

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1898</b>	<b>Date: January 29, 2010</b>
	<b>Change Request 6782</b>

**Subject: Dialysis Adequacy, Infection and Vascular Access Reporting**

**I. SUMMARY OF CHANGES:** This change requires new reporting for dialysis adequacy, infection and vascular access and will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by MIPPA 153c.

**New / Revised Material**

**Effective Date: July 1, 2010**

**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.*

<b>R/N/D</b>	<b>Chapter / Section / Subsection / Title</b>
R	8/50.3 Required Information for In-Facility Claims Paid Under the Composite Rate
R	8/50.9 Coding for Adequacy of Dialysis, Vascular Access and Infection
R	25/75.3 Form Locators 31-41

**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: 1898	Date: January 29, 2010	Change Request: 6782
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**SUBJECT: Dialysis Adequacy, Infection and Vascular Access Reporting**

**Effective Date:** July 1, 2010

**Implementation Date:** July 6, 2010

## I. GENERAL INFORMATION

**A. Background:** Section 153c of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires CMS to implement a quality based payment program for dialysis services effective January 1, 2012. CMS currently collects two monthly measurements of quality of care via the ESRD claims submitted by dialysis providers: hemoglobin or hematocrit as a measure of anemia management and urea reduction ratio (URR) as a measure of hemodialysis adequacy.

The source data for the two current quality measures are collected on dialysis provider claims. The anemia management quality measure uses the most recent hemoglobin or hematocrit lab value, collected using value codes 48 or 49 on bill type 72x. The hemodialysis adequacy measure uses the current month's urea reduction ratio (URR) lab value, collected using HCPCS modifiers G1 through G6 on hemodialysis line items (revenue center 082x and HCPCS 90999).

These two quality measures meet the minimum requirements as mandated in MIPPA §153c; however, the URR measure of dialysis adequacy does not provide data for the entire ESRD dialysis population. Not having dialysis adequacy data for a segment of the dialysis population (peritoneal dialysis patients) is problematic in the development of a quality based payment program that will decrease provider payment by up to 2% based on quality outcome data because with the missing data CMS will not be able to assess all ESRD dialysis providers based on the same criteria.

MIPPA §153c also requires the use of quality measures endorsed by a consensus organization. CMS recently reexamined and received National Quality Forum (NQF) endorsement for the ESRD quality measures. Both CMS and NQF found that dialysis adequacy is best measured by Kt/V for both hemodialysis and peritoneal dialysis patients. The National Quality Forum granted time-limited endorsement of URR for hemodialysis patients and recommended that CMS drop it in favor of Kt/V as soon as possible. While dialysis adequacy is measured monthly for in-center hemodialysis patients, dialysis adequacy is measured less frequently for peritoneal dialysis patients (at least every four months). Therefore it is necessary to track both the date of the most recent measurement and the result of the most recent measurement.

Finally, MIPPA §153c provides for the use of additional quality measures for the quality based payment program as determined by the Secretary of Health and Human Services. Two additional quality measures could easily be collected using HCPCS modifiers for hemodialysis patients to record vascular access. The first measure is use of an arteriovenous fistula with two needles, which is recognized as the best vascular access because it is associated with the least infections. The second measure is the use of any vascular catheter, which is recognized as the worst vascular access because it is associated with the most infections. Collecting vascular access data will allow CMS to develop a more robust quality based payment program in order to implement national policy without additional data collection burden on dialysis providers, who are already required to collect these data under the Fistula First Initiative.

**B. Policy:** The CMS will require the reporting of the Kt/V reading and date of the reading, vascular access and infection data on ESRD claims with dates of service on or after July 1, 2010. This new data reporting requirement will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by MIPPA §153c. CMS is requesting a July 2010 implementation date because the quality incentive payment must be in part based on provider improvement over time, thus, CMS requires an accurate measurement of baseline provider performance. The CMS will require that providers continue to report the existing G1 through G6 modifiers for URR at this time.

**New quality data required on ALL ESRD claims with dates of service on or after July 1, 2010:**

Claim level codes:

- **Value code D5:** Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the claim date of service.
- **Occurrence code 51:** Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the claim date of service.

In the event that the provider has not performed the Kt/V test for the patient the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. The occurrence code date should not be reported on the claim in the case of no Kt/V reading being reported.

