CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1929	**Date: March 9, 2010**
	Change Request 6801

Transmittal 1917, dated February 5, 2010, is being rescinded and replaced by Transmittal 1929, dated March 9, 2010 to remove obsolete information in section 75.1, Form Locator 15 and to add the code 2 title which is "Clinic or Physician's Office". All other material remains the same.

SUBJECT: Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List

I. SUMMARY OF CHANGES: The following Point of Origin for Admission or Visit (formerly Source of Admission) codes, discontinued by the National Uniform Billing Committee (NUBC), will be discontinued for use by the Fiscal Intermediary Standard System (FISS): 7-Discontinued Effective July 1, 2010, B-Discontinued Effective July 1, 2010, C-Discontinued Effective July 1, 2010.

Medicare systems changes for codes B and C are included in Change Request (CR) 6757. Medicare systems changes for Condition Code 47 (used to replace code B) are also included in CR 6757. This CR updates the IOM language to Chapter 25 for Point of Origin for Admission or Visit codes 7, B, C, and Condition Code 47. This CR also directs Medicare systems changes for code 7.

Point of Origin for Admission or Visit code 1"s, Chapter 25 example and definition has been updated. Point of Origin for Admission or Visit code 2"s, Chapter 25 definition has also been updated. The processing of these codes is not being changed.

New / Revised Material
Effective Date: July 1, 2010
[NOTE: Unless otherwise specified, the effective date is the date of service.]
Implementation Date: July 6, 2010

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	25/75.1/Form Locators 1-15
R	25/75.2/Form Locators 16-30

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1929	Date: March 9, 2010	Change Request: 6801

Transmittal 1917, dated February 5, 2010, is being rescinded and replaced by Transmittal 1929, dated March 9, 2010 to remove obsolete information in section 75.1, Form Locator 15 and to add the code 2 title which is "Clinic or Physician's Office". All other material remains the same.

SUBJECT: Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List

Effective Date: July 1, 2010
[NOTE: Unless otherwise specified, the effective date is the date of service.]

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background: The following Point of Origin for Admission or Visit (formerly Source of Admission) codes, discontinued by the National Uniform Billing Committee (NUBC), will be discontinued for use by the Fiscal Intermediary Standard System (FISS):

7 Discontinued Effective July 1, 2010

B Discontinued Effective July 1, 2010

C Discontinued Effective July 1, 2010

Medicare systems changes for codes B and C are included in Change Request (CR) 6757. Medicare systems changes for Condition Code 47 (used to replace code B) are also included in CR 6757. This CR updates the Internet Only Manual (IOM) language to Chapter 25 for Point of Origin for Admission or Visit codes 7, B, C, and Condition Code 47. This CR also directs Medicare systems changes for code 7.

Point of Origin for Admission or Visit code 1's, Chapter 25 example and definition language has been updated. Point of Origin for Admission or Visit code 2's, Chapter 25 definition language has also been updated. The processing of these codes is not being changed.

B. Policy: Form Locator 15 (Point of Origin for Admission or Visit) of the UB-04 and its electronic equivalence is a required field on all institutional inpatient claims and outpatient registrations for diagnostic testing services. This code indicates the point of patient origin for the admission or visit of the claim being billed.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6801.1	Medicare systems shall no longer accept Point of Origin for Admission or Visit code 7 on institutional claims.						X			X	COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6801.2	Contractors shall be aware of the IOM language updates to Chapter 25 for codes 1, 2, 7, B, C, and 47.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6801.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

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

V. CONTACTS

Pre-Implementation Contact(s): Matt Klischer, Matthew.Klischer@cms.hhs.gov, 410.786.7488

Post-Implementation Contact(s): Matt Klischer, Matthew.Klischer@cms.hhs.gov, 410.786.7488

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: ***For Medicare Administrative Contractors (MACs)*****, include the following statement:**

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

75.1 - Form Locators 1-15

(Rev. 1929, Issued: 03-09-10; Effective Date: 07-01-10; Implementation Date: 07-06-10)

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

Required. The minimum entry is the provider 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. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

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

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

FL 3a - Patient Control Number

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

FL 3b – Medical/Health Record Number

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

FL 4 - Type of Bill

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

Code Structure

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

1 Hospital

2 Skilled Nursing

3 Home Health (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)

4 Religious Nonmedical (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) (CMS will process this as the 2nd digit)

1 Inpatient (Part A)

2 Inpatient (Part B) - (For HHA non PPS claims, Includes HHA visits under a Part B plan of treatment, for HHA PPS claims, indicates a Request for Anticipated Payment - RAP.) Note: For HHA PPS claims, CMS determines from which Trust Fund payment is made. Therefore, there is no need to indicate Part A or Part B on the bill.

