beginning with the 2004 calendar year, the plan shall submit to the Director, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report, information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers.
REASONS FOR DENYING, ADJUSTING OR CONTESTING A CLAIM	A payer shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the payer shall provide an accurate and clear written explanation of the specific reasons for the action taken, within the specified time frames.
REASONABLY RELEVANT INFORMATION – CONTRACT LANGUAGE	A payer shall not include a contract provision with a provider to require the submission of medical records that are not reasonably relevant for the adjudication of a claim.
REQUESTS FOR MEDICAL RECORDS (non-emergency and authorized services)	Requests for medical records to determine payer liability must be reasonably necessary.
REQUESTS FOR MEDICAL RECORDS (emergency and unauthorized services)	Requests for medical records to determine payer liability must be reasonably necessary.
MANDATED CONTRACTUAL PROVISIONS	Contracts between a plan and a delegated entity must specify that: • The entity must comply with specific sections of both Health and Safety Code and title 28, which outline the claims adjudication and dispute resolution provisions. (See complete list of these sections on page 14 of the AB1455 Final Text) • The entity will submit a signed and verified Quarterly Claims Report within 30 days of the end of the quarter, which will indicate compliance with certain sections of Health and Safety Code and title 28.

ITEM	DESCRIPTION
	• The entity will disclose all documents related to Provider Dispute Resolutions (PDR) process and outcomes. • The entity will provide an unconditional right of appeal for medical necessity or Utilization Review related disputes directly to the plan within 60 working days from the delegated entity's Date of Determination. • The plan may assume claims payment responsibility in certain instances where entity fails to fulfill responsibilities of claims payment, corrective action plans (see section 1375.4(b)(4) of H&S Code)
PROVISION OF INFORMATION FOR CONTRACTING PROVIDERS, FEE SCHEDULE, AND OTHER REQUIRED INFORMATION (disclosures)	Effective 1/1/04, upon initial contracting with providers and upon written request by a contracted provider, the following information shall be provided: • Directions (including address, phone, fax) for electronic transmission, physical delivery and mailing of claims including the procedure for confirming receipt and phone number for inquiries; • Any specific claim submission requirements such as attachments or supplemental documentation commonly required; and • The identity of the office responsible for PDR including specific address/ directions for submitting single or multiple substantially similar provider disputes as well as timeframes for resolution. Effective 1/1/04, upon initial contracting with providers, annually thereafter and upon written request, the following must be disclosed electronically: • Complete fee schedule including disclosures (see 1300.75.4.1(b) of H&S Code) • Detailed payment rules, policies, non-standard coding methodologies used to adjudicate claims. Examples include clearly explaining the methodology used to arrive as a global payment, clearly stating policies used to modify coding, payment of modifiers, multiple procedures, assistant surgeons, injectables, etc. These rules should be accepted by nationally recognized organizations.
WAIVER PROHIBITED	A payer shall not require or allow a provider to waive any right conferred upon the provider or any obligation imposed by the payer by specific provisions in the Health and Safety Code and title 28 relating to claims processing or payment.
NOTICE TO PROVIDER OF DISPUTE RESOLUTION MECHANISM	Whenever a payer contests, adjusts or denies a claim it shall inform the provider of the ability to dispute and include the procedure for obtaining forms, along with mailing address for submission of disputes

ITEM	DESCRIPTION
PROVIDER DISPUTE FILING DEADLINE	Payer shall not impose a deadline for submission of a dispute:
	For disputes involving claims, billing or contract disputes not less than 365 days from action or in case if inaction, no less than 365 days after the "time" for contesting or denying claims has expired. For disputes related to Demonstrable, Unfair Payment Pattern, time frame for submission shall not be less than 365 days from "payers" most recent action or in the case of inaction, not less than 365 days after the "time" for contesting or denying claims has expired.
ACKNOWLEDGE RECEIPT OF PROVIDER DISPUTE	In the case of electronic dispute submission, acknowledgement shall be provided within 2 working days from receipt or in the case of paper dispute submission, acknowledgement will be provided within 15 working days.
	This acknowledgment is to be provided by the office designated to receive provider disputes
TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION	A payer shall resolve each provider dispute or amended dispute in a written determination within 45 days of receipt.
RESCIND OR MODIFY AN AUTHORIZATION AFTER SERVICES ARE RENDERED	A payer shall not rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization.