Line level codes to be reported on dialysis revenue code lines:

- **Modifier V8:** Infection present
- **Modifier V9:** No infection present

**New quality data required on ALL ESRD Hemodialysis claims with dates of service on or after July 1, 2010:**

Line level codes to be reported on hemodialysis revenue code lines:

**Vascular Access for ESRD Hemodialysis Patients** – An indicator of the type of vascular access used for the delivery of hemodialysis at the last hemodialysis session of the month. The code is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.

- **Modifier V5:** Vascular Catheter
- **Modifier V6:** Arteriovenous Graft
- **Modifier V7:** Arteriovenous Fistula

Note: The modifiers V5-V9 are effective January 1, 2010 and the Medicare Integrated Code Editor has been updated to allow the reporting of these codes for claims with dates of service on or after January 1, 2010. Therefore, providers may voluntarily report these modifiers for claims with dates of service January 1, 2010 through July 1, 2010.

## II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A / B  M A C	D M M A C	F I  I E R	C A R R I E R	R H H I	Shared-System Maintainers		
					F I S S	M C S	V M S	C W F	
6782.1	Medicare contractors shall accept new value code D5 and occurrence code 51 for claims with dates of service on or after July 1, 2010.					X			
6782.2	Medicare contractors shall allow the occurrence code 51 date to be prior to the from date of the claim and as late as the through date on the claim.	X		X		X			
6782.3	Medicare contractors shall return to the provider 72x bill types with dates of service on or after July 1, 2010 that do not contain a value code D5.	X		X		X			
6782.4	Medicare contractors shall return to the provider 72x bill types with dates of service on or after July 1, 2010 that do not contain the occurrence code 51 except those reporting a D5 value code with 9.99.	X		X		X			
6782.5	Medicare contractors shall return to the provider 72x bill types with dates of service on or after July 1, 2010 billing for hemodialysis when the latest line item date of service billing for revenue code 0821 does not contain one of the following modifiers: <ul style="list-style-type: none"> <li>• <b>Modifier V5:</b> Vascular Catheter</li> <li>• <b>Modifier V6:</b> Arteriovenous Graft</li> <li>• <b>Modifier V7:</b> Arteriovenous Fistula</li> </ul>	X		X		X			
6782.6	Medicare contractors shall return to the provider 72x bill types with dates of service on or after July 1, 2010 when one of the following modifiers is not present on each dialysis revenue code line (0821, 0831, 0841, 0851): <ul style="list-style-type: none"> <li>• <b>Modifier V8:</b> Infection present</li> <li>• <b>Modifier V9:</b> No infection present</li> </ul>	X		X		X			



## V. CONTACTS

**Pre-Implementation Contact(s):** Policy comments Tom Dudley 410-786-1442, Claims processing Wendy Tucker 410-786-3004

**Post-Implementation Contact(s):** Appropriate Regional Office

## VI. FUNDING

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

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

**Section B: For *Medicare Administrative Contractors (MACs)*:**

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

# Medicare Claims Processing Manual

## Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

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*(Rev. 1898, 01-29-10)*

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Crosswalk to Source Material

50.9 - Coding for Adequacy of *Dialysis, Vascular Access and Infection*

## **50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate**

*(Rev. 1898, Issued: 01-29-10; Effective Date: 07-01-10; Implementation Date: 07-06-10)*

The electronic form required for billing ESRD claims is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-04 (Form CMS-1450) hardcopy form. A table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25, §100.

### **Type of Bill**

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The “Through” date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or “new” bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect HICNs, duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.

**Statement Covers Period (From-Through)** - Hospital-based and independent renal dialysis facilities:

The beginning and ending service dates of the period included on this bill. Note: ESRD services are subject to the monthly billing requirements for repetitive services.

### **Condition Codes**

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

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

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 – **Information Only Bill**- Providers enter this code to indicate the patient is a member of a Medicare Advantage plan.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

### **Occurrence Codes and Dates**

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

*51 – Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis patients, this date may be before the current billing period but should be within 4 months of the claim date of service.*

### **Occurrence Span Code and Dates**

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Use of this code will not be necessary for ESRD claims with dates of service on or after April 1, 2007 due to the requirement of ESRD line item billing.

