CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Direct Data Entry (DDE) User's Manual
for Medicare Part A

Palmetto GBA℠
PARTNERS IN EXCELLENCE℠

A CMS Contracted Intermediary and Carrier

February 2008

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION 1

Provider Contact Center Numbers 1
Keyboard....1
Keyboard Function Keys 2
Status/Location Codes 3
Document Control Number (DCN) 4

SECTION 2 – CONNECTION INSTRUCTIONS 5

Connection Procedures 5
North Carolina Sign-on....6
Gulf Coast/Midwest Sign-On 8
Southeast/Southwest Sign-On....8
Sign-Off Procedures....9
North Carolina Sign-Off 10
Gulf Coast/Midwest Sign-Off....10
Southeast/Southwest Sign-Off....10
Changing Passwords 10
South Carolina & RHHI Providers 10
North Carolina Providers Only 10

SECTION 3 – MAIN MENU 12

SECTION 4 – CLAIM INQUIRY 13

Beneficiary/CWF 13
Beneficiary/CWF Screens....14
DRG (Pricer/Grouper) 29
DRG/PPS Inquiry Screen....29
Claims Summary Inquiry....35
Claims Summary Inquiry Screen 36
Performing Claims Inquiries....39
Viewing an Additional Development Request (ADR) Letter 39
Revenue Codes....39
Revenue Code Table Inquiry Screen 40
Claims Count Summary....41
Claim Summary Totals Inquiry Screen....41
Check History Inquiry....42
Check History Screen 43
HCPC Inquiry 43
HCPC Inquiry Screen 44
Diagnosis & Procedure Code Inquiry 46
ICD-9-CM Code Inquiry Screen....47
Adjustment Reason Code Inquiry....47
Adjustment Reason Codes Inquiry Selection Screen....48
FISS Reason Codes Inquiry....49
Reason Codes Inquiry Screen 49

ANSI Reason Code Inquiry 51
ANSI Reason Code Narrative 52

SECTION 5 – CLAIM ENTRY 54

General Information 54
Transmitting Data 54
Electronic UB-04 Claim Entry 55
UB-04 Claim Entry – Page 1 55
UB-04 Claim Entry – Page 2 59
UB-04 Claim Entry – Page 2, Line Level Reimbursement (MAP171A) 61
UB-04 Claim Entry – Page 2 (MAP171D) 67
UB-04 Claim Entry – Page 3 76
UB-04 Claim Entry – Page 4 80
UB-04 Claim Entry – Page 5 82
UB-04 Claim Entry – Page 6 83
Roster Bill Entry 85
ESRD CMS-382 Form 87

SECTION 6 – CLAIM CORRECTION 91

Online Claims Correction 91
Claim Summary Inquiry 92
Claims Correction Processing Tips 93
Correcting Revenue Code Lines 93
RTP Selection Process 94
Suppressing RTP Claims 95
Claims Sort Option 96
Claims and Attachments Corrections 96
Adjustments 96
Claim Voids/Cancels 97
Valid Claim Change Condition Codes 98

SECTION 7 – ONLINE REPORTS 99

050 Report – Claims Returned to Provider 101
201 Report – Pended, Processed and Returned Claims 102
316 – Errors on Initial Bills 105

SECTION 8 – HEALTH INSURANCE QUERY ACCESS 108

Part A CWF Send Process 108
Part A Response Process 108
CWF Host Sites 109
HIQA Inquiry Screen 109
HIQA Page 1 110
HIQA Page 2 112
HIQA Page 3 114
HIQA Page 4 115
HIQA Page 5 116
HIQA Page 6 117

SECTION 9 – HEALTH INSURANCE QUERY FOR HHA 118

Part A CWF Send Process 118
Part A Response Process....118
CWF Host Sites....119
HIQH Inquiry Screen....120
HIQH Page 1....121
HIQH Page 2....122
HIQH Page 3....123
HIQH Page 4....124
HIQH Page 5....125
HIQH Page 6 & Page 7....126

APPENDIX – ACRONYMS 127

The information provided in this manual was current as of February 2008. Any changes or new information superseding the information in this manual are provided in the Medicare Part A Bulletins/Advisories with publication dates after February 2008. Medicare Part A Bulletins/Advisories are available at www.PalmettoGBA.com

SECTION 1 – INTRODUCTION

Direct Data Entry (DDE) Online Remote Terminal Access was designed as an integral part of the Fiscal Intermediary Standard System (FISS). It gives Medicare providers direct access to information on their claims. The FISS is a menu driven system. The menu item chosen determines the system's functional capability. The Main Menu includes the following sub-menus: Inquiry, Claim Entry and Attachment, and Claim Correction. A DDE Medicare provider may perform the following functions electronically:

- Type and send UB-04 claims
- Correct, adjust, and cancel claims
- Inquire about patients' eligibility
- Access the Revenue Code, HCPCS Code, and ICD-9 Code inquiry tables
- Access the Reason Code and Adjustment Reason Code inquiry tables
- Determine DRG for Inpatient Hospital Claims

Provider Contact Center Numbers

Please check this user's manual for answers to your question before you contact Customer Support. The guidelines in the manual may answer your question and eliminate the need for you to contact a Customer Support Representative. For questions and information not covered in this manual, please refer to the following phone numbers:

NC & SC Part A Providers.....1-877-567-9249

All RHHI.....1-866-801-5301

Keyboard

The following table provides an overview of common keyboard commands and their respective functions, and language related to navigating the DDE system.

Command/Term	Function
Cursor	The cursor is the flashing underline that identifies where you are (in what field you are located) on the screen.
↑ ← ↓ →	Use the keyboard arrow keys to move one character at a time in any direction within a field.
[TAB]	Press the tab key to advance to the next field.
[SHIFT]-[TAB]	Press and hold down the SHIFT key, while you press the TAB key to move back to the previous field. When your cursor is in the top field, this [SHIFT]-[TAB] will move your cursor to the bottom field.
n	In examples shown in this manual, an "n" indicates a variable number from 0 to 9. One or more numbers may show as variables. For example, "72n" represents the numbers 720-729, while "72nnn" represents the numbers 72000-72999.
[CTRL]-[R]	If your screen "freezes" or "locks up," press and hold down the Control key, while you press the letter "R." This will reset the screen. Note: Do not use this key combination if you see the clock symbol "(X)" displayed at the bottom of the screen (see next term).
(X) 	One of these symbols displays at the bottom of the screen when the system is processing your request. Do not press any key until the symbol goes away and the blinking cursor returns.
[END]	Press the [END] key to clear, or delete, the value in a field. Do not use the spacebar to clear a field, as spaces may be recognized as a character in FISS

Keyboard Function Keys

The keyboard function keys (also referred to as Program Function keys), are used to initiate the functions as specified in the following table. Your keyboard may identify these keys as [PF1], [PF2], [PF3], etc. or as [F1], [F2], [F3], etc.

Function Key	Function
[F1]	**The FISS Help Function –** Press [F1] to obtain a description of a reason code.
[F2]	**Revenue Code Jump –** From claim page 3 (MAP1033), press [F2] to jump to MAP171D for the first Revenue Code in error. Also, if your cursor is placed on a specific Revenue Code line on page 3, press [F2] to jump to the same Revenue Code on MAP171D.
[F3]	**Exiting a Menu or Submenu –** Depending on the location of the cursor in the system, press [F3] to exit a menu/submenu and return to the previous screen.
[F4]	**Exiting the System –** Pressing [F4] exits the entire system or terminates the session. After pressing [F4], type "CSSF LOGOFF" and then press [ENTER] to complete the exit process.
[F5]	**Scrolling Backwards in a Screen Page –** Not all information on a page may be seen on the screen at one time. To review hidden data from the same screen page, press [F5] to scroll backwards.
[F6]	**Scrolling Forward in a Screen Page –** To view hidden data from the same screen page, press [F6] to scroll forward.
[F7]	**View Previous Page –** Press [F7] to review a previous page or move backward one page at a time.
[F8]	**Page Forward –** Press [F8] to view the next page or to move forward one page at a time.
[F9]	**Updating Data –** Due to the system's design, a claim will not be accepted until either all front-end edits are corrected or the system is instructed to reject or return the claim. By pressing [F9], the system will return claim errors for correction and update and store data entered while in the entry or correction transaction mode.
[F10]	**Screen Left –** Moves left to columns 1-80 within a claim record. This also allows access to the last page of beneficiary history when in claim summary by HIC.
[F11]	**Screen Right –** Moves right to columns 81-132.

Status/Location Codes

The Status/Location (S/LOC) code for Medicare DDE screens indicates whether a particular claim is paid, suspended, rejected, returned for correction, etc. The six-character alphanumeric code is made up of a combination of four sub-codes: the claim status, processing type, location, and additional location information. Each S/LOC code is made up of two alpha characters followed by four numeric characters. For example, P B9997 is a status location code.

- The first position (position a) is the claim's current status. In this example "P" indicates that the claim has been *paid* (or *partially paid*).
- The second position (position b) is the claim processing type. In the example, "B" indicates *batch*.
- The third and fourth positions (positions cc) are the location of the claim in FISS. In the example, "99" indicates that the *session terminated*.
- The last two positions (positions dd) are for additional location information. In the example, "97" indicates that the provider's claim is *final on-line*.

A provider may perform certain transactions when there is a specific S/LOC code on the claim. Other transactions cannot be done at all with certain S/LOC codes. The following table provides descriptions of the S/LOC code components.

FISS S/LOC Codes			
Status (Position a)	**Processing Type (Position b)**	**Driver Location (Positions cc)**	**Location (Positions dd)**
A = Good I = Inactive S = Suspense M = Manual Move P = Paid/Partial Pay R = Reject D = Deny T = RTP U = Ret to PRO	M = Manual O = On-line B = Batch	01 = Status/Location 02 = Control 04 = UB-04 Data 05 = Consistency (I) 06 = Consistency (II) 15 = Administrative 25 = Duplicate 30 = Entitlement 35 = Lab/HCPC 40 = ESRD 50 = Medical Policy 55 = Utilization 60 = ADR 63 = HHPPS Pricer 65 = PPS/Pricer 70 = Payment 75 = Post Pay 80 = MSP Primary 85 = MSP Secondary 90 = CWF 99 = Session Term AA-ZZ = User defined	00 = Batch Process 01 = Common 02 = Adj. Orbit 10 = Inpatient 11 = Outpatient 12 = Special Claims 13 = Medical Review 14 = Program Integrity 16 = MSP 18 = Prod. QC 19 = System Research 21 = Waiver 65 = Non DDE Pacemaker 66 = DDE Pacemaker 67 = DDE Home Health 96 = Payment Floor 97 = Final Online 98 = Final Off-line 99 = Final Purged/ Awaiting CWF Response 22-64 = User defined 68-79 = User defined AA-ZZ = User defined

Document Control Number (DCN)

The DCN number is located on the remittance advice. This number must be used with adjustment/ cancellation bills.

Field Position	Field	Definition
1 - 1	Plan Code	Code used to differentiate between plans that share a processing site. This code will always be a "1."
1 - 1	Century Code	Code used to indicate the century in which the DCN was established. Valid values include: 1 = 1900-1999 2 = 2000 +
2 - 3	Year	The last two digits of the year during which the claim was entered. This is system generated.
4 - 6	Julian Date	Julian days corresponding to the calendar entry date of the claim. This is system generated.
7 - 10	Batch Sequence	Primary sequencing field, beginning with 0000 and ending with 9999. This is system generated with automated DCN assignment.
11 - 12	Claim Sequence	Secondary sequencing field, beginning with 00 and ending with 99.
13	Split/Demo Indicator	Site-specific field used on split bills. Valid values include: C = Medicare Choices Claim E = ESRD Managed Care V = VA Demo P = Encounter Claim 0 = When not used at a site
14	Origin	Code designating method of claim entry into the system. Valid values are: 0 = Unknown 1 = EMC/UB-04/CMS Format 2 = EMC Tape/UB-04/Other Format 3 = EMC Tape/Other ("Other" is defined as PRO Automated Adjustment for FISS) 4 = EMC Telecom/UB-04 (DDE Claim) 5 = EMC Telecom/Not UB-04 6 = Other EMC/UB-04 7 = Other EMC/Not UB-04 8 = UB-04 Hardcopy 9 = Other Hardcopy
15 - 21	Reserved	Used in the Home Health A/B shift automated adjustment. Valid valued include: H = (in first position) System generated Trailer 16 adjustment P = (in second position) System generated Trailer 15 adjustment Blank = Reserved for future use
22 - 23	Site Code	When "Use Site Processing" on the Site Control is set to "Y," these positions coincide with the value indicated in the "Site" field on the Operator Control File.

SECTION 2 – CONNECTION INSTRUCTIONS

Palmetto GBA uses AT&T Passport software through IVANS network services to establish the connection between the provider and Palmetto GBA. You must first connect to IVANS before selecting DDE functions.

Palmetto GBA's Part A and RHHI contracts are divided into three claims processing regions. The three regions are:

1. **North Carolina Region** – The NC Region is for NC Part A transactions only. Note that RHHI for NC is included in the Southeast Region.
2. **Gulf Coast & Midwest Region** - The Gulf Coast/Midwest Regions consists of the following states for RHHI transactions:

Gulf Coast	Midwest
Alabama	Illinois
Florida	Indiana
Georgia	Ohio
Mississippi	

3. **Southeast/Southwest Region (including South Carolina Part A)**- The Southeast/Southwest Region consists of the following states:

Southeast	Southwest
Kentucky	Arkansas
North Carolina – RHHI only	Louisiana
South Carolina – both Part A & RHHI	New Mexico
Tennessee	Oklahoma
	Texas

Connection Procedures

1. Ensure that your modem and telephone line are properly connected.
2. Double-click on the **AT&T Global Network Client** shortcut icon on your desktop. If you are unable to locate the AT&T Global Network Client icon, you can select **Start** from the Windows Taskbar, **Programs**, **AT&T Global Network Client**, and then **AT&T Global Network Client.**
3. The AT&T Global Network Client will open and is ready for your password. Verify your Login Profile, enter your initial password, and then click "connect". The About window will close. From the Passport - A toolbar, pull down the **Terminal** menu and click "**Connect**."
4. Once you are connected, the AT&T Global Network Client connection status window will display. Note: You may minimize this window, but do not close it until you are ready to disconnect.
5. After connecting to the AT&T Global Network Client, click on the Passport IP icon from your desktop. If you are unable to locate the Passport IP icon, you can select Start from the Windows Task BAR, and select Programs, AT&T Passport for Windows, and Passport IP.
6. From the Passport IP Communications Window, choose Terminal from the Main menu and then Connect.
7. Once you have a connection established to AT&T through Passport IP, the Product Selection Screen will display.

NORTH CAROLINA SIGN-ON

A. At the **PRODUCT SELECTION** screen, your cursor will be positioned at the arrow (===>) in the lower left hand corner. Select the number corresponding to **A3PTPX** and press **ENTER**.