3 Outpatient (For non-PPS HHAs, includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment). For home health agencies paid under PPS, CMS determines from which Trust Fund, Part A or Part B. Therefore, there is no need to indicate Part A or Part B on the bill.

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 for “nonpatients,” and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim. NOTE: 24X is discontinued effective 10/1/05.

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) (CMS will process this as the 2nd digit)

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 (CMHC)

7-8 Reserved for National Assignment

9 OTHER

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

1 Hospice (Nonhospital Based)

2 Hospice (Hospital Based)

3 Ambulatory Surgical Center Services to Hospital Outpatients

4 Free Standing Birthing Center

5 Critical Access Hospital

6-8 Reserved for National Assignment

9 OTHER

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

A	Admission/Election Notice	Used when the hospice or Religious Non-medical Health Care Institution is submitting Form CMS-1450 as an Admission Notice.
B	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation Notice	Used when the Form CMS-1450 is used as a notice of termination/revocation for a previously posted Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.
C	Hospice Change of Provider Notice	Used when Form CMS-1450 is used as a Notice of Change to the hospice provider.
D	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel	Used when Form CMS-1450 is used as a Notice of a Void/Cancel of Hospice/Medicare Coordinated Care Demonstration/Religious Non-medical Health Care Institution election.
E	Hospice Change of Ownership	Used when Form CMS-1450 is used as a Notice of Change in Ownership for the hospice.
F	Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For FI or A/B MAC use only.
G	CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For FI or A/B MAC use only.
H	CMS Initiated Adjustment Claim	Used to identify adjustments initiated by CMS. For FI or A/B MAC use only.
I	FI Adjustment Claim (Other than QIO or Provider)	Used to identify adjustments initiated by the FI. For FI or A/B MAC use only
J	Initiated Adjustment Claim-Other	Used to identify adjustments initiated by other entities. For FI or A/B MAC use only.
K	OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For FI or A/B MAC use only.
M	MSP Initiated Adjustment	Used to identify adjustments initiated by MSP. For

	Claim	FI or A/B MAC use only. Note: MSP takes precedence over other adjustment sources.
P	QIO Adjustment Claim	Used to identify an adjustment initiated as a result of a QIO review. For FI or A/B MAC use only.
0	Nonpayment/Zero Claims	Provider uses this code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement, or termination of the plan of care.
1	Admit Through Discharge Claim	The provider uses this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an Employer Group Health Plan (EGHP).
2	Interim-First Claim	Used 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. For HHAs, used for the submission of original or replacement RAPs.
3	Interim-Continuing Claims (Not valid for PPS Bills)	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 (Not valid for PPS Bills)	This code is used 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(s) Only	When the provider submits late charges on bills to the FI or A/B MAC as bill type XX5, these bills contain only additional charges.
7	Replacement of Prior Claim	This is used to correct a previously submitted bill. The provider applies this code to the corrected or "new" bill.

8	Void/Cancel of a Prior Claim	The provider uses this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.
9	Final Claim for a Home Health PPS Episode	This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

Bill Type Codes

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

Bill Type Code

011X	Hospital Inpatient (Part A)
012X	Hospital Inpatient Part B
013X	Hospital Outpatient
014X	Hospital Other Part B
018X	Hospital Swing Bed
021X	SNF Inpatient
022X	SNF Inpatient Part B
023X	SNF Outpatient
028X	SNF Swing Bed
032X	Home Health
033X	Home Health
034X	Home Health (Part B Only)
041X	Religious Nonmedical Health Care Institutions
071X	Clinical Rural Health
072X	Clinic ESRD

073X Clinic – Freestanding (Effective April 1, 2010)

074X Clinic OPT

075X Clinic CORF

076X Community Mental Health Centers

077X Federally Qualified Health Centers (Effective April 1, 2010)

081X Nonhospital based hospice

082X Hospital based hospice

083X Hospital Outpatient (ASC)

085X Critical Access Hospital

FL 5 - Federal Tax Number

Required. The format is NN-NNNNNNN.

FL 6 - Statement Covers Period (From-Through)

Required. The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY). Days before the patient's entitlement are not shown. With the exception of home health PPS claims, the period may not span two accounting years. The FI or A/B MAC uses the "From" date to determine timely filing.

FL 7

Not Used.