### **Document Control Number (DCN)**

Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the DCN of the claims to be adjusted.

### **Value Codes and Amounts**

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence.

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period With an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the hemoglobin reading taken before the last administration of Erythropoietin (EPO) during this billing cycle. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken before the start of the billing period.

49 - Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 49 is changed to indicate the patient's most recent hematocrit reading taken before the start of the billing period.

67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

Reporting value code 67 will not be required for claims with dates of service on or after April 1, 2007.

68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

Medicare no longer requires value code 68 for claims with dates of service on or after January 1, 2008.

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the FI and forwarded to CWF. (See [§120](#) for discussion of ESRD networks).

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. This height is as the patient presents.

*D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.*

## **Revenue Codes**

The revenue code for the appropriate treatment modality under the composite rate is billed (e.g., 0821 for hemodialysis). Services included in the composite rate and related charges must not be shown on the bill separately. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

082X - 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. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

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

083X - 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 instilling a special solution into the abdomen using the peritoneal membrane as a filter.

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

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

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 CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

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 CCPD/HOME/OTHER

088X – Miscellaneous Dialysis – Charges for Dialysis services not identified elsewhere.

0 - General Classification DAILY/MISC

1 – Ultrafiltration DAILY/ULTRAFILT

2 – Home dialysis aid visit HOME DIALYSIS AID VISIT

9 -Other misc Dialysis DAILY/MISC/OTHER

### **HCPCS/Rates**

All hemodialysis claims must include HCPCS 90999 on the line reporting revenue code 082x.

### ***Modifiers***

Modifiers are required *with* ESRD Billing for *reporting the* adequacy of *dialysis, presence of infection and the vascular access. For information on modifiers required for these quality measures see* 50.9 of this chapter.

For information on reporting the GS modifier for reporting a dosage reduction of epoetin alfa or darbepoetin alfa, see sections 60.4 and 60.7 of this chapter.

## **Service Date**

Report the line item date of service for each dialysis session and each separately payable item or service.

## **Service Units**

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered. For claims with dates of service on or after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

082X - (Hemodialysis) – Sessions

083X - (Peritoneal) – Sessions

084X - (CAPD) - Days covered by the bill

085X - (CCPD) - Days covered by the bill

Effective April 1, 2007, the implementation of ESRD line item billing requires that each dialysis session be billed on a separate line. As a result, claims with dates of service on or after April 1, 2007 should not report units greater than 1 for each dialysis revenue code line billed on the claim.

## **Total Charges**

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities must show their customary charges that correspond to the appropriate revenue code. They must not enter their composite or the EPO` rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see [§90.3](#) for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in as 0001 represents the total of all charges billed.

### **Principal Diagnosis Code**

Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease.

**NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

## **50.9 - Coding for Adequacy *of Dialysis, Vascular Access and Infection***

*(Rev. 1898, Issued: 01-29-10; Effective Date: 07-01-10; Implementation Date: 07-06-10)*

### **A. *Reporting the Urea Reduction Ratio(URR) for ESRD Hemodialysis Claims***

All hemodialysis claims must indicate the most recent Urea Reduction Ratio (URR) for the dialysis patient. Code all claims using HCPCS code 90999 along with the appropriate G modifier listed in section B.

Claims for dialysis treatments must include the adequacy of hemodialysis data as measured by URR. Dialysis facilities must monitor the adequacy of dialysis treatments monthly for facility patients. Home hemodialysis and peritoneal dialysis patients may be monitored less frequently, but not less than quarterly. If a home hemodialysis patient is not monitored during a month, the last, most recent URR for the dialysis patient must be reported.

HCPCS code 90999 (unlisted dialysis procedure, inpatient or outpatient) must be reported in field location 44 for all bill types 72X. The appropriate G-modifier in field location 44 (HCPCS/RATES) is used, for patients that received seven or more dialysis treatments in a month. Continue to report revenue codes 0820, 0821, 0825, and 0829 in field location 43.

G1 - Most recent URR of less than 60%

G2 - Most recent URR of 60% to 64.9%

G3 - Most recent URR of 65% to 69.9%

G4 - Most recent URR of 70% to 74.9%

G5 - Most recent URR of 75% or greater

For patients that have received dialysis 6 days or less in a month, facilities use the following modifier:

G6 - ESRD patient for whom less than seven dialysis sessions have been provided in a month.