B. The TPX Sign-On screen (Figure 1) will display. NC Providers follow instruction steps 8 – 12 then proceed to step 15.

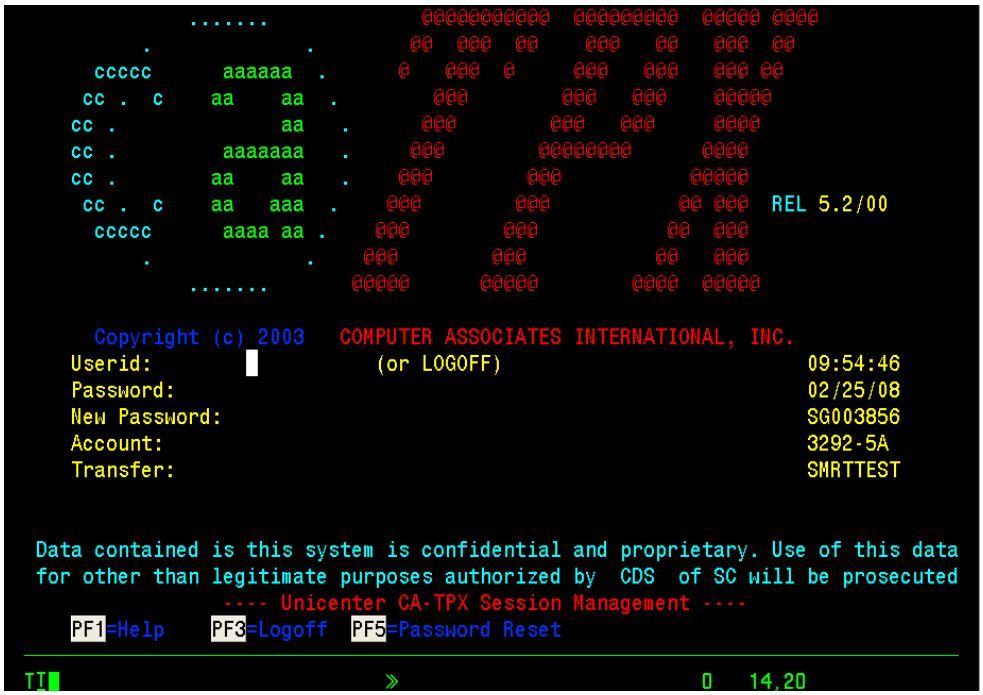


Figure 1 – CICS SignOn Screen

8. At the USERID prompt, type your DDE User ID and press [TAB]. DDE User ID numbers are assigned to individuals at each facility who utilize the DDE system.

9. At the PASSWORD prompt, type in your password and then press [ENTER].

If this is your first time logging on using your new DDE User ID, use the default password that was included in your EDI confirmation.

As you enter your default password, nothing will show on the screen but you will see the cursor move to the right. After you press <ENTER>, the system will prompt you to change the password. Follow the directions noted on the screen regarding password requirements when changing your password.

Note: Your password will expire every 30 days and you must make at least 12 password changes before you can repeat a previously used password. If you receive a notice that your password has "expired," please follow the directions noted on the screen when changing your password. If you receive a notice that your password has been "revoked," please refer to the **Changing Passwords (North Carolina Providers)** section. If you have not used DDE for several months, it may be automatically revoked and please contact the Palmetto GBA EDI Technology Support Center toll-free at 1-866-749-4301 for assistance.

10. After you correctly enter your User ID and password, the TPX Menu Screen (Figure 2) will display.

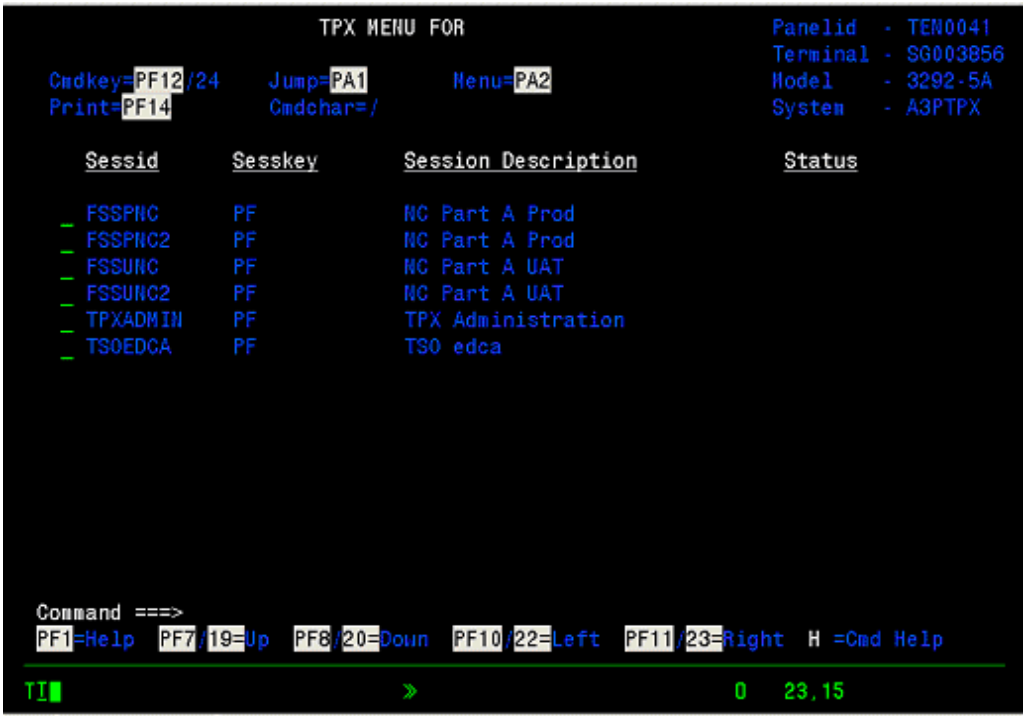


Figure 2 – TPX Menu Screen

11. Select the NC Part A Prod Session from the menu with an S indicator on the line and Press [Enter].

12. After your selection from the TPX menu, the Companion Data Services Sign-On Screen (Figure 3) will display. At the USERID Prompt, type the same DDE User ID and password used previously on the TPX Sign-On Screen.

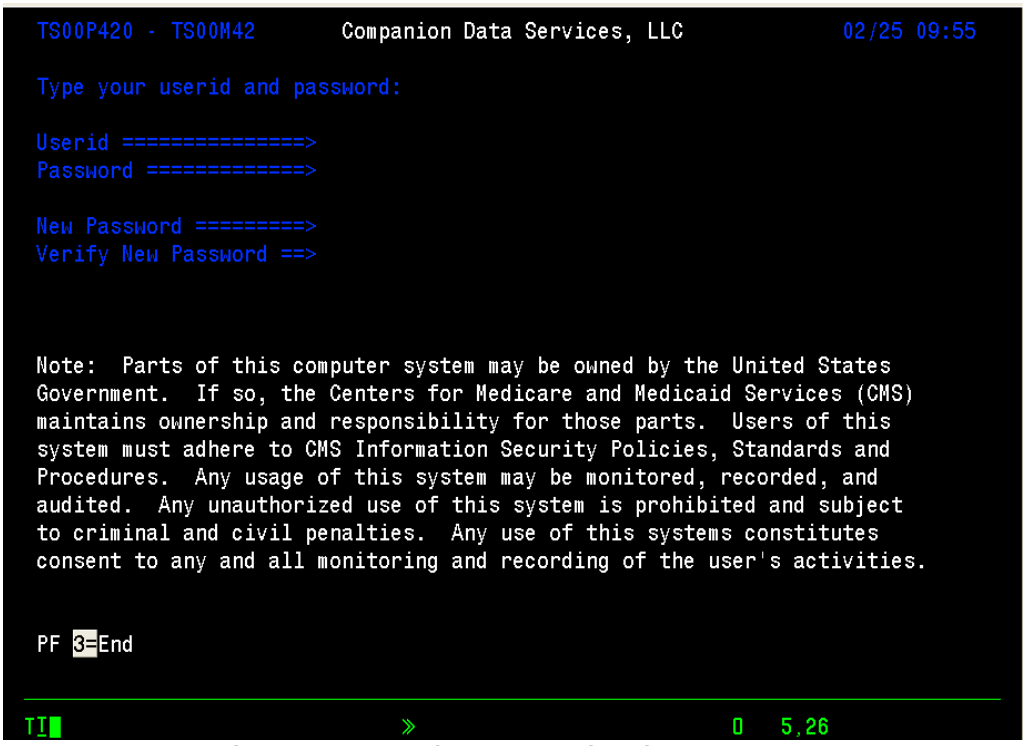


Figure 3 – Companion Data Service Sign-On Screen

GULF COAST/MIDWEST SIGN-ON

A. At the PRODUCT SELECTION screen, your cursor will be positioned at the ===> in the lower left hand corner of the screen. Type the number corresponding to option GCDDE and press [ENTER].

B. Press [ESC] or [Scroll Lock] to clear the screen.

C. On the blank screen, type "CSSN" and press [ENTER].

D. The Sign-On screen (Figure 4) will display.

SOUTHEAST/SOUTHWEST SIGN-ON

A. At the PRODUCT SELECTION screen, your cursor will be positioned at the ===> in the lower left hand corner of the screen. Select the number corresponding to option CARESC and press [ENTER].

B. Press [ESC] or [Scroll Lock] to clear the screen.

C. On the blank screen, type "CSSN" and press [ENTER].

D. The Sign-On screen (Figure 4) will display.

Figure 4-The Sign-On Screen

13. At the USERID prompt, type your DDE User ID and press [TAB]. DDE User ID numbers are assigned to individuals at each facility who utilize the DDE system.

14. At the PASSWORD prompt, type in your password and then press [ENTER].

If this is your first time logging on using your new DDE User ID, use the default password that was included in your EDI confirmation.

As you enter your default password, nothing will show on the screen but you will see the cursor move to the right. After you press <ENTER>, the system will prompt you to change the password. Follow the directions noted on the screen regarding password requirements when changing your password.

Note: Your password will expire every 30 days and you must make at least 12 password changes before you can repeat a previously used password. If you receive a notice that your password has "expired," please follow the directions noted on the screen when changing your password. If you receive a notice that your password has been "revoked," please call the Palmetto GBA EDI Technology Support Center toll-free at 1-866-749-4301. If you have not used DDE for several months, it may be automatically revoked.
Instructions listed below are for all providers (North Carolina, Gulf Coast/Midwest and Southeast/Southwest):

15. Type FSS0 (F, S, S, zero) directly over the screen message and press [ENTER].

Note: You must type a *numeric zero* when typing in **FSS0**. If you accidentally type an alpha 'O', the system will give you an error message.

16. The Main Menu (Figure 5) will display. From the Main Menu, you may select the function you wish to perform on the DDE system. Refer to the appropriate section of this manual for the function you wish to use.

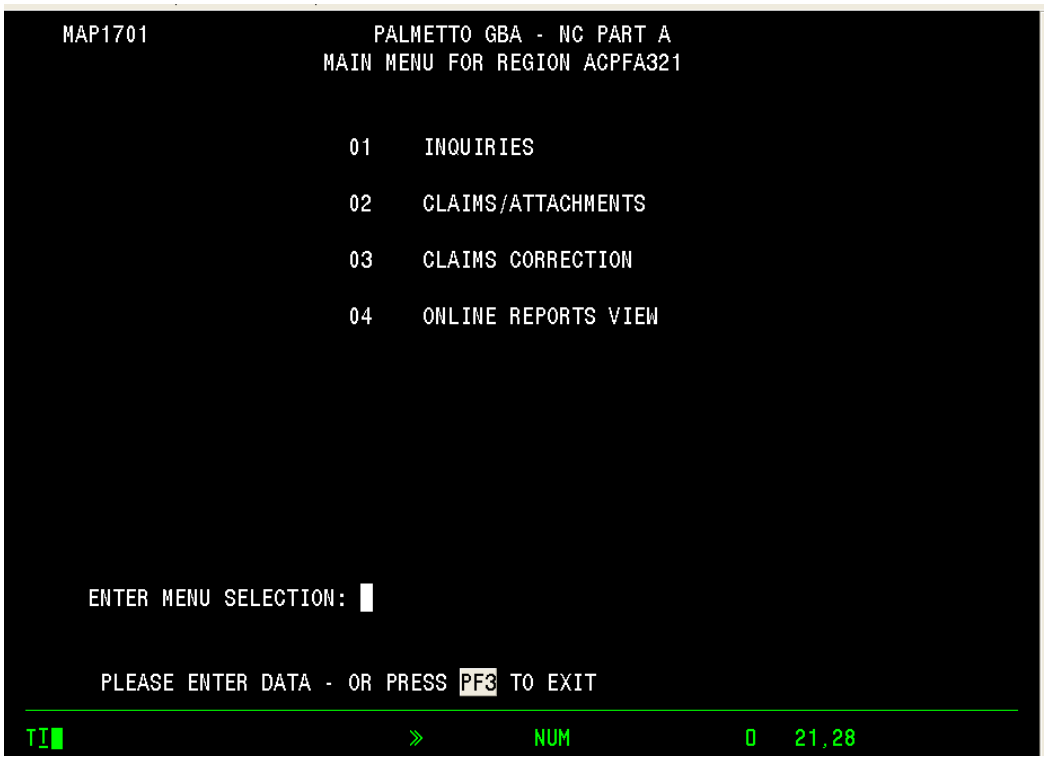


Figure 5 – The Main Menu

Sign-Off Procedures

To end communication between your terminal and Palmetto GBA's host system (FISS), you must sign off. The terminal will sign off automatically when the network is disabled.

To help the computer function at optimum speed, always sign off completely and correctly when you are not using the system.

1. Press **[F3]** from the Main Menu.

2. The screen will display "SESSION SUCCESSFULLY TERMINATED."

NORTH CAROLINA SIGN-OFF

A. Type "**CESF LOGOFF**" over the message and press **[ENTER]**.

B. Type **/K** to sign-off from the TPX Menu Screen and press **[ENTER**].

GULF COAST/MIDWEST SIGN-OFF

Type "**CSSF LOGOFF**" over the message and press **[ENTER]**.

SOUTHEAST/SOUTHWEST SIGN-OFF

Type "**CSSF LOGOFF**" over the message and press **[ENTER]**.

3. Pull down the **Terminal** menu from the toolbar and select **Disconnect**.
4. Pull down the **Terminal** menu again and select **Close**.

Changing Passwords

SOUTH CAROLINA & RHHI PROVIDERS

Your password will expire every thirty days. On the day after it expires, when you type your password, the system will automatically prompt you to change your password. Rules for passwords will display on the system when you change your password.