FL 8 - Patient's Name/ID

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

FL 9 - Patient's Address

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

FL 10 - Patient's Birth Date

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

FL 11 - Patient's Sex

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

FL 12 - Admission/Start of Care Date

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

FL 13 - Admission Hour

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

FL 14 – Priority (Type) of Admission or Visit

Required on inpatient bills only. This is the code indicating 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

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 a trauma activation.

6-8 Reserved for National Assignment

9 Information Not Available

FL 15 – Point of Origin for Admission or Visit

Required. The provider enters the code indicating the source of the referral for this admission or visit.

Code Structure:

1	*Non-Health Care Facility Point of Origin*	*Inpatient: The patient was admitted to this facility.*
	Examples: Includes patients coming from home or workplace.	*Outpatient: The patient presented to this facility for outpatient services.*
2	*Clinic or Physician's Office*	*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) <u>Usage Note</u>: Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D).	Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or an outpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility. * For transfers from hospital inpatient in the same facility, see code D.
5	Transfer from a SNF or Intermediate Care Facility (ICF)	Inpatient: The patient was admitted to this facility as a transfer from a SNF or ICF 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 or ICF where he or she was a resident.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. Outpatient: The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.
7	Emergency Room (ER) <u>Usage Note</u>: <u>Excludes</u> patients who came to the ER from another health care facility.	*Discontinued July 1, 2010* Outpatient: The patient received unscheduled services in this facility's emergency department and discharged without an inpatient admission. Includes self-referrals in emergency situations that require immediate medical attention.
8	Court/Law Enforcement <u>Usage Note</u>: Includes transfers from incarceration facilities.	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.

9	Information Not Available	Inpatient: The means by which the patient was admitted to this facility is not known. Outpatient: For Medicare outpatient bills, this is not a valid code.
A		Reserved for national assignment.
B	Transfer From Another Home Health Agency	*Discontinued July 1, 2010. See Condition Code 47.*
C	Readmission to Same Home Health Agency	*Discontinued July 1, 2010*
D	Transfer from hospital inpatient in the same facility 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.
E	Transfer from Ambulatory Surgery Center	For Medicare bills, this is not a valid code.
F	Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program	For Medicare bills, this is not a valid code.
G-Z		Reserved for national assignment.

75.2 - Form Locators 16-30
(Rev. 1929, Issued: 03-09-10; Effective Date: 07-01-10; Implementation Date: 07-06-10)

FL 16 – Discharge Hour

Not Required.

FL 17 – Patient Discharge Status

Required. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's discharge status as of the "Through" date of the billing period (FL 6).

Code Structure

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care.
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
04	Discharged/transferred to a Facility that Provides Custodial or Supportive Care (Effective October 1, 2009)
05	Discharged/ Transferred to a Designated Cancer Center or Children's Hospital. Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions.
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care.
07	Left against medical advice or discontinued care
08	Reserved for National Assignment
*09	Admitted as an inpatient to this hospital
10-19	Reserved for National Assignment
20	Expired (or did not recover - Religious Non Medical Health Care Patient)
21	Discharged/transferred to Court/Law Enforcement
22-29	Reserved for National Assignment
30	Still patient or expected to return for outpatient services
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)
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 transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration (VA) hospital or 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	Discharged/transferred to Hospice - home
51	Discharged/transferred to Hospice - medical facility
52-60	Reserved for national assignment

Code	Structure
61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)
67-69	Reserved for national assignment
70	Discharge/transfer to another type of health care institution not defined elsewhere in the code list. (effective 4/1/08)
71-99	Reserved for national assignment

*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.

FLs 18 - 28 - Condition Codes

Situational. The provider enters the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period.

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

Code	Title	Definition
		receive payment from the plan.
05	Lien Has Been Filed	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 30 Months of Entitlement Covered By Employer Group Health Insurance	Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 30 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 FI or A/B MAC 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 FI or A/B MAC 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

Code	Title	Definition
		does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits and does not have his/her father's last name.
20	Beneficiary Requested Billing	Provider realizes services are non-covered level of care 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.
26	VA Eligible Patient Chooses 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 the 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

Code	Title	Definition
		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 a 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

Code	Title	Definition
35		Reserved for assignment by the NUBC
36	General Care Patient in a Special Unit	(Not used 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.

Code	Title	Definition
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.