For services beginning January 1, 2003, and after, if the modifier is not present, FIs must return the claim to the provider for the appropriate modifier. Effective April, 2007 due to the requirement of line item billing, at least one revenue code line for hemodialysis on the claim

must contain one of the URR modifiers shown above. The URR modifier is not required on every hemodialysis line on the claim.

The techniques to be used to draw the pre- and post-dialysis blood urea Nitrogen samples are listed in the National Kidney Foundation Dialysis Outcomes Quality Initiative Clinical Practice Guidelines for Hemodialysis Adequacy, Guideline 8, Acceptable Methods for BUN sampling, New York, National Kidney Foundation, 2000, pp.53-60.

### ***B. Reporting the Vascular Access for ESRD Hemodialysis Claims***

*ESRD claims for hemodialysis with dates of service on or after July 1, 2010 must indicate the type of vascular access used for the delivery of the hemodialysis at the last hemodialysis session of the month. One of the following codes is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.*

*Modifier V5: Vascular Catheter*

*Modifier V6: Arteriovenous Graft*

*Modifier V7: Arteriovenous Fistula*

### ***C. Reporting the Kt/V for ALL ESRD Claims***

*All ESRD claims with dates of service on or after July 1, 2010 must indicate the applicable Kt/V reading for the dialysis patient. The reading result and the date of the reading must be reported on the claim using the following claim codes:*

*Value Code D5 – Result of last Kt/V reading. For in-center hemodialysis patients this is the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis this may be before the current billing period but should be within 4 months of the claim date of service.*

*This code is effective and required on all ESRD claims with dates of service on or after July 1, 2010. In the event that no Kt/V reading was performed providers must report the D5 with a value of 9.99.*

*Occurrence Code 51 – Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients and home hemodialysis patients, this date may be before the current billing period but should be within 4 months of the claim date of service. This code is effective for ESRD claims with dates of service on or after July 1, 2010. If no Kt/V reading was performed do not report this code.*

### ***D. Reporting of Infection for ALL ESRD Claims***

*All ESRD claims with dates of service on or after July 1, 2010 must indicate on the claim if an infection was present at the time of treatment. Claims must report on each dialysis revenue code line one of the following codes:*

*Modifier V8: Infection present*

*Modifier V9: No infection present*

# Medicare Claims Processing Manual

## Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

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### 75.3 - Form Locators 31-41

*(Rev. 1898, Issued: 01-29-10; Effective Date: 07-01-10; Implementation Date: 07-06-10)*

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

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

#### GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

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

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

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

Code	Title	Definition
01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
02	No-Fault Insurance Involved -	Date of an accident, including auto or other,

<b>Code</b>	<b>Title</b>	<b>Definition</b>
	Including Auto Accident/Other	where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Date of an accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Date of an accident that relates to the patient's employment.
05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08		Reserved for national assignment.
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.
11	Onset of Symptoms/Illness	(Outpatient claims only.) Date that the patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual (CDI)	(HHA Claims Only.) The provider enters the date that the patient/beneficiary becomes a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under Respite Care Benefit.
13-15		Reserved for national assignment
16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical, occupational or

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

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

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

<b>Code</b>	<b>Title</b>	<b>Definition</b>
	Begins	For Medicare purposes, a beneficiary must have regular, coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making a cost outlier payment.
48-49	Payer Codes	For use by third party payers only. The CMS assigns for FI use. Providers do not report these codes.
50		Reserved for State Assignment.
<i>51</i>	<i>Date of Last Kt/V Reading</i>	<i>For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. Effective 7/1/2010.</i>
52-69		Reserved for State Assignment.
A1	Birth Date-Insured A	The birth-date of the insured in whose name the insurance is carried.
A2	Effective Date-Insured A Policy	The first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer A.
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as "Split Bill Date"). Effective 10/1/03.
A5-AZ		Reserved for national assignment
B1	Birth Date-Insured B	The birth-date of the individual in whose name the insurance is carried.
B2	Effective Date-Insured B Policy	The first date the insurance is in force.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer B.
B4-BZ		Reserved for national assignment
C1	Birth Date-Insured C	The birth-date of the individual in whose name the insurance is carried.
C2	Effective Date-Insured C Policy	The first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made by payer C.
C4-CZ		Reserved for National Assignment.
D0-DQ		Reserved for National Assignment.
DR		Reserved for Disaster Related Code
DS-DZ		Reserved for National Assignment
E0		Reserved for National Assignment
E1	Birth Date-Insured D	Discontinued 3/1/07.
E2	Effective Date-Insured D Policy	Discontinued 3/1/07.
E3	Benefits Exhausted	Discontinued 3/1/07.
E4-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Birth Date-Insured E	Discontinued 3/1/07.
F2	Effective Date-Insured E Policy	Discontinued 3/1/07.
F3	Benefits Exhausted	Discontinued 3/1/07.
F4-FZ		Reserved for national assignment