To change your password, follow these steps:

1. When you log on for the first time or after your password has expired, you will enter your user ID and your existing (or default) password. After pressing the **[ENTER]** key, the system will display the message, "Your password has expired. Please enter your new password." The screen will now contain two "New Password" fields.
2. Your cursor will be located in the first "New Password" field. Type in your new password. Nothing will show on the screen as you type but you will see the cursor move to the right. After you have finished typing, press **[TAB]**.
3. Verify your new password by typing it identically again and press **[ENTER]**.
4. The system displays the message "SIGNON IS COMPLETE."
5. Type **FSS0** (F, S, S, zero) and press **[ENTER]**. The Main Menu displays.

Note: If you receive a notice that your password has been "revoked," please call the Palmetto GBA EDI Technology Support Center toll-free at 1-866-749-4301. If you have not used DDE for several months, it may be automatically revoked.

NORTH CAROLINA PROVIDERS ONLY

Your password will expire every thirty days. On the day after it expires, when you type your password, the system will automatically prompt you to change your password. Rules for passwords will display on the system when you change your password.

To change your password, follow these steps:

1. When you log on for the first time or after your password has expired, you will enter your user ID and your existing (or default) password. After pressing the [ENTER] key, the system will display the message, "Your password has expired. Please enter your new password." The screen will now contain one "New Password" field.

2. Your cursor will be located in the "New Password" field. Type in your new password. Nothing will show on the screen as you type but you will see the cursor move to the right. After you have finished typing, press [ENTER].
3. Verify your new password by typing it identically again in the same "New Password" field and press [ENTER].
4. The system displays the TPX Menu Screen. Follow via the instructions in Section 2 – Connection Instructions above to complete your sign-on.

Note: If you receive a notice that your password has been "revoked," a password utility has been provided for your own password resets. Follow the instructions listed below:

1. Proceed to the CDS EDC TPX session screen.
2. Press the PF5 key as shown on the menu at the bottom of screen. The Self-Service Password Reset screen appears and prompts you to key in a valid RACF ID and PIN.
3. Press ENTER.
4. A message will appear at the bottom of screen providing the new temporary password. Press PF12 to return to the TPX sign on screen.

   Once returned to the TPX session sign-on screen, you can now sign-on using the new temporary password.

   - The password length must be eight (8) characters.
   - Passwords must have at least one (1) of these special characters: @, # or $.
   - Passwords must start with a letter and must have at least one (1) number and one (1) letter (not a number of special character).

NOTE: A password can only be reset by the user with this process once in a 24-hour period.

SECTION 3 – MAIN MENU

The DDE Online system includes the Main Menu (Figure 6) that displays after completing the logon procedure. Each menu option from the Main Menu displays a sub-menu for that option. **Note:** Palmetto GBA does not utilize Main Menu Option 04, Online Reports View.

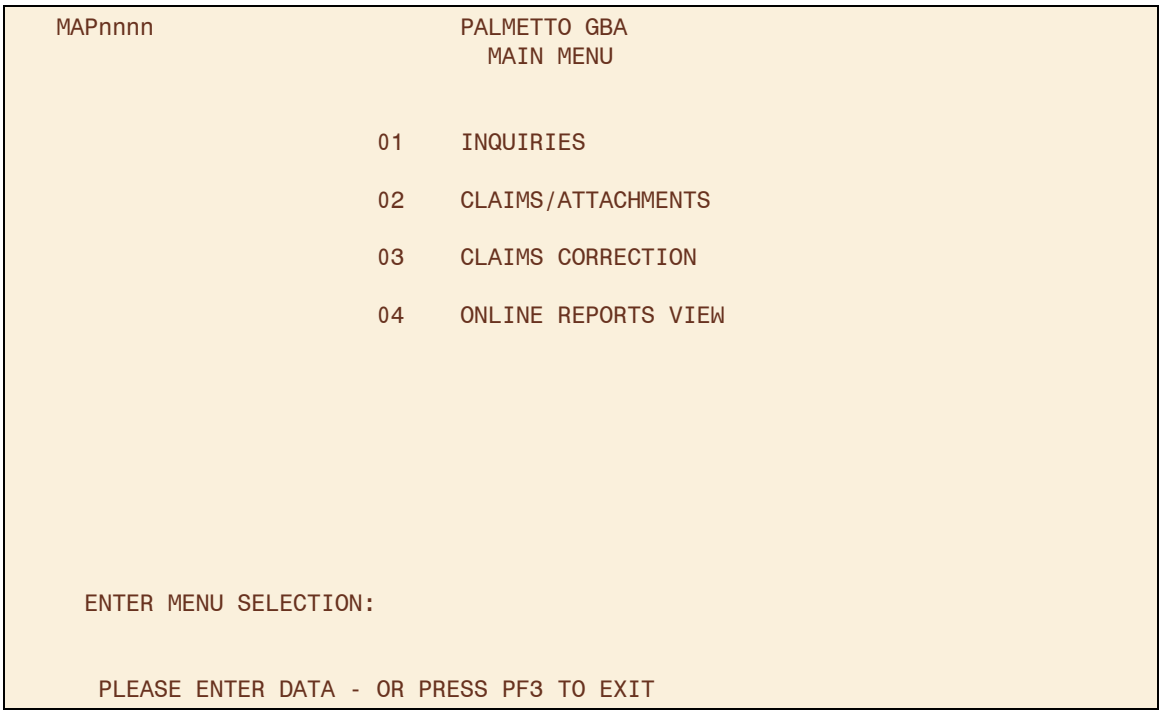


Figure 6– The Main Menu

The Inquiries (01), Claims/Attachments (02), and Claims Correction (03) sub-menus are explained in the following sections.

SECTION 4 – CLAIM INQUIRY

The Inquiry Menu (Main Menu option 01) gives FISS users access to the following claims information:

- Beneficiary/Common Working File (CWF) Eligibility (*this information is also available in HIQA and HIQH*)
- Healthcare Common Procedure Coding System (HCPCS) Codes
- Drug Related Grouper (DRG)
- International Classification of Diseases (ICD-9) Codes
- Claims
- Adjustment Reason Codes
- Revenue Codes
- Reason Codes
- Claims Count Summary
- American National Standards Institute (ANSI) Reason Codes (two-digit codes located on the remittance advice)
- Check History

The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information. **[TAB]** to the PROVIDER field and type in the appropriate provider number.

To access the Inquiry Menu, select option 01 from the Main Menu. The Inquiry Menu will display (Figure 7). Information on each of the Inquiry Menu options follows.

```
MAPnnnn                      PALMETTO GBA
                             INQUIRY MENU


     BENEFICIARY/CWF         10    HCPC CODES              14

     DRG (PRICER/GROUPER)    11    DX/PROC CODES           15

     CLAIMS                  12    ADJUSTMENT REASON CODES 16

     REVENUE CODES           13    REASON CODES            17

     CLAIM COUNT SUMMARY     56    ANSI REASON CODES       68

     CHECK HISTORY           FI     ZIP CODE FILE          19




  ENTER MENU SELECTION:


   PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 7 – Inquiry Menu

Beneficiary/CWF

Select option "10" from the Inquiry Menu to access the Beneficiary/CWF screens. These screens display current Medicare Part A and Part B entitlement and utilization information about a specific beneficiary. There are several pages (screens) of eligibility information:

- Screens 1 & 2 (MAP1751 & MAP1752): Patient eligibility information in the FISS

- Screens 3 & 4 (MAP1755 & MAP1756): Patient eligibility information housed at the CWF
- Screen 5 (MAP1757): Patient PAP, Mammography and Transplant information
- Screen 6 (MAP1758): Patient Hospice Benefit periods 1 and 2
- Screen 7 (MAP175C): Patient Hospice Benefit periods 3 and 4, *if applicable*
- Screen 8 (MAP1759): Patient Medicare Secondary Payer (MSP) information, *if applicable* (this page will not exist for all beneficiaries)
- Screen 9 (MAP175D, MAP175E and MAP175F): CWF Home Health information, *if applicable*
- Screen 10 (MAP175G: CWF MAP Period, *if applicable*
- Screen 11 (MAP175H): CWF HMO period, *if applicable*
- Screen 12 (MAP175I): CWF Hospice period, *if applicable*

To begin the inquiry process, enter the following information on screen 1 **as it appears on the patient's Medicare card**:

- Health Insurance Claim (HIC) number
- Last name & first initial
- Sex (M or F)
- Date of birth (in MMDDYYYY format)

[TAB] to move between fields on the screen. *Only press* **[ENTER]** *when all fields have been completed.*

BENEFICIARY/CWF SCREENS

Page 1 – Field descriptions are provided in the table following Figure 8.

```
MAPnnnn           M E D I C A R E  A  O N L I N E  S Y S T E M
XX                       ELIGIBILITY DETAIL INQUIRY

HIC                  CURR XREF HIC                PREV XREF HIC
TRANSFER HIC                    C-IND      LTR DAYS
LN                         FN                  MI    SEX
DOB           DOD
ADDRESS: 1                                    2
         3                                    4
         5                                    6
     ZIP:

                           CURRENT ENTITLEMENT
PART A EFF DT          TERM DT          PART B EFF DT          TERM DT

 CURRENT                   BENEFIT PERIOD DATA
FRST BILL DT           LST BILL DT          HSP FULL DAYS     HSP PART DAYS
SNF FULL DAYS     SNF PART DAYS     INP DED REMAIN            BLD DED PNTS

                           PSYCHIATRIC
PSY DAYS REMAIN       PRE PHY DAYS USED      PSY DIS DT          INTRM DT IND

    PLEASE ENTER DATA - HIC, LN, FN, SEX, AND DOB.
          PRESS PF3-EXIT  PF8-NEXT PAGE
```

Figure 8 – Beneficiary/CWF, Page 1

Field Name	Description
HIC	Type the patient's health insurance claim (HIC) number as it appears on the Medicare ID card.

Field Name	Description
CURR XREF HIC	If the HIC number has changed for the beneficiary/patient, this field represents the most recent number (the HIC number as returned by CWF).
PREV XREF HIC	This field is no longer in use.
TRANSFER HIC	This field is no longer in use.
C-IND	Century Indicator – This field represents a one-position code identifying if the patient's date of birth is in the 18th or 19th century. Valid values are: 8 = 1800s 9 = 1900s
LTR DAYS	The lifetime reserve days remaining.
LN	The patient's last name.
FN	The patient's first name.
MI	The patient's middle initial.
SEX	The patient's sex.
DOB	The patient's date of birth in MMDDYYYY format.
DOD	The patient's date of death.
ADDRESS	The patient's street address, city, and state of residence.
ZIP	The zip code for state of residence.
Current Entitlement	
PART A EFF DT	The date a beneficiary's Medicare Part A benefits become effective.
TERM DT	The date a beneficiary's Medicare Part A benefits were terminated.
PART B EFF DT	The date a beneficiary's Medicare Part B benefits became effective.
TERM DT	The date a beneficiary's Medicare Part B benefits were terminated.
Current Benefit Period Data	
FRST BILL DT	The beginning date of benefit period.
LST BILL DT	The ending date of benefit period.
HSP FULL DAYS	The remaining full hospital days.
HSP PART DAYS	The remaining hospital co-insurance days.
SNF FULL DAYS	The full days remaining for a skilled nursing facility.
SNF PART DAYS	The partial days remaining for a skilled nursing facility.
INP DED REMAIN	The Part A inpatient deductible amount the beneficiary must pay.
BLD DED PNTS	The remaining blood deductible pints.
Psychiatric	
PSY DAYS REMAIN	The remaining psychiatric days.
PRE PHY DYS USED	Number of pre-entitlement psychiatric days the beneficiary has used.
PSY DIS DT	Date patient was discharged from a level of care
INTRM DT IND	Code that indicates an interim date for psychiatric services. Valid values are: Y = Date is through date of interim bill / utilization day N = Discharge date / not a utilization day

Page 2 – Field descriptions are provided in the table following Figure 9.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                      ELIGIBILITY DETAIL INQUIRY
RI 1
                        PART B DATA
SRV YR      MEDICAL EXPENSE              BLD DED REM    PSY EXP
SRV YR      BLD DED                      CSH DED


                        PLAN DATA
ID CD           OPT CD        EFF DT             CANC DT
ID CD           OPT CD        EFF DT             CANC DT
ID CD           OPT CD        EFF DT             CANC DT

                      HOSPICE DATA
PERIOD    1ST DT             PROVIDER          INTER
OWNER CHANGE ST DT           PROVIDER          INTER
2ND ST DT          PROVIDER          INTER        TERM DT
OWNER CHANGE ST DT           PROVIDER          INTER
1ST BILL DT         LST BILL DT         DAYS BILLED



      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE  PF8-CWF INQUIRY
```

Figure 9 – Beneficiary/CWF Page 2

Field Name	Description
RI	In DDE/CWF this Reason for Inquiry field is hard-coded with a "1" needed for HIQA Inquiry. Valid values are: 1 = Inquiry 2 = Admission Inquiry
Part B Data	
SRV YR	The calendar year for current Medicare part B services that are associated with the cash deductible amount entered in the Medical Expense field.
MEDICAL EXPENSE	The cash deductible amount satisfied by the beneficiary for the service year.
BLD DED REM	The remaining of pints of blood to be met.
PSY EXP	The dollar amount associated with psychiatric services.
SRV YR	The calendar year for current Medicare Part B services that are associated with the cash deductible amount entered in the Medical Expense field and with the Blood Deductible field.
BLD DED	This field is no longer applicable.
CSH DED	This field is no longer applicable.
PLAN Data	
ID CD	**Plan Identification Code -** This field identifies the Plan Identification code. This is a five-position alphanumeric field. This field occurs three times. The structure of the identification number is: Position 1 H Position 2 & 3 State Code Position 4 & 5 Plan number within the state

Field Name	Description
OPT CD	This field identifies whether the current Plan services are restricted or unrestricted. Valid values are: Unrestricted— 1 = Intermediary to process all Part A and B provider claims. 2 = Plan to process claims for directly provided service and for services from Providers with effective arrangements. Restricted— A = Intermediary to process all Part A and B provider claims. B = Plan to process claims only for directly provided services. C = Plan to process all claims.
EFF DT	The effective date for the Plan benefits.
CANC DT	The termination date for the Plan benefits.
Hospice Data	
PERIOD	Specific Hospice election period. Valid values are: 1 = The first time a beneficiary uses Hospice benefits. 2 = The second time a beneficiary uses Hospice benefits.
1ST DT	First Hospice Start Date (in MMDDYY format) of the beneficiary's effective period (1-4) with the Hospice Provider.
PROVIDER	A 13-character alphanumeric field that identifies each hospice provider.
INTER	A 6-character alphanumeric field that identifies each Intermediary number for the hospice Provider (1-4).
TERM	The termination date of a beneficiary's election period.
OWNER CHANGE ST DT	The Change of Ownership Start Date field will display the start date of a change of ownership within the period for the first provider.
PROVIDER	The number of the Medicare hospice provider.
INTER	The Intermediary number for the hospice Provider.
2ND ST DT	A 6-character field that identifies the start date for each 2nd hospice period (1-4).
PROVIDER	A 13-character alphanumeric field that indicates each identification number of the 2nd hospice provider.
INTER	A 6-character alphanumeric field that identifies each Intermediary number for the 2nd hospice provider (1-4).
TERM DT	A 6-digit numeric field that identifies each termination date for hospice services for this hospice Provider (1-4).
OWNER CHANGE ST DT	Displays the start date of a change of ownership within the period for the second provider.
PROVIDER	The Provider number of the Medicare hospice provider.
INTER	The Intermediary number for the hospice provider.
1ST BILL DT	A 6-digit numeric field (in MMDDYY format) that identifies the date of each earliest hospice bill (1-4).
LST BILL DT	A 6-digit numeric field (in MMDDYY format) that identifies each most recent hospice date (1-4).
DAYS BILLED	A 3-digit numeric field that identifies the cumulative number of days billed to date for the beneficiary under each hospice election (1-4).