Code	Title	Definition
		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	Claim indicates patient has ambiguous gender characteristic (e.g. transgendered or hermaphrodite) Effective January 1, 2010.
46	Non-Availability Statement on File	A non-availability 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*	*The patient was admitted to this 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 that 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.
51-54		Reserved for assignment by the NUBC
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because a

Code	Title	Definition
		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-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. Effective 10/01/04
60	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 or A/B MAC indicates the cost outlier portion paid value code 17.
61	Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI or A/B MAC indicates the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Bill was paid under PIP. The FI or A/B MAC 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 FI or A/B MAC records this from its system.
65	Non-PPS Bill	(Not reported by providers.) Bill is not a PPS bill. The FI or A/B MAC records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Cost	The hospital is not requesting additional

Code	Title	Definition
	Outlier Payment	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&AH 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 erythropoetin alpha (EPO) or darbepoetin alpha.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services 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 Reimbursement	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

Code	Title	Definition
		speech pathology services were provided off-site.
80	Home Dialysis-Nursing Facility	Home dialysis furnished in a SNF or Nursing Facility.
81-99		Reserved for assignment by the NUBC

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

A0	TRICARE External Partnership Program	Not used for Medicare.
A3	Special Federal Funding	This code is for uniform use by State uniform billing committees.
A5	Disability	This code is for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment	Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services.
A7-A8		Reserved for assignment by the NUBC
A9	Second Opinion Surgery	Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
AA	Abortion Performed due to Rape	Self-explanatory
AB	Abortion Performed due to Incest	Self-explanatory
AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Self-explanatory
AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself	Self-explanatory
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory
AF	Abortion Performed due to Emotional/psychological Health	Self-explanatory

Code	Title	Definition
	of the Mother	
AG	Abortion Performed due to Social Economic Reasons	Self-explanatory
AH	Elective Abortion	Self-explanatory
AI	Sterilization	Self-explanatory
AJ	Payer Responsible for Copayment	Self-explanatory
AK	Air Ambulance Required	For ambulance claims. Air ambulance required – time needed to transport poses a threat
AL	Specialized Treatment/bed Unavailable	For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate facility.
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required.
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening.
AO-AZ		Reserved for assignment by the NUBC
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.
B1	Beneficiary is Ineligible for Demonstration Program	Full definition pending
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the Ambulance Fee Schedule
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable Law.
B4	Admission Unrelated to Discharge	Admission unrelated to discharge on same day.
B5-C0		Reserved for assignment by the NUBC
QIO Approval Indicator Codes		
C1	Approved as Billed	Claim has been reviewed by the QIO and has been fully approved including any outlier.
C3	Partial Approval	The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as

Code	Title	Definition
		code “M0” in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code “77” in FL 36 or code “46” in FL 39-41).
C4	Admission Denied	The patient’s need for inpatient services was reviewed and the QIO found that none of the stay was medically necessary.
C5	Post-payment Review Applicable	Any medical review will be completed after the claim is paid.
C6	Preadmission/Pre-procedure	The QIO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
C8-CZ		Reserved for assignment by the NUBC
Claim Change Reasons		
D0	Changes to Service Dates	Self-explanatory
D1	Changes to Charges	Self-explanatory
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Changes In Clinical Codes (ICD) for Diagnosis and/or Procedure Code	Use for inpatient acute care hospital, long-term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF).
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory

Code	Title	Definition
DA – DQ		Reserved for assignment by the NUBC
DR	Disaster related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
DS – DZ		Reserved for assignment by the NUBC
E0	Change in Patient Status	Self-explanatory
E1 – FZ		Reserved for assignment by the NUBC
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.
G1 – GZ		Reserved for assignment by the NUBC
H0	Delayed Filing, Statement Of Intent Submitted	Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
H1		Reserved for assignment by the NUBC
H2		Not used for Medicare billing
H3-LZ		Reserved for assignment by the NUBC
M0	All Inclusive Rate for Outpatient Services (Payer Only Code)	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient.
M1-MW		Reserved for payer assignment
MX	Wrong Surgery on Patient (Payer Only Code)	Code, assigned by the contractor, indicating the wrong surgery was performed on the patient.
MY	Surgery on Wrong Body Part (Payer Only Code)	Code, assigned by the contractor, indicating surgery was performed on the wrong body part.

Code	Title	Definition
MZ	Surgery on Wrong Patient (Payer Only Code)	Code, assigned by the contractor, indicating surgery was performed on the wrong patient.
N0-OZ		Reserved for assignment by the NUBC
P0-PZ		Reserved for national assignment. FOR PUBLIC HEALTH DATA REPORTING ONLY
Q0-VZ		Reserved for assignment by the NUBC
W0	United Mine Workers of America (UMWA) Demonstration Indicator	United Mine Workers of America (UMWA) Demonstration Indicator ONLY
W1		Reserved for assignment by the NUBC
W2-W5		Not used for Medicare billing
W6-ZZ		Reserved for assignment by the NUBC