<b>Code</b>	<b>Title</b>	<b>Definition</b>
G0		Reserved for national assignment
G1	Birth Date-Insured F	Discontinued 3/1/07.
G2	Effective Date-Insured F Policy	Discontinued 3/1/07.
G3	Benefits Exhausted	Discontinued 3/1/07.
G4-LZ		Reserved for national assignment
M0-MQ		See instructions in FLs 35 and 36 – Occurrence Span Codes and Dates
MR		Reserved for Disaster Related Code
MS-ZZ		Reserved for national assignment

### **FLs 35 and 36 - Occurrence Span Code and Dates**

Required For Inpatient.

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

#### **Code Structure**

<b>Code</b>	<b>Title</b>	<b>Definition</b>
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) The From/Through dates for a hospital stay of at least 3 days that qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Non-utilization Dates (For Payer Use on Hospital Bills Only)	The From/Through dates during a PPS inlier stay for which the beneficiary has exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Hospital Prior Stay Dates	(Part A claims only.) The From/Through dates given by the patient of any hospital stay that ended within 60 days of this hospital or

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		SNF admission.
72	First/Last Visit	The actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.
74	Non-covered Level of Care	The From/Through dates for a period at a non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span codes 76, 77, or 79. Codes 76 and 77 apply to most non-covered care. Used for leave of absence, or for repetitive Part B services to show a period of inpatient hospital care or outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A, but not valid for HHA under PPS.
75	SNF Level of Care	The From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since QIOs no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLs 24-30). It is not applicable to swing-bed hospitals that transfer patients from the hospital to a SNF level of care.
76	Patient Liability	The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. Codes should be used only where the FI or the QIO has approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability- Utilization Charged	The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care). The beneficiary's record is charged with Part A days, Part A or Part B deductible and Part B coinsurance. The provider may collect the Part A or Part B deductible and coinsurance

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) The From/Through dates given to the hospital by the patient of any SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and, therefore, is not shown in FL 36.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
80	Prior Same-SNF Stay Dates for Payment Ban Purposes	The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.
M0	QIO/UR Stay Dates	If a code "C3" is in FL 24-30, the provider enters the From and Through dates of the approved billing period.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient stay

Code	Title	Definition
M5-ZZ		Reserved for National Assignment

**FL 37 - (Untitled)**

**Not used.** Data entered will be ignored.

**FL 38 - Responsible Party Name and Address**

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

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

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

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

Code	Title	Definition
01	Most Common Semi-Private Rate	To provide for the recording of hospital’s most common semi-private rate.
02	Hospital Has No Semi-Private Rooms	Entering this code requires \$0.00 amount.
03		Reserved for national assignment
04	Inpatient Professional Component Charges Which Are Combined Billed	The sum of the inpatient professional component charges that are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. <b>(Used only by some all-inclusive rate hospitals.)</b>

<b>Code</b>	<b>Title</b>	<b>Definition</b>
05	Professional Component Included in Charges and Also Billed Separately to Carrier	<p>(Applies to Part B bills only.) Indicates that the charges shown are included in billed charges FL 47, but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the carrier processes the bill for physician's services. These charges are also deducted when computing interim payment.</p> <p>The hospital uses this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.</p>
06	Medicare Part A and Part B Blood Deductible	<p>The product of the number of un-replaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each un-replaced pint furnished.</p> <p>If all deductible pints have been replaced, this code is not to be used.</p> <p>When the hospital gives a discount for un-replaced deductible blood, it shows charges after the discount is applied.</p>
07		Reserved for National Assignment
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	<p>The product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission.</p>
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	<p>The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. The provider may not use this code on Part B bills.</p> <p>For Part B coinsurance use value codes A2, B2 and C2.</p>
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing	<p>The product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. The</p>