Page 3 – NOT IN FILE (NIF) ERROR – This response on the reply record indicates that the beneficiary record for which the Fiscal Intermediary submitted a claim is not in the CWF Region being accessed by your Intermediary. Further research may be needed throughout the CWF Hosts to locate the information. Sometimes, because of the complexity of the CWF, it may take extra time to locate the records of a beneficiary. The claim will 'orbit' until all hosts have been polled and, if the information is not found successfully, a CWF error message will be received (Figure 10).

```
MAPnnnA          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                              NOT IN FILE

CLAIM nnnnnnnnnA    NAME J SMITH   DOB 030319  SEX F  INTER 58300  PROV nnnnnn
APP DT         REASON CD 1  DATE/TIME 20033021401  REQ ID BDMS
DISP CD 50   TYPE 4

                       DATE TRANSFER INITIATED TO CMS :

                   DATE CMS  INDICATED NIF/AT OTHER SITE:









      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE
```

Figure 10 – Beneficiary/CWF Page 3

Page 3 – Field descriptions are provided in the table following Figure 11.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                              ACCEPTED

CLAIM nnnnnnnnnA    NAME J SMITH   D.O.B. 080219  SEX M   INTER 58300
PROV nnnnnn  PROV IND
APP DT          REASON CD 1  DATE/TIME 20033030901  REQ ID BDMS
DISP CD 25   TYPE 3  CENT D.O.B    D.O.D

A:CURR-ENT DT 080176  TERM DT         PRI-ENT DT         TERM-DT
B:CURR-ENT DT 080176  TERM DT         PRI-ENT DT         TERM-DT

LIFE: RSRV 60  PYSCH 190

 CURRENT                BENEFIT PERIOD DATA
FRST BILL DT  033098  LST BILL DT 040798  HSP FULL DAYS 52  HSP PART DAYS 30
SNF FULL DAYS 20  SNF PART DAYS 80  INP DED REMAIN     0.00  BLD DED PNTS 0
PRIOR                  BENEFIT PERIOD DATA
FRST BILL DT  102997  LST BILL DT 111297  HSP FULL DAYS 55  HSP PART DAYS 30
SNF FULL DAYS 11  SNF PART DAYS 80  INP DED REMAIN     0.00  BLD DED PNTS 0

CURR B: YR 03  CASH 090.00  BLOOD 3  PSYCH 02200.00  PT 01590.00  OT 01590.00
PRIR B: YR 02  CASH 100.00  BLOOD 3  PSYCH 02200.00  PT 00500.00  OT 00500.00

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 11 – Beneficiary/CWF Page 3

Field Name	Description
CLAIM	The beneficiary's Medicare number as it appears on the Medicare ID card.
NAME	The beneficiary's first initial and last name.
DOB	The beneficiary's date of birth (in MMDDYY format).
SEX	Valid values are: F = Female M = Male U = Unknown
INTER	The Intermediary number for the Provider.
PROV	The CMS-assigned identification number of the institution that rendered services to the beneficiary/patient. It is system generated for external operators that are directly associated with one Provider (as indicated on the operator control file).
PROV IND	**Provider Indicator –** This field identifies the provider number indicator. This is a one-position alphanumeric field. The valid values are: ' ' The provider number is a Legacy or OSCAR number 'N' The provider number is an NPI number
APP DT	The date the beneficiary was admitted to the hospital (Application date).
REASON CD	Reason Code – Indicates the reason for the injury. Valid values are: 1 = Status inquiry 2 = Inquiry relating to an admission
DATE/TIME	The date and time in Julian YYDDDHHMMSS format.
REQ ID	Requested ID – Identifies person submitting inquiry.
DISP CD	The CWF disposition code assigned to a claim when it is processed through a CWF host site. Valid values include: 01 = Part A inquiry approved; beneficiary has never used Part A services (Type 3 reply). 02 = Part A inquiry approved; beneficiary has had some prior utilization. 03 = Part A inquiry rejected. 04 = Qualified approval; may require further investigation. 05 = Qualified approval; according to CMS's records, this inquiry begins a new benefit period.
TYPE	Identifies the type of CWF reply. Valid value: 3 = Accept
CENT D.O.B	Century of the Beneficiary/patient's date of birth. Valid values are: 8 = 18th Century 9 = 19th Century
D.O.D	Identifies the date of death of the beneficiary/patient.
Part A	
CURR-ENT DT	Current Part A benefits entitlement date (in MMDDYY format).
TERM DT	Termination date for Part A benefits (in MMDDYY format).
PRI-ENT DT	Prior entitlement date for Part A benefits (in MMDDYY format).
TERM DT	Prior termination date for Part A benefits (in MMDDYY format).
Part B	
CURR-ENT	Current Part B benefits entitlement date (in MMDDYY format).
TERM DT	Termination date for Part B benefits (in MMDDYY format).
PRI-ENT DT	Prior entitlement date for Part B benefits (in MMDDYY format).
TERM DT	Prior termination date for Part B benefits (in MMDDYY format).
LIFE: RSRV	Number of lifetime reserve days remaining (00-60).
PSYCH	Number of lifetime psychiatric days available (000-190).

Field Name	Description
Current Benefit Period Data	
FRST BILL DT	The date of the earliest billing action in the current benefit period (in MMDDYY format).
LST BILL DT	The date of the latest billing action in the current benefit period (in MMDDYY format).
HSP FULL DAYS	The number of regular hospital full days the beneficiary/patient has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary/patient has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary/patient has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary/patient has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary/patient for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary/patient for the benefit period.
Prior Benefit Period Data	
FRST BILL DT	The date of the earliest billing action in the current benefit period.
LST BILL DT	The date of the latest billing action in the current benefit period.
HSP FULL DAYS	The number of regular hospital full days the beneficiary/patient has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary/patient has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary/patient has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary/patient has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary/patient for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary/ patient for the benefit period.
Current B	
YR	The most recent Medicare Part B year (in YY format).
CASH	The remaining Part B cash deductible.
BLOOD	The remaining Part B blood deductible pints.
PSYCH	The remaining psychiatric limit.
PT	The physical therapy dollars remaining.
OT	The occupational therapy dollars remaining.
Prior B	
YR	The prior Medicare Part B year (in YY format).
CASH	The Part B cash deductible remaining to be met in the prior year.
BLOOD	The Part B blood deductible pints remaining to be met in the prior year.
PSYCH	The remaining psychiatric limit in the prior year.
PT	Physical therapy dollars remaining in the prior year.
OT	Occupational therapy dollars remaining in the prior year.

Page 4 – Field descriptions are provided in the table following Figure 12.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                               ACCEPTED

DATA IND 0000000000  NAME SMITH.JOHN.L                ZIP 29440

PLAN: ENR CD
CURR PLAN: CURR ID 00000  OPT CD 0  ENR          TERM
PRIR PLAN: PRI ID 00000   OPT CD 0  ENR          TERM

OTHER ENTITLEMENTS OCCURRENCE CD/DATE 0          / 0

ESRD CD/DATE             /

CAT DATA: PSYCH 190  DISCHG          IND 0  DAYS USED      BLOOD

YR 89  APP           MET 00560.00  BLD 3  CO 08  FL 142  FRM         TO
IND      INT        ADM         FRM         TO           APP
ADJ IND    CALC DED           CMS  DT
YR 89  APP           MET 00560.00  BLD 3  CO 08  FL 142  FRM         TO
IND      INT        ADM         FRM         TO           APP
ADJ IND    CALC DED           CMS  DT

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 12 – Beneficiary/CWF Page 4

Field Name	Description	
DATA IND	Data Indicators – 10-Digit Numeric Field. Valid position values are:	
	Pos. 1 – Part B Buy-In	0 = Does not apply 1 = State buy-in involved
	Pos. 2 – Alien indicator	0 = Does not apply 1 = Alien non-payment provision may apply
	Pos. 3 – Psych Pre-Entitlement	0 = Does not apply 1 = Psychiatric pre-entitlement reduction applied
	Pos. 4 – Reason for Entitlement	0 = Normal Entitlement 1 = Disability (DIB) 2 = End Stage Renal Disease (ESRD) 3 = Has or had ESRD, but has current DIB 4 = Old age but had or has ESRD 8 = Has or had ESRD and is covered under premium Part A 9 = Covered under premium Part A
	Pos. 5 – Part A Buy-In	0 = No Part A Buy-In 1 = Part A Buy-In
	Pos. 6 – Rep Payee Indicator	0 = Does not apply 1 = Selected for GEP Contract 2 = Has Rep Payee 3 = Both Conditions Apply
	Pos. 7-10 – Not used at this time	Pre-filled with zeros.
NAME	Displays last name, first name, and middle initial of the beneficiary/patient.	
ZIP	Zip Code of the residence of the beneficiary.	

Field Name	Description
PLAN: ENR CD	Number of periods of Plan enrollment code. Valid values include: 0 = Zero periods of enrollment 1 = One period of enrollment 2 = Two periods of enrollment 3 = More than two periods of enrollment
Current Plan	
CUR ID	Current Plan ID code assigned by CMS. Position — Description 1 — H or 1-9 2 & 3 — State code 4 & 5 — Plan number within the state
OPT	Plan Option Code. Valid values are: Restricted— A = Intermediary to process all claims. B = Plan to process claims for directly provided services. C = Plan to process all claims. Unrestricted— 1 = Intermediary to process all Part A and Part B provider claims 2 = Plan to process claims for directly provided services from providers with effective arrangements
ENR	The enrollment date of the Plan benefits (in MMDDYY format).
TERM DT	The termination date of the Plan benefits (in MMDDYY format).
Prior Plan	
PRI ID	Prior Health ID code assigned by CMS: 1 — H or 1-9 2 & 3 — State code 4 & 5 — Plan number within the state
OPT	Plan Option Code: Restricted— A = Intermediary to process all claims. B = Plan to process claims for directly provided services. C = Plan to process all claims. Unrestricted— 1 = Intermediary to process all Part A and Part B provider claims 2 = Plan to process claims for directly provided services from providers with effective arrangements
ENR	The enrollment date of the Plan benefits for the prior year (in MMDDYY format).
TERM	Termination date of the Plan benefits for the prior year (in MMDDYY format).

Field Name	Description
OTHER ENTITLEMENTS OCCURRENCE CD/DATE	The first two occurrence codes and dates indicating another Federal Program or another type of insurance that may be the primary payer. Valid occurrence code values include: A = Working Aged beneficiary or spouse covered by Employer Group Health Plan (EGHP) B = End Stage Renal Disease (ESRD) beneficiary in 30-month coordination period and covered by employer health plan C = Medicare has made a conditional payment pending final resolution D = Automobile no-fault or other liability insurance involvement E = Workers' Compensation F = Veteran's Administration program, public health service or other federal agency program G = Working disabled beneficiary or spouse covered by Employer Group Health Plan H = Black Lung I = Veteran's Administration Program Occurrence Codes — Date Definition 1 or 2: Date is the effective date of applicable program involvement. A - I: Date is the date of previous claim where Medicare was determined to be secondary.
ESRD CD/ DATE	The home dialysis method and effective date in MMDDCCYY format. Valid values are: 1 = Beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claim. 2 = Beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and beneficiary submits claim to Carrier.
Cat Data	
PSYCH DISCHG IND	The remaining lifetime psychiatric days.
DISCHG	Last or through discharge date (in MMDDYY format).
IND	Identifies whether the discharge date is an interim date. Valid values are: 0 = Initialized 1 = Interim
DAYS USED	The number of pre-entitlement psychiatric days used by the beneficiary/patient.
BLOOD	The number of blood pints carried over from 1988 to 1989.
Days (2 occurrences)	
YR	The catastrophic trailer year.
APP	Identifies whether a December inpatient stay has been applied to the current year deductible
MET	The remaining inpatient hospital deductible.
BLD	The remaining blood deductible.
CO	The remaining skilled nursing facility coinsurance days.
FL	Number of full SNF days remaining.
FRM	The "From Date" of the earliest processed bill.
TO	The "Through Date" of the earliest processed bill.
IND	The yearly data indicators:

Field Name	Description	
	Pos. 1	0 = Not Used 2 = Clerical Involvement 3 = Religious Non-Medical Healthcare Institution/SNF Usage 4 = Both 1 and 2
	Pos. 2	0 = Not Used 1 = Through Date is Interim
	Pos. 3-4	For Future Use
INT	The fiscal intermediary number for earliest processed hospital bill with a deductible.	
ADM	The "Admission Date" for the earliest processed hospital bill with a deductible.	
FROM	The "From Date" for the earliest hospital bill processed with a deductible.	
TO	The "Through Date" for the earliest hospital bill processed with a deductible.	
APP	Deductible amount applied for the earliest hospital bill processed with a deductible.	
ADJ IND	The type of adjustment made. Valid values are: 0 = No Adjustment 1 = Downward Adjustment 2 = Upward Adjustment	
CALC DED	The amount of deductible calculated.	
CMS DATE	The date the claim was processed by CMS.	