Claims submitted by mail are considered filed on the date physically received at address.
Claims must be submitted within 90 days for contracted providers and 180 days for non-contracted providers. Claims submitted outside of these time frames maybe denied as untimely.

MEDICAL RECORD DOCUMENTATION

WHAT IS DOCMENTATION AND WHY IS IT IMPORTANT?

The primary purpose of medical documentation is to ensure that patient treatment is recorded for quality of care and continuity of treatment. Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time;
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- Accuracy and timeliness of claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services provided have been accurately reported.

To be reasonable and necessary, items and services must have been established as safe and effective. That is:

- Consistent with symptoms or diagnosis of the illness under treatment;
- Necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational);
- Not furnished primarily for the convenience of the patient, the attending physician, other medical professionals, or family members; and
- Furnished at the most appropriate level, which can be provided safely and effectively to the patient. Complete records are those that contain all pertinent and essential information related to the patient's status. Each entry must be "stand-alone" (i.e., must support the fact that the level of service billed was rendered). Furthermore, these records must substantiate the service performed and indicate the proper treatment plan.

DOCUMENTATION TIPS

In documenting medical records to support services provided to patients, special emphasis should be placed on assuring that they:

- Are consistent with the clinical descriptors and definitions contained in *CPT*;
- Would be widely accepted by clinicians and minimize any changes in record-keeping practices; and
- Would be interpreted and applied uniformly by users across the country.

The use of non-standardized medical abbreviations is not acceptable.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles may be modified to account for these variable circumstances in providing E/M services.
1. The medical record should be ***complete and legible***.
2. The documentation of each patient encounter should include the reason for the encounter and relevant history, physical examination findings and prior diagnostic test results; assessment, clinical impression or diagnosis; plan for care; and date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The signature of the person documenting the medical records should always be identifiable (e.g., legible), and the documentation should be authenticated and dated. In some instances, especially during inpatient hospitalization, a sample of the physician's/provider's signature may be requested. This is done to ensure that the requested records are correctly distinguished.

A rubber stamp signature on the medical record is not sufficient as evidence of the physician's presence unless initialed by the physician. The rationale for this policy is that the rubber stamp signature does not afford the required degree of assurance of the physician's involvement in the patient's care to qualify as the attending physician. This system affords no security that others will not use the stamp in the absence of the physician.

Computerized signatures are, under certain circumstance, acceptable. The payer must be assured that the individual in question has his or her own confidential code or password to generate a computerized
signature. The department heads of hospitals, clinic managers, and medical record departments can provide these assurances. These systems are subject to inspection by payer if it is suspected that a security has been broken.

Please note: Any reimbursement made for services not substantiated by sufficient documentation are considered an overpayment and must be refunded.

PROVIDER DISPUTE RESOLUTION PROCESS

AB 1455 requires a Health Plan and its capitated providers to establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

How to File a Provider Dispute:

A Provider Dispute Resolution Form is included in Appendix B of the manual or on the following web site links:

Sharp Community Medical Group – www.sharp.com/scmgproviders
Sharp Rees-Stealy - www.sharp.com/srsproviders
Sharp Health Plan - www.sharp.com/healthplan

In order for a provider dispute to be recorded and filed, the dispute must include the following:

- it must be in writing
- the provider name
- the provider contact information
- the name and ID of the enrollee
- the date of service and billed amount
- the claim number on the explanation of benefits/payment
- clearly identify the disputed item
- a clear explanation of basis for provider's feeling that the payment, request for overpayment return, request for addition information, contest, denial or adjustment is correct

All provider dispute requests submitted without the information outlined above will be returned to the requestor with a letter stating what information is needed before a review can be performed. Failure to submit the above requested documentation in a timely manner will result in processing delays and/or denial of your provider disputes. A provider dispute request should always include sufficient information to determine why you are requesting a review, and why the service should be paid. Medical records for the service in question, as well as any other supporting documentation, should be submitted.