<b>Code</b>	<b>Title</b>	<b>Definition</b>
	Period	provider uses this code only on bills spanning 2 calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	The product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. The provider uses this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. It may not use this code on Part B bills.
12	Working Aged Beneficiary Spouse With an EGHP	That portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field to claim a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	That portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the EGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
14	No-Fault, Including Auto/Other Insurance	That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. If it received no payment or a reduced no-fault payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
15	Worker's Compensation (WC)	That portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that

Code	Title	Definition
		<p>the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.</p>
16	PHS, Other Federal Agency	<p>That portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges.</p> <p><b>NOTE:</b> A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).</p>
17	Operating Outlier Amount	<p>(Not reported by providers.) The FI reports the amount of operating outlier payment made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.</p>
18	Operating Disproportionate Share Amount	<p>(Not reported by providers.) The FI reports the operating disproportionate share amount applicable. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital DSH adjustment in this entry.</p>
19	Operating Indirect Medical Education Amount	<p>(Not reported by providers.) The FI reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.</p>
20	Payer Code	<p>(For internal use by third party payers only.)</p>
21	Catastrophic	<p>Medicaid-eligibility requirements to be determined at State level.</p>
22	Surplus	<p>Medicaid-eligibility requirements to be determined at State level.</p>
23	Recurring Monthly Income	<p>Medicaid-eligibility requirements to be determined at</p>

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		State level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at State level.
25	Offset to the Patient-Payment Amount – Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount – Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount – Vision and Eye Services	Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount – Dental Services	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount – Chiropractic Services	Chiropractic Services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
31	Patient Liability Amount	The FI approved the provider charging the beneficiary the amount shown for non-covered accommodations, diagnostic procedures, or treatments.
32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount – Podiatric Services	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount – Other Medical Services	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount – Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36		Reserved for national assignment.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
37	Units of Blood Furnished	The total number of units of whole blood or packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete units rounded upwards, e.g., 1 1/4 units is shown as 2. This entry serves as a basis for counting units towards the blood deductible.
38	Blood Deductible Units	The number of unreplaced deductible units of blood furnished for which the patient is responsible. If all deductible units furnished have been replaced, no entry is made.
39	Units of Blood Replaced	The total number of units of blood that were donated on the patient's behalf. Where one unit is donated, one unit is considered replaced. If arrangements have been made for replacement, units are shown as replaced. Where the hospital charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for un-replaced units), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039X revenue code series (blood administration) or under the 030X revenue code series (laboratory).
40	New Coverage Not Implemented by Managed Care Plan	(For inpatient service only.) Inpatient charges covered by the Managed Care Plan. (The hospital uses this code when the bill includes inpatient charges for newly covered services that are not paid by the Managed Care Plan. It must also report condition codes 04 and 78.)
41	Black Lung (BL)	That portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in its payment. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
42	Veterans Affairs (VA)	That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		applying to Medicare charges on this bill.
43	Disabled Beneficiary Under Age 65 With LGHP	That portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that it is applying to covered Medicare charges on this bill. The provider enters six zeros (0000.00) in the amount field, if it is claiming a conditional payment because the LGHP has denied coverage. Where it received no payment or a reduced payment because of failure to file a proper claim, it enters the amount that would have been payable had it filed a proper claim.
44	Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received	That portion that the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due.
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, indicating that the QIO has denied all or a portion of this billing period, the provider shows the number of days determined by the QIO to be covered while arrangements are made for the patient's post discharge. The field contains one numeric digit.
47	Any Liability Insurance	That portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. It enters six zeros (0000.00) in the amount field if it is claiming a conditional payment because there has been a substantial delay in the other payer's payment.
48	Hemoglobin Reading	The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.