Page 5 – Field descriptions are provided in the table following Figure 13.

```
MAPnnnn           M E D I C A R E  A  O N L I N E  S Y S T E M
XX                                ACCEPTED

HH-REC  CN nnnnnnnnnA     NM SMITH    IT J   DB 08021919   SX M

PAP RSK    PAP DATE 000000
                         TECHCOM   PROCOM
MAMMO RSK    MAMMO DATES  0000      0000
                          0000      0000
                          0000      0000

TRANSPLANT INFO:   COV IND   TRAN IND   DIS DATE
                                         000000
                                         000000
                                         000000


         EPISODE      EPISODE       DOEBA        DOLBA
          START         END
        20030501     20030629     20030501     20030503


      PROCESS COMPLETED  ---   PLEASE CONTINUE
         PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 13 – Beneficiary/CWF Page 5

Field Name	Description
HH-REC	The requested Home Health record.
CN	Displays the identification number for a claim. If an adjustment or a RTP is being processed, enter the DCN for the claim. If this is a MSP claim leave field blank.
NM	The last name of the beneficiary/ patient.
IT	The first initial of the beneficiary/ patient name.

Field Name	Description
DB	The date of birth of the beneficiary /patient.
SX	Sex of the beneficiary/patient. Valid values: Y = Female M = Male
PAP RSK	PAP Risk Indicator. Valid values are: Y = Yes N = No
PAP DATE	The date of the beneficiary's last PAP Smear.
MAMMO RSK	The mammography risk indicator. Valid values are: Y = Yes N = No
Mammo Dates	
TECHCOM	The date the technician interpreted the mammography screening.
PROCOM	The date the mammography screening required an interpretation by a physician.
Transplant Info	
COV IND	The "Transplant Covered Indicator." Valid values are: Y = Covered Transplant N = Non-covered Transplant
TRAN IND	The type of transplant performed. Valid values are: 1 = Allogeneous Bone Marrow 2 = Autologous Bone Marrow H = Heart Transplant K = Kidney Transplant L = Liver Transplant
DIS DATE	The discharge date for the transplant patient. There may be up to three discharge dates displayed.
HHPPS	
EPISODE START	The start date of an episode.
EPISODE END	The end date of an episode.
DOEBA	The first service date of the HHPPS period.
DOLBA	The last service date of the HHPPS period.

Page 6 – Field descriptions are provided in the table following Figures 14 and 15.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                               ACCEPTED

HOSPICE INFO FOR PERIODS 1 AND 2:

PERIOD    1ST  ST DATE         PROV         INTER
OWNER CHANGE ST DATE           PROV         INTER
2ND ST DATE         PROV         INTER        TERM DATE
OWNER CHANGE ST DATE           PROV         INTER
1ST BILLED DT         LAST BILLED DT
DAYS BILLED      REVO IND

PERIOD    1ST  ST DATE         PROV         INTER
OWNER CHANGE ST DATE           PROV         INTER
2ND ST DATE         PROV         INTER        TERM DATE
OWNER CHANGE ST DATE           PROV         INTER
1ST BILLED DT         LAST BILLED DT
DAYS BILLED      REVO IND




      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 14 – Beneficiary/CWF, Hospice Info for Periods 1 and 2

```
MAPnnnC          M E D I C A R E  A  O N L I N E  S Y S T E M
xx                               ACCEPTED

HOSPICE INFO FOR PERIODS 3 AND 4:

PERIOD    1ST  ST DATE         PROV         INTER
OWNER CHANGE ST DATE           PROV         INTER
2ND ST DATE         PROV         INTER        TERM DATE
OWNER CHANGE ST DATE           PROV         INTER
1ST BILLED DT         LAST BILLED DT
DAYS BILLED      REVO IND

PERIOD    1ST  ST DATE         PROV         INTER
OWNER CHANGE ST DATE           PROV         INTER
2ND ST DATE         PROV         INTER        TERM DATE
OWNER CHANGE ST DATE           PROV         INTER
1ST BILLED DT         LAST BILLED DT
DAYS BILLED      REVO IND




      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 15 – Hospice Info for Periods 3 and 4

Field Name	Description
HOSPICE INFO FOR PERIODS 1 AND 2	There are four occurrences of Hospice Information on two screens to provide for the four most recent hospice periods.

Field Name	Description
PERIOD 1 (or 3)	
PERIOD	The Hospice Benefit Period Number. Valid values are: 1 = First time a beneficiary uses hospice benefits 2 = Second time a beneficiary uses hospice benefits
1ST START DATE	The beneficiary's effective period with the Hospice Provider (in MMDDYY format).
PROV	The hospice's Medicare provider number.
INTER	The hospice's Intermediary number.
OWNER CHANGE ST DATE	The start date of a change of ownership for the first Provider, within the election period.
PROV	The number of the Medicare hospice Provider.
INTER	The Intermediary number.
2ND START DATE	The date the second benefit period began.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Intermediary number.
TERM DATE	The date the hospice benefit period was terminated.
OWNER CHANGE ST DATE	The start date of a change of ownership within the period for the second Provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Intermediary number.
1ST BILLED DT	The date of each earliest hospice bill date (in MMDDYY format).
LAST BILLED DT	Each most recent hospice bill date (in MMDDYY format).
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.
PERIOD 2 (or 4)	
PERIOD	The Hospice Benefit Period Number. Valid values are: 1 = First time a beneficiary uses hospice benefits 2 = Second time a beneficiary uses hospice benefits
1ST START DATE	The beneficiary's effective period with the Hospice Provider (in MMDDYY format).
PROV	The hospice's Medicare provider number.
INTER	The hospice's Intermediary number.
OWNER CHANGE ST DATE	The start date of a change of ownership for the first Provider, within the election period.
PROV	The number of the Medicare hospice Provider.
INTER	The Intermediary number.
2ND START DATE	The date the second benefit period began.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Intermediary number.
TERM DATE	The date the hospice benefit period was terminated.
OWNER CHANGE ST DATE	The start date of a change of ownership within the period for the second Provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Intermediary number.
1ST BILLED DT	The date of each earliest hospice bill date (in MMDDYY format).
LAST BILLED DT	Each most recent hospice bill date (in MMDDYY format).
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

There are five (5) possible pages of Medicare Secondary Payer (MSP) CWF information. Page 1 is shown in Figure 16.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                                ACCEPTED
                                MSP DATA  PAGE    OF

  EFFECTIVE DATE:          SUBSCRIBER NAME:
TERMINATION DATE:            POLICY NUMBER:
        MSP CODE:              INSURER TYPE:
                         PATIENT RELATIONSHIP:
                                REMARKS CODES:

            INSURER INFORMATION
   NAME:                                      GROUP NO:
ADDRESS:                                          NAME:



          EMPLOYER DATA
   NAME:                                       EMPLOYEE ID:
ADDRESS:                                     EMPLOYEE INFO:



      PROCESS COMPLETED  ---   PLEASE CONTINUE
         PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Figure 16 – Medicare Secondary Payer CWF Information

Field Name	Description
EFFECTIVE DATE	The date of the Medicare Secondary Payer (MSP) coverage.
SUBSCRIBER NAME	First and last name of the individual subscribing to the MSP coverage.
TERMINATION DATE	Date the coverage terminates under the payer listed.
POLICY NUMBER	The policy number with the payer listed.
MSP CODE	The type of insurance coverage. Valid values are: A = Working aged beneficiary or spouse covered by employer health plan B = End Stage Renal Disease beneficiary in his 12 month coordination period and covered by employer health plan C = Medicare has made a conditional payment pending final resolution D = Automobile no-fault E = Workers' Compensation F = Public Health Service or other federal agency program G = Disability H = Black Lung I = Veteran's Administration program L = Liability
INSURER TYPE	This field is not currently in use.
PATIENT RELATIONSHIP	Identifies the relationship of the beneficiary/patient to the insured under the policy listed. Refer to NUBC Manual
REMARKS CODES	Identifies information needed by the contractor to assist in additional development. Up to three remarks codes may be displayed. Each code is a two-character alphanumeric field. Each site determines the values.

Field Name	Description
INSURER INFORMATION	
NAME	Name of the insurance company that may be primary over Medicare.
GROUP NO	The group number for the policyholder with this insurer name.
ADDRESS	The street, city, state and zip code for the insurer.
NAME	The name of the insurer group.
EMPLOYER DATA	
NAME	Name of employer that provides/may provide health coverage for the beneficiary/patient.
EMPLOYEE ID	Identification number assigned by the employer to the beneficiary/patient.
ADDRESS	The street, city, state and zip code of the employer.
EMPLOYEE INFO	This field is not currently in use.

DRG (Pricer/Grouper)

Select option "11" from the Inquiry Menu to access the DRG/PPS Inquiry screen. The DRG/PPS Inquiry screen displays detailed payment information calculated by the Pricer and Grouper software programs. Its purpose is to provide specific DRG assignment and PPS payment calculations. It should be used to research PPS information as it pertains to an inpatient stay.

To start the inquiry process, enter the following information:

- Diagnosis code
- Procedure code
- Sex
- Century indicator
- Discharge status
- Date of Inquiry
- Provider number
- Review code
- Total charges
- Date of birth **or** age
- Approved length of stay
- Covered days
- Number of lifetime reserve days

[TAB] to move between fields on the screen. *Only press* **[ENTER]** *when all fields have been completed.*

DRG/PPS Inquiry Screen

Field descriptions are provided in the table following Figure 17.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
xx                           DRG/PPS INQUIRY

DIAG CD:
PROC CD:
SEX      C-I      DISCHARGE STATUS          DT            PROV 420018
REVIEW CODE       TOTAL CHARGES             DOB           OR AGE
APPROVED LOS      COV DAYS                  LTR DAYS      PAT LIAB
RETURNED FROM GROUPER:
   D.R.G.                  MAJOR DIAG CAT         RTN CD
   PROC CD USED            DIAG CD USED           SEC DIAG USED
   GROUPER VER
RETURNED FROM PRICER:
   RTN CD     WAGE INDEX                 OUTLIER DAYS
   AVG# LENGTH OF STAY                   OUTLIER DAYS THRESHOLD
   OUTLIER COST THRESHOLD                INDIRECT TEACHING ADJ#
   TOTAL BLENDED PAYMENT                 HOSPITAL SPECIFIC PORTION
   FEDERAL SPECIFIC PORTION              DISP# SHARE HOSPITAL AMT
   PASS THRU PER DISCHARGE               OUTLIER PORTION
   PTPD + TEP                            STANDARD DAYS USED
   LTR DAYS USED                         PROV REIMB
   PRICER VER
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 17 – DRG/PPS Inquiry Screen

Field Name	Description
DIAG CD	ICD-9-CM Diagnosis Codes – Six-character alphanumeric fields that identify up to nine codes for coexisting conditions on a particular claim. The *admitting* diagnosis is not entered.
PROC CD	ICD-9-CM Procedure Codes – Required for inpatient claims. Seven-digit field identifying the principle procedure (first) and up to five additional procedures.
SEX	The Beneficiary's Sex
C-I	Century Indicator – If you enter D.O.B. (date of birth), you must enter the century indicator. Valid values are: 8 =1800-1899 9 =1900-1999
DISCHARGE STATUS	The Patient's Discharge Status Code. Refer to UB-04 Manual.
DT	The date of discharge in MMDDYY format.
PROV	The hospital's Medicare provider number.

Field Name	Description
REVIEW CODE	Indicates the code used in calculating the standard payment. Valid values are: 00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers 01 = Pay days outlier – Calculates standard payment and the day outlier portion of the payment if the covered days exceed the outlier cutoff for DRG 02 = Pay cost outlier – Calculates the standard payment and the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold; if the length of stay exceeds the outlier cutoff, no payment is made and a return code of '60' is returned 03 = Pay per diem days – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if the covered days equal or exceed the average length of stay the standard payment is calculated – It also calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers 05 = Pay transfer with cost – Pays transfer with cost outlier approved 06 = Pay transfer no cost – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate any cost outlier portion of the payment 07 = Pay without cost – Calculates the standard payment without cost portion 09 =Pay transfer special DRG post acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will calculate the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 11 =Pay transfer special DRG no cost post acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate the cost outlier portion of the payment
TOTAL CHARGES	The total covered charges submitted on the claim.
D.O.B	The beneficiary's date of birth (MMDDYYYY format).
OR AGE	The beneficiary's age at the time of discharge. This field may be used instead of the date of birth and century indicator.
APPROVED LOS	The approved length of stay (LOS) is necessary for the Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases, to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay.

Field Name	Description
COV DAYS	The number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary.
LTR DAYS	The number of lifetime reserve days. This 2-digit field may be left blank.
PAT LIAB	The Patient Liability Due identifies the dollar amount owed by the beneficiary to cover any coinsurance days or non-covered days or charges.

After the DRG has been assigned by the system and the PPS payment has been determined, the following information will be displayed on the screen under RETURNED FROM GROUPER or RETURNED FROM PRICER.

Field Name	Description
D.R.G.	The DRG code assigned by the CMS grouper program using specific data from the claim, such as length of stay, covered days, sex, age, diagnosis and procedure codes, discharge data and total charges.
MAJOR DIAG CAT	Identifies the category in which the DRG resides. Valid values are: 01 = Diseases and Disorders of the Nervous System 02 = Diseases and Disorders of the Eye 03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat 04 = Diseases and Disorders of the Respiratory System 05 = Diseases and Disorders of the Circulatory System 06 = Diseases and Disorders of the Digestive System 07 = Diseases and Disorders of the Hepatobiliary System and Pancreas 08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue 09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast 10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders 11 = Diseases and Disorders of the Kidney and Urinary Tract 12 = Diseases and Disorders of the Male Reproductive System 13 = Diseases and Disorders of the Female Reproductive System 14 = Pregnancy, Childbirth, and the Puerperium 15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period 16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders 17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms 18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites) 19 = Mental Diseases and Disorders 20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders 21 = Injuries, Poisonings, and Toxic Effects of Drugs 22 = Burns 23 = Factors Influencing Health Status and Other Contacts with Health Services 24 = Multiple Significant Trauma 25 = Human Immunodeficiency Viral Infections
RTN CD	The Return Code reflects the status of the claim when it has returned from the Grouper Program. Return codes 00-49 describe how the bill was priced: 00 = Priced standard DRG payment

Field Name	Description
	01 = Paid as day outlier/send to PRO for post payment review 02 = Paid as cost outlier/send to PRO for post payment review 03 = Paid as per diem/not potentially eligible for cost outlier 04 = Standard DRG but covered days indicate day outlier but day or cost outlier status was ignored 05 = Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 = Pay per diem days for transfers without an approved outlier 10 = Bad state code for SNF Rug Demo or Post Acute Transfer for Inpatient PPS Pricer DRG is 209, 210 or 211 12 = Post acute transfer with specific DRGs of 14, 113, 236, 263, 264, 429, 483 14 = Paid normal DRG payment with per diem days - or > average length of stay 16 = Paid as a Cost Outlier with per diem days - or > average length of stay 20 = Bad revenue code for SNF Rug Demo or invalid HIPPS code for SNF PPS Pricer 30 = Bad Metropolitan Statistical Area (MSA) Code Return codes 50-99 describe why the bill was not priced: 51 = No provider-specific information found 52 = Invalid MSA in provider file 53 = Waiver State - not calculated by PPS 54 = DRG not '001' - '468' or '471' - '910' 55 = Discharge date is earlier than provider's PPS start date 56 = Invalid length of stay 57 = Review Code not '00' - '07' 58 = Charges not numeric 59 = Possible day outlier candidate 60 = Review code '02' and length of stay indicates day outlier, bill is thus not eligible as cost outlier 61 = Lifetime reserve days are not numeric 62 = Invalid number of covered days (i.e., more than approved length of stay, non-numeric, or lifetime reserve days greater than covered days) 63 = Review code of '00' or '03' and bill is cost outlier candidate 64 = Disproportionate share percentage and bed size conflict on provider specific file 98 = Cannot process bill older than 10/01/87
PROC CD USED	ICD-9-CM procedure code(s) that identifies the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims.
DIAG CD USED	Identifies the primary ICD-9-CM diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	ICD-9-CM diagnosis code used by the Grouper program for calculation.
GROUPER VER	The program identification number for the Grouper program used.
Returned From Pricer	
RTN CD	A Return Code that identifies the status of the claim when it has returned from the Pricer program. Return codes 00-49 describe how the bill was priced: 00 = Priced standard DRG payment 01 = Paid as day outlier/send to PRO for post payment review 02 = Paid as cost outlier/send to PRO for post payment review 03 = Paid as per diem/not potentially eligible for cost outlier 04 = Standard DRG but covered days indicate day outlier but day or cost outlier status was ignored 05 = Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 = Pay per diem days for transfers without an approved outlier