To further assist us expediting your request for review, please include the following information with your request:

- A copy of the claim as originally submitted, including reports or any other attachments.
- A copy of the corresponding Remittance Advice statement.
- Any additional information that may support your claim or justify the medical necessity for services.

Suggestions for additional documentation include:
1. Operative, consultation, pathology reports (if applicable), x-ray results, etc.
2. Literature from medical journals substantiating the necessity of the services rendered
3. Nurses notes or progress notes.

Some common appeal issues are:

- Medical necessity denials such as "this many services are not covered for this condition" or "this service is not covered for the reported condition";

- Bundled services (i.e., procedures included in a primary procedure);
  - The number or quantity of services billed.

Where to send disputes:

In order for disputes to be processed timely they must be directed to the appropriate Post Office Box or unit listed below. Failure to direct disputes to the addresses listed below could result in delays to acknowledge and respond to disputes.

MAILING ADDRESS
Sharp Community Medical Group PO Box 939034 San Diego, Ca 92193 Att: Provider Dispute Resolution Unit
Sharp Rees-Stealy P O Box 939035 San Diego, CA 92193 Att: Provider Dispute Resolution Unit
Sharp Health Plan 8520 Tech Way San Diego, CA 92123 Att: Provider Dispute Resolution Unit

Provider Dispute Resolution Timeframes

Description	Turnaround Time Frame
Filing of a provider dispute related to an individual claim, billing dispute, or contractual dispute.	365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired.
For a dispute related to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider.	365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired
Amended Provider Dispute	A provider may submit within 30 working days of the date of receipt of a returned provider dispute for purposes of requesting missing information
Description	**Turnaround Time Frame**
Resolution and issuance or written determination for each provider dispute or amended provider dispute.	Resolution and a written determination must be completed with 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional	A provider has the right to submit an appeal for a de novo review and resolution to the Plan for a period of 60 working days from the capitated provider's Date of Determination.

right of appeal for that claim dispute to the plan's dispute resolution process.	
Resolution of a provider dispute or amended provider dispute involving a claim which is determined in whole or in part in favor of the provider, shall include the payment of any outstanding monies determined to be due, and all interest and penalties.	Payment is due with 5 working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.

OVERPAYMENTS

When it has been determined that an overpayment has been made on a claim, a request for refund for overpayment will be generated. The provider has 30 days to respond to the request. If the request is not responded to in writing and the provider contractually agrees, we will begin recouping the overpaid amount from any payment made under the tax identification number (TIN) from which the overpayment was originally made.

Please send correspondence on Overpayments to the address listed on the request for refund.

PUBLICATIONS

You can avoid common billing problems and excessive denials of your claims by first obtaining all the "tools of the trade". The following publications are recommended for successful claims submission.

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY (CPT)

The *Physicians' Current Procedural Terminology (CPT)* is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and practitioners. It provides a uniform language to accurately describe medical, surgical, and diagnostic services. The CPT book is updated annually. Maintaining a current copy of this publication is very important for submitting accurate claims. **Warning:** Although a code is published in the CPT it does not mean that all or part of its description is suitable for Medicare billing. The American Medical Association is assisted by the Centers for Medicare & Medicaid Services (CMS) and others in developing codes and descriptors for the CPT.

HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURE CODING SYSTEM (HCPCS*)*

HCPCS is a national uniform coding system for reporting physician and supplier services under the Medicare program. HCPCS is based on the CPT coding system. It is the only procedure coding system acceptable for Medicare billing. The use of other coding systems in the submission of Medicare claims will result in rejection of claims as unclean, or produce claims processing delays and/or denial of services. There are three levels of codes and modifiers:

Level I, the highest level, contains numeric codes assigned by the AMA. These codes are listed in the *American Medical Association's Physicians' Current Procedural Terminology* or CPT.

Level II contains physician and non-physician service codes not included in the Level I, such as injections or J-codes. These alphanumeric codes are developed by CMS to cover ambulance, dental, medical and other services, supplies (durable medical equipment, orthotics, prosthetics, etc.), drugs and procedures not found in the CPT. The *HCPCS Level II Code* book can be purchased from most technical bookstores or medical publishing companies.

Level III codes are those assigned by the local Medicare carriers for services that are not found in Level I or Level II. These codes are also alphanumeric and are different for each carrier. These codes are published by the carriers.

INTERNATIONAL CLASSIFICATION OF DISEASES, TENTH REVISION, CLINICAL MODIFICATION (ICD-10-CM)

Medicare requires physicians to include a complete diagnosis code (or codes) on each claim form submitted for payment. The Centers for Medicare & Medicaid Services (CMS) has adopted the *International Classification of Diseases, Tenth Revision, Clinical Modification or ICD-10-CM* coding system for this purpose.

In reporting ICD-10-CM diagnosis codes, physicians will be describing the patient's condition using terminology which includes specific diagnoses as well as symptoms, problems, complaints or other reason for the medical service. The diagnosis on a claim must be reported to the highest level of specificity.

Therefore, you must maintain a current ICD-10-CM manual.
You may consult the *Medicare B Resource* / *Medicare B-Special Notice* for changes; however, we recommend you purchase the manual annually. The ICD-10-CM is updated every year in October.

Please be advised that effective on and after 10/1/15 all referrals must be submitted with an ICD10 code. All claims with dates of service on or after 10/1/15 must be submitted with an ICD10 code and will be rejected if a ICD9 code is submitted. A referral that is approved with a ICD9 code prior to 10/1/15 and the service was provided on 10/1/15 and after, the claim must be coded with an ICD10. Refer to the 2015 ICD-10-CM.

FRAUD AND ABUSE

FRAUD

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and make, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent kind of fraud arises from a false statement or misrepresentation made, caused to be made, that is material to entitlement of payment. Attempts to defraud insurance plans take a variety of forms. Some examples are:

- Billing for services or supplies that were not provided
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished
- Altering a claim form to obtain a higher amount paid
- Soliciting, offering, or receiving a kickback, bribe or rebate
- Use of another person's health insurance card to obtain medical care

ABUSE

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse take such forms as, but is not limited to:

- Unbundled charges
- Excessive charges
- Medically unnecessary services
- Improper billing practices

Although these practices may initially be considered as abuse, review of the circumstances may reflect they are or could be considered fraudulent.

WHERE TO FIND THE ANSWERS
CUSTOMER SERVICE DIRECTORY

Customer Service Units	Telephone Number
Sharp Community Medical Group	858-499-2550
Sharp Rees-Stealy	858-499-2410
Sharp Health Plan	619-228-2490

APPENDIX A: THE INTERNET

The Internet is a very valuable tool in researching certain questions or issues.

Use the following links to obtain billing and claim payment information and provider dispute forms:

Sharp Community Medical Group – www.sharp.com/scmgproviders
Sharp Rees-Stealy - www.sharp.com/srsproviders
Sharp Health Plan - www.sharp.com/healthplan

OTHER HELPFUL PROVIDER WEB SITES
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
www.medicare.gov
Official website for CMS.