<b>Code</b>	<b>Title</b>	<b>Definition</b>
49	Hematocrit Reading	The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers (i.e. two digits) are to be right justified to the left of the dollar/cents delimiter. Decimals (i.e. one digit) are to be reported to the right.
50	Physical Therapy Visits	The number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	The number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	The number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	The number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.
54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type f admission of 4 and on other claims as required by State law.
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse – Home Visit Hours (HHA only)	The number of hours of skilled nursing provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (Rounded to the nearest whole hour.)
57	Home Health Aide – Home Visit Hours (HHA only)	The number of hours of home health aide services provided during the billing period. The provider counts only hours spent in the home. It excludes travel time. It reports in whole hours, right justified to the left of the dollars/cents delimiter. (The number is rounded to the nearest whole hour.)

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

					1	3		
--	--	--	--	--	---	---	--	--

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

- |    |                                     |                                                                                                                                                                                                                                                                                                                 |
|----|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 58 | Arterial Blood Gas (PO2/PA2)        | Indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. The provider reports right justified in the cents area. (See note following code 59 for an example.) |
| 59 | Oxygen Saturation (O2 Sat/Oximetry) | Indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill. The hospital reports right justified in the cents area. (See note following this code for an example.)      |

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

						5	7
--	--	--	--	--	--	---	---

A reading of 100 percent is shown as:

						1	0	0
--	--	--	--	--	--	---	---	---

Code	Title	Definition
60	HHA Branch MSA	The MSA in which HHA branch is located. (The HHA reports the MSA when its branch location is different than the HHA's main location – It reports the MSA number in dollar portion of the form locator, right justified to the left of the dollar/cents delimiter.)

<b>Code</b>	<b>Title</b>	<b>Definition</b>
61	Place of Residence Where Service is Furnished (HHA and Hospice)	<p>MSA number or Core Based Statistical Area (CBSA) number (or rural State code) of the place of residence where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.</p> <p>For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.</p>
62	HH Visits – Part A (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by <a href="#">§1812(a)(3)</a> of the Social Security Act.
63	HH Visits – Part B (Internal Payer Use Only)	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
64	HH Reimbursement – Part A (Internal Payer Use Only)	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
65	HH Reimbursement – Part B (Internal Payer Use Only)	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
66	Medicare Spend-down Amount	The dollar amount that was used to meet the recipient's spend-down liability for this claim.
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. The

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		provider counts only the hours spent in the home, excluding travel time. It reports in whole hours, right justifying to the left of the dollar/cent delimiter. (Rounded to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Indicates the number of units of EPO administered and/or supplied relating to the billing period. The provider reports in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

	3	1	0	6	0		
--	---	---	---	---	---	--	--

<b>Code</b>	<b>Title</b>	<b>Definition</b>
69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.
71	Funding of ESRD Networks	(For third party payer use only.) The FI reports the amount the Medicare payment was reduced to help fund ESRD networks.
72	Flat Rate Surgery Charge	(For third party payer use only.) The standard charge for outpatient surgery where the provider has such a charging structure.
73-75	Payer Codes	(For use by third party payers only.)
76	Provider's Interim Rate	(For third party payer internal use only.) Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled

<b>Code</b>	<b>Title</b>	<b>Definition</b>
69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.
70	Interest Amount	(For use by third party payers only.) The contractor reports the amount of interest applied to this Medicare claim.  nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0
--	--	--	--	--	---	---	---	---

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

<b>Code</b>	<b>Title</b>	<b>Definition</b>
		inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
84-99		Reserved for national assignment.
A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer.  For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.
A3	Estimated Responsibility Payer A	Amount the provider estimates will be paid by the indicated payer.
A4	Covered Self-Administrable Drugs – Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma. For use with Revenue Code 0637. See The Medicare Benefit Policy Manual).
A5	Covered Self-Administrable Drugs – Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-Administrable Drugs	The amount included in covered charges

<b>Code</b>	<b>Title</b>	<b>Definition</b>
	– Diagnostic Study and Other	for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54. (Effective 1/01/05)
A9	Patient Height	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height. (Effective 1/01/05)
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/2003
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/2003
AC-B0		Reserved for national assignment.
B1	Deductible Payer B	The amount the provider assumes will be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.

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

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

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

<b>Code</b>	<b>Title</b>	<b>Definition</b>
Y5-ZZ		outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.  Reserved for national assignment