Field Name	Description
	10 = Bad state code for SNF Rug Demo or Post Acute Transfer for Inpatient PPS Pricer DRG is 209, 210 or 211 12 = Post acute transfer with specific DRGs of 14, 113, 236, 263, 264, 429, 483 14 = Paid normal DRG payment with per diem days - or > average length of stay 16 = Paid as a Cost Outlier with per diem days - or > average length of stay 20 = Bad revenue code for SNF Rug Demo or invalid HIPPS code for SNF PPS Pricer 30 = Bad Metropolitan Statistical Area (MSA) Code Return codes 50-99 describe why the bill was not priced: 51 = No provider-specific information found 52 = Invalid MSA in provider file 53 = Waiver State - not calculated by PPS 54 = DRG not '001' - '468' or '471' - '910' 55 = Discharge date is earlier than provider's PPS start date 56 = Invalid length of stay 57 = Review Code not '00' - '07' 58 = Charges not numeric 59 = Possible day outlier candidate 60 = Review code '02' and length of stay indicates day outlier; bill is thus not eligible as cost outlier 61 = Lifetime reserve days are not numeric 62 = Invalid number of covered days (i.e., more than approved length of stay, non-numeric, or lifetime reserve days greater than covered days) 63 = Review code of '00' or '03' and bill is cost outlier candidate 64 = Disproportionate share percentage and bed size conflict on provider specific file 98 = Cannot process bill older than 10/01/87
WAGE INDEX	Provider's wage index factor for the state where the services were provided to determine reimbursement rates for the services rendered.
OUTLIER DAYS	The number of outlier days that exceed the cutoff point for the applicable DRG.
AVG # LENGTH OF STAY	The predetermined average length of stay for the assigned DRG.
OUTLIER DAYS THRESHOLD	Shows the number of days of utilization permissible for this claim's DRG code. Day outlier payment is made when the length of stay (including days for a beneficiary awaiting SNF placement) exceeds the length of stay for a specific DRG plus the CMS-mandated adjustment calculation.
OUTLIER COST THRESHOLD	Additional payment amount for claims with extraordinarily high charges. Payment is based on the applicable Federal rate percentage times 75% of the difference between the hospital's cost for the discharge and the threshold established for the DRG.
INDIRECT TEACHING ADJ#	The amount of adjustment calculated by the Pricer for teaching hospitals.
TOTAL BLENDED PAYMENT	The total PPS payment amount consisting of the Federal, hospital, outlier and indirect teaching reductions (such as Gramm Rudman) or additions (such as interest).
HOSPITAL SPEC. PORTION	The hospital portion of the total blended payment.
FEDERAL SPEC. PORTION	The Federal portion of the total blended payment.

Field Name	Description
DISP# SHARE HOSPITAL AMT	The percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also SSI.
PASS THRU PER DISCHARGE	Identifies the pass through discharge cost.
OUTLIER PORTION	The dollar amount calculated that reflects the outlier portion of the charges.
PTPD + TEP	The sum of the pass through per discharge cost plus the total blended payment amount.
STANDARD DAYS USED	The number of regular Medicare Part A days covered for this claim.
LTR DAYS USED	The number of lifetime Reserve Days used during this benefit period.
PROV REIM	The actual payment amount to the provider for this claim. This will be the amount on the Remittance Advice/Voucher.
PRICER VER	The program version number for the Pricer program used.

Claims Summary Inquiry

Select option "12" from the Inquiry Menu to access the Claims Summary Inquiry screen. The Claims Summary Inquiry screen displays specific claim history information for *all* **pending** (RTP claims, MSP claims, Medical Review claims) and **processed** (paid, rejected, denied) claims. The claim status information is available on-line for viewing immediately after the claim is updated/entered on DDE. The entire claim (six pages) can be viewed on-line through the claim inquiry function **but it cannot be updated from this screen.**

Common status and location codes (S/LOC) (see Section 1 for more information) are listed in the following table.

Code	Description
P B9996	Payment Floor.
P B9997	Paid/Processed Claim.
P B7501	Post-Pay Review.
P B7505	Post-Pay Review.
R B9997	Claims Processing Rejection.
D B9997	Medical Review Denial.
T B9900	Daily Return to Provider (RTP) Claim – Not yet accessible.
T B9997	RTP Claim – Claim may be accessed and corrected through the Claim and Attachments Corrections Menu (Main Menu Option 03).
S B0100	Beginning of the FISS batch process.
S B6000	Claims awaiting the creation of an Additional Development Request (ADR) letter. [Do not press [F9] on these claims because the FISS will generate another ADR.]
S B6001	Claims awaiting a provider response to an ADR letter.
S B9000	Claims ready to go to a Common Working File (CWF) Host Site.
S B9099	Claims awaiting a response from a CWF Host Site.
S M0nnn	Suspended claims/adjustments requiring Palmetto GBA staff intervention (the "n" denotes a variety of FISS location codes).

CLAIMS SUMMARY INQUIRY SCREEN

Field descriptions for the Claim Summary Inquiry screen are provided in the table following Figure 18.

```
MAPnnnn          M E D I C A R E   A   O N L I N E   S Y S T E M
xx                       CLAIM SUMMARY INQUIRY
                        NPI
      HIC               PROVIDER nnnnnn          S/LOC          TOB
 OPERATOR ID  DDEDKA       FROM DATE          TO DATE           DDE SORT
 MEDICAL REVIEW SELECT
      HIC             PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS









    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Figure 18 – Claim Summary Inquiry Screen

Field Name	Description
NPI	This field identifies the National Provider Identifier number.
HIC	Type the health insurance claim number to view a particular beneficiary's claims data.
PROVIDER	Your Medicare ID number will automatically display. **Note:** If your facility has sub-units/aliases (e.g., SNF, ESRD, CORF, ORF) the provider number of the sub-unit must be typed in this field. If the correct provider number associated with the claim you wish to view is not entered, an error message ("`PROCESS COMPLETE --- NO MORE DATA THIS TYPE`") will be received.
S/LOC	Status and location allows you to type a particular status and location you want to view. See Section 1 for more information regarding status and location codes.
TOB	Type of bill allows you to enter a particular type of bill you want to view. The TOB field consists of 3 digits. The first position indicates the type of facility. The second indicates the type of care. The third position indicates the bill frequency. The first tow positions are required for a search.
OPERATOR ID	Operator ID is automatically displayed and indicates the individual who accessed the screen.
FROM DATE	Type the "From Date" of service you want to view (in MMDDYY format).
TO DATE	Type the "To Date" of service you want to view (in MMDDYY format).
DDE SORT	This field allows the listed claims to be sorted according to specific criteria. Note: This is only accessible in Claims Correction mode.
Medical Review Select	This field is used to narrow the claim selection for inquiry. This provides the ability to view only claims pending or returned for medical review. Note: This field is only accessible in Claims Correction mode.

Field Name	Description
SEL	This field is used to select a claim to view or update. Tab down to the claim and enter an "S" to view or a "U" to update. Note: When this screen appears, this field is blank.
First Line Of Data	
HIC	Patient's health insurance claim number as it was originally typed.
PROV/MRN	Medicare provider number/Medical Record Number assigned to the facility by CMS. MRN-USED IN Claims Correction mode.
S/LOC	The status/location code assigned to the claim by the FISS.
TOB	The type of facility, bill classification and frequency of the claim in a particular period of care.
ADM DT	The admission date on the claim.
FRM DT	The "From Date" on the claim.
THRU DT	The "Through Date" on the claim.
REC DT	The date the claim was received in the FISS.
Second Line Of Data	
SEL	Type an "**S**" under this field to the left of a specific claim to select that claim. Press [ENTER] to display "detailed" claim information for the claim you selected. See the Claim Entry section of the DDE manual for descriptions of the fields on the entire claim inquiry screen.
LAST NAME	The beneficiary's last name.
FIRST INIT	The beneficiary's first initial.
TOT CHG	The total charges billed on the claim.
PROV REIMB	The provider's reimbursement amount. This field is signed to indicate positive or negative amounts.
PD DT	The date the claim was paid, partially paid, or processed.
CAN DT	The date the claim was canceled.
REAS	Reason code assigned by the FISS (refer to the on-line reason code file).

Field Name	Description
NPC	Non-payment code used by the system to deny or reject charges. Valid values are: B = Benefits exhausted C = Non-covered care (discontinued) E = First claim development (Contractor 11107) F = Trauma code development (Contractor 11108) G = Secondary claims investigation (Contractor 11109) H = Self reports (Contractor 11110) J = 411.25 (Contractor 11111) K = Insurer voluntary reporting (Contractor 11106) N = All other reasons for non-payment P = Payment requested Q = MSP Voluntary Agreements (Contractor 88888) Q = Employer Voluntary Reporting (Contractor 11105) R = Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely, or waiver of liability T = MSP Initial Enrollment Questionnaire (Contractor 99999) T = MSP Initial Enrollment Questionnaire (Contractor 11101) U = MSP HMO Cell Rate Adjustment (Contractor 55555) U = HMO/Rate Cell (Contractor 11103) V = MSP Litigation Settlement (Contractor 33333) W = Workers Compensation X = MSP cost avoided Y = IRS/SSA data match project, MSP cost avoided (Contractor 77777) Y = IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102) Z = System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim; this code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed 00 = COB Contractor (Contractor 11100) 12 = Blue Cross – Blue Shield Voluntary Agreements (Contractor 11112) 13 = Office of Personnel Management (OPM) Data Match (Contractor 11113) 14 = Workers' Compensation (WC) Data Match (Contractor 11114)
#DAYS	Not available in inquiry mode.

PERFORMING CLAIMS INQUIRIES

1. To start the inquiry process, enter the beneficiary's Medicare number, or leave out the beneficiary's Medicare number and enter any of the following fields:
   - ♦ Type of bill (TOB)
   - ♦ S/LOC
     - Type an "**S**" in the first position of the S/LOC field to view all the suspended claims
     - Type a "**P**" in the first position of the S/LOC field to view all the paid/processed claims
     - Type a "**T**" in the first position of the S/LOC field to view claims returned for correction
   - ♦ From Date
   - ♦ To Date
2. Once the appropriate claim history displays, type an "**S**" in the SEL field in front of the claim you wish to view.
3. Press **[ENTER]** to display the DDE electronic claim. Refer to Section 5 – Claim Entry for illustrations of the UB-04 claim screens and field descriptions.

   Note: You may only select one claim at the time.

VIEWING AN ADDITIONAL DEVELOPMENT REQUEST (ADR) LETTER

An ADR is an additional development request for medical records. Palmetto GBA's medical review department uses ADRs to request medical records from providers during the medical review process. Do the following to view an ADR letter for claims in the ADR status/location:

1. Type "**S B6**" in the S/LOC field.
2. Press **[ENTER]** and all claims in an S B6000 or S B6001 status/location will display.
3. Type an "**S**" in the SEL field of the desired claim and press **[ENTER]**.
4. The ADR letter immediately follows claim page 6 (MAP 1716). The ADR will consist of 2 pages. **Note:** Do not use the [F9] function key with these claims. If you press [F9], the FISS will generate a new ADR.

Revenue Codes

Select option "**13**" from the Inquiry Menu to access the Revenue Code Table Inquiry screen. This screen provides information regarding revenue codes that are billable for certain types of bills with the Fiscal Intermediary's system. This should be referenced when you need to determine:

- ♦ The type of revenue codes that are allowed with certain types of bills
- ♦ If a HCPCS code is required
- ♦ If a unit is required
- ♦ If a rate is required

To start the inquiry, type in the revenue code about which you are inquiring and press **[ENTER]**.

REVENUE CODE TABLE INQUIRY SCREEN

Field descriptions are provided in the table following Figure 19.

```
MAPnnnn          M E D I C A R E  A   O N L I N E   S Y S T E M
xx                        REVENUE CODE TABLE INQUIRY

               REV CD 0551
EFF DT 070166    IND F                    TERM DT

NARR SKILLED NURS/VISIT

        ALLOW:              HCPC:              UNITS:             RATE:
 TOB      EFF-DT TRM-DT      EFF-DT TRM-DT      EFF-DT TRM-DT      EFF-DT TRM-DT
 ---    --------------     --------------     --------------     --------------
 33X    Y 070166           V 070199           Y 070166           N
 34X    N                  N                  N                  N
 71X    Y 070166           N                  Y 070166           N
 72X    N                  N                  N                  N
 73X    N                  N                  N                  N
 74X    Y 070166           N                  Y 070166           N
 75X    Y 070166           N                  Y 070166           N
 81X    N                  N                  N                  N
 82X    N                  N                  N                  N
 83X    N                  N                  N                  N

      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Figure 19 – Revenue Code Table Inquiry Screen

Field Name	Description
REV CD	Type the revenue code (0001-9999) that identifies a specific accommodation, ancillary service or billing calculation.
EFF DT	Date the code became effective/active.
IND	The effective date indicator instructs the system to either use the "from" date on the claim or the System Run Date to perform edits for this revenue code. Valid codes are: F = From date R = Receipt date D = Discharge date
TERM DT	Date the code was terminated/no longer active.
NARR	English-language description of the code.
TOB	Identifies all Type of Bill codes within the Medicare Part A system that are allowed by Medicare.
ALLOW	Identifies whether the revenue code is currently valid for a specific Type of Bill. Valid values are: Y = Yes N = No
HCPC	Identifies whether a Healthcare Common Procedure Code (HCPC) is required from specific types of providers for this Revenue Code by Type of Bill. Valid values are: Y = HCPC required for all providers N = HCPC not required V = Validation of HCPC is required F = HCPC required only for claims from free-standing ESRD facility H = HCPC required only for claims from hospital-based ESRD facility

Field Name	Description
UNITS	Identifies if the revenue code requires units to be present for a specific Type of Bill. Valid values are: Y = Yes N = No
RATE	Identifies if the revenue codes require a rate to be present for a specific Type of Bill. Valid values are: Y = Yes N = No

Claims Count Summary

Select option "**56**" from the Inquiry Menu to access the Claim Summary Totals Inquiry screen. This screen provides a mechanism for providers to obtain information on:

- Total number of pending claims
- Total charges billed
- Total reimbursement for claims in each FISS status/location

The data on this screen updates with each nightly FISS cycle. Palmetto GBA recommends that providers review this screen at the start of each day to monitor the progress of submitted claims.