Evaluation and Management Documentation Guidelines
http://www.cms.hhs.gov/medlearn/emdoc.asp

Federal Registry
http://www.archives.gov/

Through the office of the Federal Register, the National Archives and Records Administration provides ready access to:
- Federal Regulations
- Public Law
- Presidential Documents

Fee Schedule for Medicare
http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/Providers~Jurisdiction%201%20Part%20B~Publications~Fee%20Schedules?opendocument

http://www.cms.hhs.gov/PFSlookup/

NPPES Registry
https://www.nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

APPENDIX B: FORM

One-Time Authorization Form

For Use by Provider
Enrollee Name_____Enrollee ID#_____

I request that payment of authorized benefits be made on my behalf to (Provider Name)
for any services furnished me. I authorization any holder of medical information about me to release to the Payer and its agents any information needed to determine these benefits or the benefits payable for related services.

_____Date_____
(Beneficiary signature)

APPENDIX C: PLACE OF SERVICE CODES

02 Telehealth
The location where health services and health related services are provided or received, through a telecommunication system (Effective January 1, 2017)

03 School
A facility whose primary purpose is education.

04 Homeless Shelter
A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

05 Indian Health Service Free-standing Facility (effective 10/1/03)
A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.

06 Indian Health Service Provider-based Facility (effective 10/1/03)
A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

07 Tribal 638 Free-Standing Facility (effective 10/1/03)
A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.

08 Tribal 638 Provider-Based Facility (effective 10/1/03)
A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members Admitted as inpatients or outpatients.

11 Office
Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 Home
Location other than a hospital or other facility, where the patient receives care in a private residence.

13 Assisted Living Facility (effective 10/1/03)
Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.

14 Group Home (effective 10/1/03)

Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.

15 Mobile Unit
A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

19 Off Campus-Outpatient Hospital
A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)

20 Urgent Care Facility
Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 Inpatient Hospital
A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital
A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room – Hospital
A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center
A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center
A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

26 Military Treatment Facility
A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31 Skilled Nursing Facility
A facility which primarily provides impatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility
A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care

services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility
A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice
A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

41 Ambulance – Land
A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 Ambulance – Air or Water
An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

49 Independent Clinic (effective 10/1/03)
A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

50 Federally Qualified Health Center
A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility
A facility that provides impatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization
A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center
A facility that provides the following services:
‥Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at the mental health facility;
‥24-hour a day emergency care services;
‥Day treatment, other partial hospitalization services, or psychosocial rehabilitation services;
‥Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and
‥Consultation and education services.

54 Intermediate Care Facility/Mentally Retarded
A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility
A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing and room and board.

56 Psychiatric Residential Treatment Facility
A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57 Non-residential Substance Abuse Treatment Facility (effective 10/1/03)
A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

60 Mass Immunization Center
A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submits these charges as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician office setting.

61 Comprehensive Inpatient Rehabilitation Facility
A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility
A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65 End Stage Renal Disease Treatment Facility
A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or care givers on an ambulatory or home-care basis

71 State or Local Public Health Care
A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic
A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical under the general direction of a physician.

81 Independent Laboratory
A laboratory certified to perform certain diagnostic and/or clinical tests independent of an institution or a physician’s office.

99 Other Unlisted Facility
Other service facilities not identified above.

APPENDIX D: Glossary of Terms

Complete Claim – means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" to determine payer liability.

For physicians and other professional providers: the CMS 1500 or its successor adopted by the Nation Uniform Claim Committee submitted on the designated paper or electronic format; CPT codes and modifiers and ICD9 codes.

For institutional providers; the UB 92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC.

CPT codes – Current Procedural Terminology published by the American Medical Association

HCPCS Level II codes – Healthcare Common Procedure Coding System. CMS developed the second level of codes.

Date of "contest," "date of notice" means the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service correctly addressed to the claimant's office or other address of record with proper postage prepaid.

Date of Payment – means the date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record.

Date of Receipt – means the working day when a claim by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

Demonstrable and unjust payment pattern – means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

Medical Necessity: Determinations on decision that are, or that could be considered, covered benefits. This includes determination for; covered medical benefits as defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits and care or service that could be considered either covered or non-covered, depending on the circumstances.

Unfair billing pattern – includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologist, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.

Utilization Management: The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.