CLAIM SUMMARY TOTALS INQUIRY SCREEN

Press **[ENTER]** to display the data applicable to the provider number identified, **or** you can type in a specific status/location or category type to narrow the search. Field descriptions are provided in the table following Figure 20.

```
MAPnnnn          M E D I C A R E   A   O N L I N E   S Y S T E M
xx                  CLAIM SUMMARY TOTALS INQUIRY

      PROVIDER nnnnnn          S/LOC          CAT

 S/LOC     CAT    CLAIM COUNT    TOTAL CHARGES    TOTAL PAYMENT









    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Figure 20 – Claim Summary Totals Inquiry Screen

Field Name	Description
PROVIDER	Automatically filled with the provider number, but accessible if the provider is authorized to view other provider numbers.
S/LOC	The status/location of the claim can be used as search criteria.
CAT	The category can be used as search criteria.
S/LOC	The status/location identifies the condition of the claim and/or location of the claim.
CAT	The Bill Category identifies the type of claims in specific locations by Type of Bill. In addition, a value that identifies the total claim number for each status/location. Valid values include: nn = First two digits of any TOB appropriate to the provider; e.g., 11, 13, 32, 72, etc. MP = Medical Policy – Medical policy applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code **is** a 5. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. NM= Non-Medical Policy – Applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code **is not** a 5. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. AD = Adjustments – Within each status/location. Claims in this category are also counted under the standard bill category. Therefore, claims in this category **are not** included in the total count (TC). TC = Total Count – Is the total within each status/location **excluding** claims with a category of AD, MN, or MP. GT = Grand Total – For the provider of all categories in all status/locations. This total will print at the beginning of the listing and associated status/locations will be blank. The grand total is displayed only when the total by Provider is requested.
CLAIM COUNT	The total claim count for each specific status/location.
TOTAL CHARGES	The total dollar amount accumulated for the total number of claims identified in the claim count.
TOTAL PAYMENT	The total dollar payment amount that has been calculated by the system. This is an accumulated dollar amount for the total number of claims identified in the claim count. For those claims suspended in locations prior to payment calculations, the total payment will equal zeros.

Check History Inquiry

Select option "**FI**" from the Inquiry Menu to access the Check History screen. This screen lists Medicare payments for the last three issued checks, paid hardcopy or electronically. If you are interested in electronic payment, contact the EDI Department. Press **[ENTER]** and the last three checks issued by Medicare will display.

Note: The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information. **[TAB]** to the PROVIDER field and type in the provider number.

CHECK HISTORY SCREEN

Field descriptions for the Check History screen are provided in the table following Figure 21.

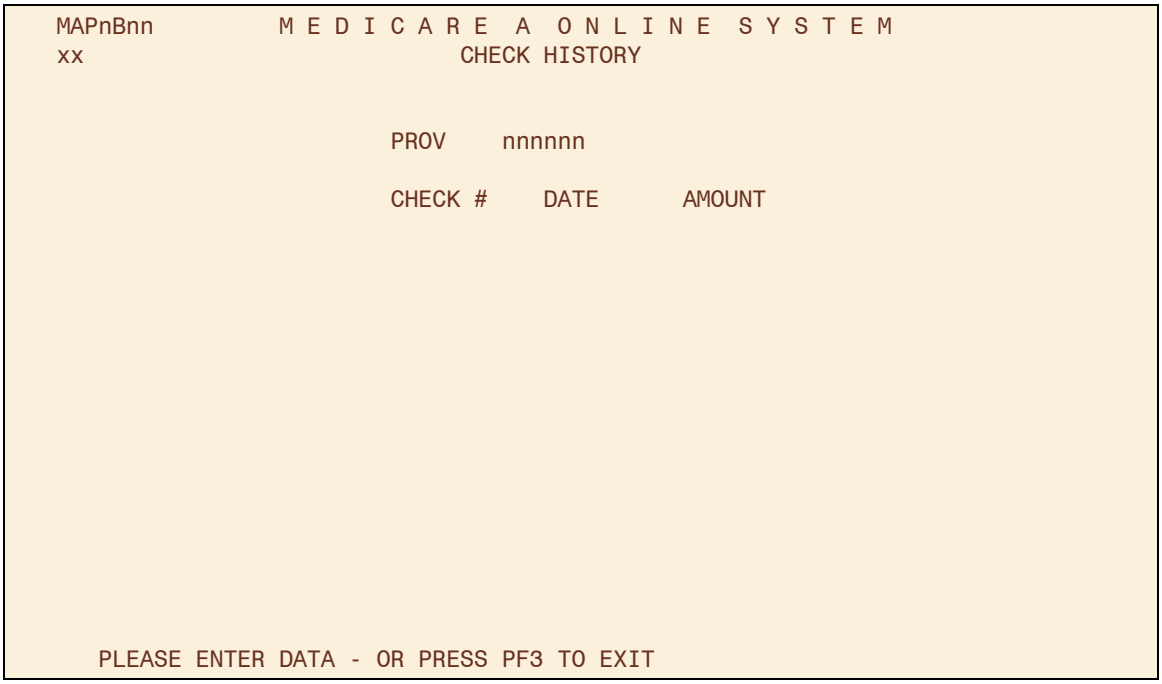


Figure 21 – Check History Screen

Field Name	Description
PROV	The Medicare assigned provider number.
CHECK #	The last three payments issued to the provider by Medicare. Leading zeros indicate a check. 'EFT' indicates electronic fund transfer.
DATE	The date when the payments were issued.
AMOUNT	The dollar amount of the last three payments issued to the provider.

HCPC Inquiry

Select option "**14**" from the Inquiry Menu to access the HCPC Inquiry screen. This screen displays the current rate utilized to price specific outpatient services identified by a HCPCS code. The FISS does **pre-payment** processing of HCPCS codes for laboratory services; but Radiology, Ambulatory Surgery Center (ASC), Durable Medical Equipment (DME), and Medical Diagnostics HCPC service codes are processed **post-payment**.

To start the inquiry process, enter the HCPCS code and the Locality code, then press **[ENTER]**.

HCPC INQUIRY SCREEN

Field descriptions for the HCPC Inquiry screen are provided in the table following Figure 22.

```
MAPnnnn       M E D I C A R E  A  O N L I N E  S Y S T E M
xx                          HCPC INQUIRY

CARRIER        LOC     HCPC       MOD    IND
EFF DT      TRM DT       PROVIDER      DRUG CODE

      E O F O C   ANES
EFF.   TRM.    F V E P A PC BASE
DATE   DATE    F R E H T TC VAL  ALLOWABLE REVENUE CODES




 HCPC DESCRIPTION



      PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 22 – HCPC Inquiry Screen

Field Name	Description
CARRIER	The Medicare Intermediary identification number. The Carrier Number will be system filled.
LOCALITY CODE	The area (or county) where the provider is located. This field accepts as a valid value only the six locality codes entered on the Provider File and "01." If a HCPC does not exist for the specific locality, the system will default to a "01," except for 90743 with a locality of "00."
HCPC	Type the five-digit HCPC code to view.
MOD	This field identifies Multiple fees for one HCPC code based on the presence or absence of a modifier in this field. The default value is blank unless a valid modifier is entered for the HCPC.
IND	HCPC Indicator-this field is not used in DDE.
EFF DT	This field identifies the National Drug Code effective date.
TRM DT	This field identifies the National Drug Code termination date.
PROVIDER	This field identifies the identification number of the Alias Provider.
DRUG CODE	This field identifies whether the HCPC is a drug. "E" The HCPC is a drug ' ' The HCPC is not a drug
EFF DT	This field identifies when the change in pricing went into effect. MMDDYY format.
TRM DT	This field identifies the termination date for each rate listed for this HCPC.
EFF	Effective Date Indicator: This indicator instructs the system to use From/Through dates on claims or use the system run date to perform edits for this particular HCPC date. Valid values are: R = Receipt Date F = From Date D = Discharge Date

Field Name	Description
OVR	The override code instructs system in applying the services to the beneficiary deductible and coinsurance. Valid values are: 0 = Apply deductible and coinsurance 1 = Do not apply deductible 2 = Do not apply coinsurance 3 = Do not apply deductible or coinsurance 4 = No need for total charges (used for multiple HCPC for single revenue code centers) 5 = RHC or CORF psychiatric M = EGHP (may only be used on the 0001 total line for MSP) N = Non-EGHP (may only be used on the 0001 total line for MSP) Y = IRS/SSA data match project; MSP cost avoided
FEE	Displays the fee indicator received in the Physician Fee Schedule file. Valid values include: B = Bundled Procedure R = Rehab/Audiology Function Test/CORF Services " "= Space
OPH	The Outpatient Hospital Indicator, with six occurrences, displays the outpatient hospital indicator received in the Physician Fee Schedule abstract test file. Valid values are: 0 = Fee applicable in Hospital Outpatient Setting 1 = Fee not applicable in Hospital Outpatient Setting " "= Space
CAT	Category Code: This field identifies the CMS category of the DME equipment. '1' Inexpensive or routinely purchased DME '2' DME items requiring frequent maintenance and substantial servicing '3' Certain customized DME items '4' Prosthetic or orthotic devices '5' Capped rental DME items '6' Oxygen and oxygen equipment

Field Name	Description
PCTC	Professional Component/Technical Component: This field identifies the indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) services Supplemental Fee Schedule. PC/TC HPSA Payment Policy '0' Pay the Health Professional Shortage Area (HPSA) bonus. '1' Globally billed, only the professional component of this service qualifies for the HPSA bonus payment. The HPSA bonus cannot be paid on the technical component of globally billed services. Action: Return the service as un-processable and instruct the provider to re-bill the service as a separate professional and technical component procedure code. The HPSA modifier should only be used with the professional component code, and the incentive payment should not be paid unless the professional component can be separately identified. '2' Professional component only, pay the HPSA bonus. '3' Technical component only, do not pay the HPSA bonus. '4' Global test only, the professional component of this service qualifies for the HPSA bonus payment. Action: Return the service as un-processable and instruct the provider to re-bill the service as a separate professional and technical component procedure code. The HPSA modifier should only be used with the professional component code, and the incentive payment should not be paid unless the professional component can be separately identified. '5' Incident codes, do not pay the HPSA bonus. '6' Laboratory physician interpretation codes, pay the HPSA bonus. '7' Physical therapy service, do not pay the HPSA bonus. '8' Physician interpretation codes, pay the HPSA bonus. '9' Concept of PC/TC does not apply, do not pay the HPSA bonus.
ANES BASE VAL	Identifies the anesthesia base values.
ALLOWABLE REVENUE CODES	Billable UB-04 revenue codes for the HCPC entered. The fourth digit of the revenue code may be stored with an "X" indicating it is variable. By leaving this field blank, the system will allow a HCPC on any revenue code.
HCPC DESCRIPTION	Narrative for the HCPC.

Diagnosis & Procedure Code Inquiry

Select option "**15**" from the Inquiry Menu to access the ICD-9-CM Code Inquiry screen. This screen displays an electronic description for the ICD-9-CM Codebook. This screen should be used as reference for ICD-9-CM code(s) to identify a specific diagnosis code or inpatient surgical procedure code for a related bill.

To inquire about an ICD-9-CM diagnosis code, type the three-, four-, or five-digit code in the STARTING ICD9 CODE field. If more than one ICD-9 code is listed, review the most current effective date and termination date. To make additional ICD-9-CM inquiries type new information over the previously entered data.

To inquire about an ICD-9-CM procedure code, type the letter P followed by the three- or four-digit procedure code in the STARTING ICD9 CODE field. Do not type the decimal point or zero-fill the code. If the code entered requires a fourth and/or firth digit, an asterisk (*) will appear after the description. If an invalid code is entered, the system will select the nearest code.

ICD-9-CM Code Inquiry Screen

Field descriptions are provided in the table following Figure 23.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
xx                          ICD-9-CM CODE INQUIRY
STARTING  ICD9 CODE:

ICD9 CODE                   DESCRIPTION:
          EFFECTIVE/TERM DATE    EFFECTIVE/TERM DATE    EFFECTIVE/TERM DATE









     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 23 – ICD-9-CM Code Inquiry Screen

Field Name	Description
STARTING ICD-9 CODE	To view all ICD-9-CM codes, press [ENTER] in this field. The ICD-9-CM code is used to identify a specific diagnosis (es) or inpatient surgical procedure(s) relating to a bill, which may be used to calculate payment (i.e., DRG) or make medical determination relating to a claim.
ICD-9 CODE	The specific ICD-9 code to be viewed.
DESCRIPTION	A description of ICD-9 code.
EFFECTIVE/ TERM DATE	The effective date of the program and the program ending date (both in MMDDYY format).

Adjustment Reason Code Inquiry

Select option "**16**" from the Inquiry Menu to access the Adjustment Reason Codes Inquiry screen. This screen provides an on-line access method to identify a two-digit adjustment reason code and a narrative description for the adjustment reason code. It can also be used to validate the adjustment reason code entered on an adjustment.

To start the inquiry process, type in an adjustment reason code and press **[ENTER]**, or just press **[ENTER]** and a list of adjustment reason codes will be displayed.

ADJUSTMENT REASON CODES INQUIRY SELECTION SCREEN

Field descriptions are provided in the table following Figure 24.

```
 MAPnnnn          M E D I C A R E   A   O N L I N E   S Y S T E M    OP: UBN0
 XX                    ADJUSTMENT REASON CODES INQUIRY               DT: 102903
                              SELECTION SCREEN
 CLAIM TYPES:
 I = INPATIENT/SNF, O = OUTPATIENT, H = HOME HEALTH/CORF, A = ALL CLAIMS
 PLAN CODE: 1        REASON CODE:
S PC RC TYPE                       NARRATIVE
  1  AA A AUTOMATED ADJUSTMENT
  1  AD I ADMISSION DENIAL – TECHNICAL DENIAL  (PRO REVIEW CODE – A)
  1  AM I ADMISSION DENIAL-NO PAYMENT (MEDICAL DENIAL) PRO REVIEW CODE-A
  1  AR I ADMISSION REVERSAL –(HARDCOPY ADJUSTMENT)
  1  AS A AMBULATORY SURGICAL CENTER
  1  AU A AUTOMOBILE
  1  AW I ADMISSION DENIAL-PAYABLE PER WAIVER
  1  BC A CWF CORRUPTED BENE CORRECTION
  1  BL A BLACK LUNG
  1  CA I COST OUTLIER APPROVED
  1  CC A CHANGE CHARGE
  1  CD I COVERED DAYS CHANGES (B)
  1  CO I COST OUTLIER-NO PAYMENT (E)
  1  CP I COST OUTLIER PARTIAL APPROVED
  1  CR A CLAIM RECONSIDERATION
      PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

Figure 24 – Adjustment Reason Codes Inquiry Selection Screen

Field	Description
CLAIM TYPES	Describes the claim types identified for each adjustment reason code.
PLAN CODE	Differentiates between plans (Intermediaries) that share a processing site. The home/host site is considered "1" by the system. It is the number assigned to the site on the System Control file. Valid values are 1-9.
REASON CODE	To view a specific adjustment reason code, enter the value in this field. To view all adjustment reason codes, press [ENTER] in this field. There are hard-coded and user-defined codes. *PRO Review Code letters are indicated in brackets.
S	Selection – Used to view information for a particular code. To select an adjustment reason code, tab to desired code, enter '**S**' in the selection field, and press **[ENTER]**.
PC	The Plan Code differentiates between plans (Intermediaries) that share a processing site. The home or host site is considered "1" by the system. It is the number assigned to the site on the System Control file. Valid values are 1-9.
RC	Displays the adjustment reason code. To review a particular adjustment reason code, enter the adjustment reason code value in this field.
TYPE	Displays the type of claim associated with this reason code. Valid values are: I = Inpatient/SNF O = Outpatient H = Home Health/CORF A = All Claims
NARRATIVE	The narrative provides a short description for the adjustment reason code.

FISS Reason Codes Inquiry

Select option "**17**" from the Inquiry Menu to access the Reason Codes Inquiry screen. This screen displays the reason code narrative used for billing errors on the claim, and it explains what fields need to be changed or completed in order to resubmit the claim for processing. The Reason Codes File contains the following data:

- Reason code identification number and effective/termination date
- Alternative reason code identification number and effective/termination date
- Status and location set on the claim
- Post payment location
- Reason code narrative
- Clean claim indicator
- Additional Development Request (ADR) orbit counter and frequency

To start the inquiry process, enter the five-digit numeric reason code and press **[ENTER]**. To make additional inquiries, type over the reason code with next reason code and press **[ENTER]**.

REASON CODES INQUIRY SCREEN

Field descriptions are provided in the table following the examples shown in Figures 25 and 26.

```
 MAPnnnn       M E D I C A R E  A  O N L I N E  S Y S T E M    OP:
 XX                        REASON CODES INQUIRY                DT:
PLAN REAS  NARR   EFF      MSN      EFF      TERM    EMC    HC/PRO  PP   CC
IND  CODE  TYPE   DATE     REAS     DATE     DATE   ST/LOC  ST/LOC  LOC  IND
 1          E
 TPTP A    B    NPCD A     B     HD CPY A    B    NB ADR     CAL DY     C/L
--------------------------------NARRATIVE-------------------------------------









     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 25 – Reason Code Inquiry Screen, Example 1

```
 MAPnnnn       M E D I C A R E  A  O N L I N E  S Y S T E M    OP: MAnnnn
 XX                      REASON CODES INQUIRY                  DT: 040503
PLAN REAS  NARR   EFF      MSN      EFF      TERM    EMC    HC/PRO  PP   CC
IND  CODE  TYPE   DATE     REAS     DATE     DATE   ST/LOC  ST/LOC  LOC  IND

 TPTP A   B    NPCD A     B     HD CPY A    B    NB ADR     CAL DY     C/L
-------------------------------NARRATIVE-------------------------------------
AN INPATIENT, OUTPATIENT, OR SNF CLAIM HAS SERVICE DATES EQUAL TO OR
OVERLAPPING A HOSPICE ELECTION PERIOD.  THEREFORE, NO MEDICARE PAYMENT CAN BE
MADE.  IF BILLING IS FOR THE TREATMENT OF A NON-TERMINAL CONDITION FOR THE
HOSPICE PATIENT, PLEASE RESUBMIT CLAIM WITH THE APPROPRIATE CONDITION CODE.









      PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
 PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
```

Figure 26 – Reason Code Inquiry Screen, Example 2

Field Name	Description
OP	Identifies the last operator who created or revised the reason code.
DT	Identifies the date that this code was last saved.
PLAN IND	Plan Indicator. All FISS shared maintenance customers will be "1"; the value for FISS shared processing customers will be determined at a later date.
REAS CODE	Identifies a specific condition detected during the processing of a record.
NARR TYPE	The "type" of reason code narrative provided. This field defaults to "E" for external message.
EFF DATE	Identifies the effective date for the reason code or condition.
MSN REAS	The Medicare Summary Notice reason code is used when MSNs requiring BDL messages are produced. The reason code on the claim will be tied to a specific MSN reason code on the reason code file that will point to a specific MSN message on the ACS/MSN file.
EFF DATE	Effective date for the MSN reason code.
TERM DATE	Termination date for the MSN reason code.
EMC ST/LOC	Identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. If it is the same for both hard copy and EMC claims, the data will only appear in the hard copy category and the system will default to the hard copy claims for action on EMC claims.
HC/PRO ST/LOC	Hardcopy/Peer Review Organization status and location code for hard copy (paper) and peer review organization claims. This is the path DDE will follow.

Press **[F8]** on the Reason Codes Inquiry screen to display the ANSI Related Reason Code Inquiry screen (Figure 27). This screen provides the ANSI reason code equivalent to the FISS reason code. Press **[F7]** to return to the Reason Codes Inquiry screen.

```
MAPnnnn       M E D I C A R E  A  O N L I N E  S Y S T E M    OP: MAnnnn
XX                 ANSI RELATED REASON CODES INQUIRY         DT: 040503

REASON CODE: C7010
PIMR ACTIVITY CODE:          DENIAL CODE: 100003          MR INDICATOR:
             PCA INDICATOR:              LMRP/NCD ID:

ANSI CODES
  ADJ REASONS: B9

  GROUPS     : CO

  REMARKS    :

  APPEALS (A): MA02  MA13


  APPEALS (B): MA01  MA13


  CATEGORY   :  EMC F2       HC F2

  STATUS     :  EMC 0188     HC 0188

          PRESS PF3-EXIT  PF7-PREV PAGE
```

Figure 27 – ANSI Related Reason Codes Inquiry Screen

ANSI Reason Code Inquiry

Select option "**68**" from the Inquiry Menu to access the ANSI (American National Standard Institute) Reason Codes Inquiry Selection Screen. This screen displays the remark codes that appear on both the standard paper remittance advice and the electronic remittance advice. These codes signify the presence of service-specific Medicare remarks and informational messages that cannot be expressed with a reason code. To start the inquiry process, enter the specific ANSI reason code and press **[ENTER]**, or you can just press **[ENTER]** and a list of ANSI reason codes will display.

Field descriptions are provided in the table following Figure 28.

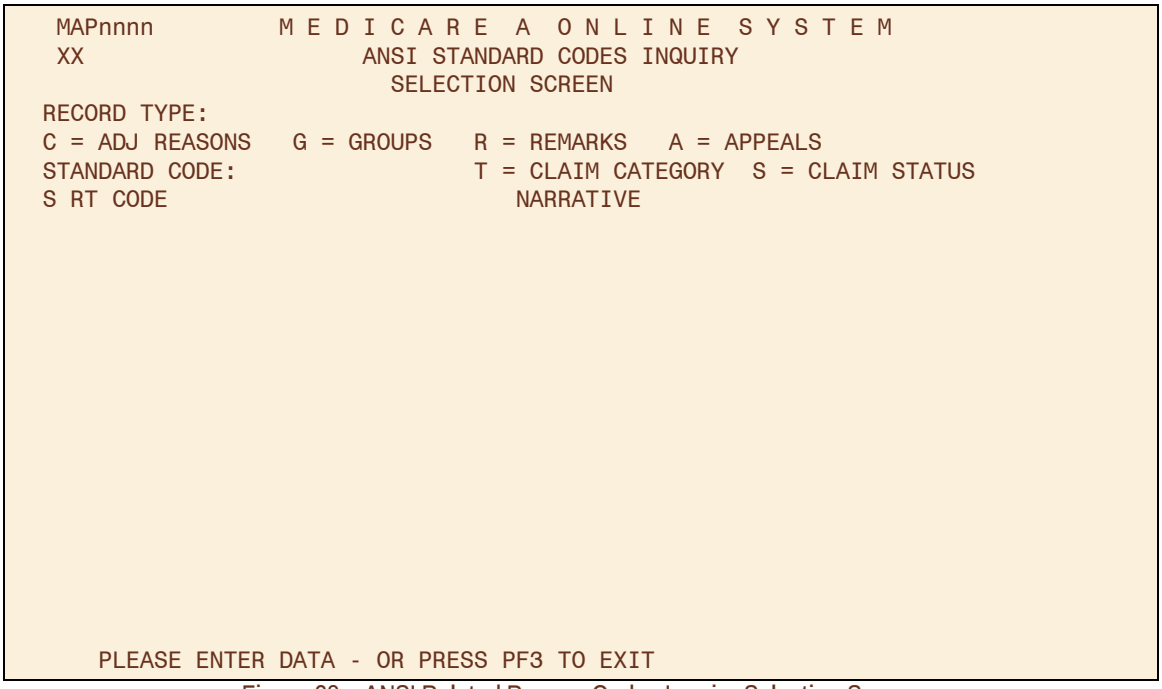


Figure 28 – ANSI Related Reason Codes Inquiry Selection Screen

Field Name	Description
RECORD TYPE	Identifies the ANSI record type for the standard code for inquiry or updating. Valid values include: A = Appeals C = Adjustment reason G = Groups R = Reference remarks S = Claim Status T = Claim category
STANDARD CODE	The standard code within the above record type for inquiry or updating. If the record code is present and no standard code is shown, all standard codes for the record type will display. If both record and standard codes are present, the standard codes are shown. All ANSI codes will be displayed in record type/ standard code sequence.
S	Code selection field to select a specific code from the listing.
RT	The record type selected.
CODE	The standard code selected.
NARRATIVE	The description of the standard code. This is the only field that can be updated for a standard code.

ANSI Reason Code Narrative

To display the entire narrative for one specific ANSI code:

1. Type an "**S**" in the S (Select) field to select the entire narrative for the ANSI reason code (see Figure 29).

```
 MAPnnnn         M E D I C A R E  A  O N L I N E  S Y S T E M
 XX                    ANSI STANDARD CODES INQUIRY
                         SELECTION SCREEN
RECORD TYPE:
C = ADJ REASONS   G = GROUPS   R = REMARKS   A = APPEALS
STANDARD CODE:                 T = CLAIM CATEGORY  S = CLAIM STATUS
S RT CODE                         NARRATIVE
  A MA01  IF YOU DISAGREE WITH WHAT WE APPROVED FOR THESE SERVICES, YOU HAVE
  A MA02  IF YOU DISAGREE WITH THIS DETERMINATION, YOU HAVE A RIGHT TO APPEA
  A MA03  IF YOU DISAGREE WITH MEDICARE APPROVED AMOUNTS AND $100 OR MORE IS
  A MA04  SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTIFY OF OR
  A MA05  INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL ENTRY ON
  A MA06  INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
S A MA07  THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID FOR
  A MA08  YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSURER. WE
  A MA09  CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YOU
  A MA10  THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU MUST
  A MA11  PAYMENT IS ON A CONDITIONAL BASIS. IF NO-FAULT, LIABILITY, WORKERS
  A MA12  YOU HAVE NOT ESTABLISHED THAT YOU HAVE THE RIGHT UNDER THE LAW TO
  A MA13  YOU MAY BE SUBJECT TO PENALTIES IF YOU BILL THE BENEFICIARY FOR
  A MA14  PATIENT BELONGS TO AN EMPLOYER-SPONSORED PREPAID HEALTH PLAN. SERV
  A MA15  YOUR CLAIM HAS BEEN SEPARATED TO EXPEDITE HANDLING. YOU WILL RECEI
     PROCESS COMPLETED  ---   PLEASE CONTINUE
 PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

Figure 29 – ANSI Related Reason Codes Inquiry Selection Screen, ANSI Reason Code List

2. Press **[ENTER]** to display the ANSI Standard Codes Inquiry screen (see Figure 30).

```
 MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M     OP: MASTER
 XX                ANSI STANDARD REASON CODES INQUIRY           DT: 083094

 RECORD TYPES ARE:
C = ADJ REASONS   G = GROUPS   R = REMARKS   A = APPEALS
                               T = CLAIM CATEGORY S = CLAIM STATUS
                          RECORD TYPE   : A

                          STANDARD CODE : MA07

                          NARRATIVE:

 THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID FOR
 REVIEW.









          PRESS PF3-EXIT  PF7-PREV PAGE
```

Figure 30 – ANSI Standard Codes Inquiry Screen

SECTION 5 – CLAIM ENTRY

This section provides information on how to enter:

- UB-04s into the DDE format
- Electronic Roster Bills
- Hospice Election Statements

The Claims and Attachments Entry Menu (Main Menu option 02) may be used for online entry of patient billing information from the UB-04. Options are available to allow entry of various attachments. The UB-04 Claim Entry consists of six (6) separate screens/pages:

Page 01 Patient information (corresponds to form locators 1-41)

Page 02 Revenue/HCPCS codes and charges (corresponds to form locators 42-49)

Page 03 Payer information, diagnoses/procedure codes (corresponds to form locators 50-57 and 67-83)

Page 04 Remarks and attachments (corresponds to form locators 84-86)

Page 05 Other payer and MSP information (corresponds to form locators 58-66)

Page 06 MSP information, crossover, and other inquiry (**does not** corresponds to any form locator)

General Information

- The online system defaults to the 111 type of bill for inpatient claims, 131 for outpatient claims, and 211 for SNF claims. If you are entering a different type of bill, then type over the default with the correct type of bill.
- On the bottom of each screen is a list of the PF function keys and the functions they perform.
- Field names within DDE will not always follow the same order as found on the UB-04 claim form. In order to help alleviate confusion, the "UB-04 X-REF" field on each page directs you to the field that correlates to the UB-04 form.
- For valid values associated with the claim entry field, please refer to your current Uniform Billing manual. The "UB-04 X-REF" field will direct you to the field that correlates to the UB-04 form noted in the manual.

TRANSMITTING DATA

- When claim entry is completed, press **[F9]** to store the claim and transmit the data.
- If any information is missing or entered incorrectly, the DDE system will display reason codes at the bottom of the claim screen so that you can correct the errors. The claim will not transmit until it is free of front-end edit errors.
- Correcting Reason Codes:
  - Press **[F1]** to see an explanation of the reason code. After reviewing the explanation, press **[F3]** to return to your claim and make the necessary corrections. If more than one reason code appears, continue this process until all reason codes are eliminated and the claim is successfully captured by the system.
  - If more than one reason code is present, pressing **[F1]** will always bring up the explanation of the first reason code unless the cursor is positioned over one of the other reason codes. Working through the reason codes in the order they are listed is the most efficient method. Eliminating the reason codes at the beginning of the list may result in the reason codes at the end of the list being corrected as well.

Note: The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information. **[TAB]** to the PROVIDER field and type in the provider number.

To access the Claim and Attachments Entry Menu (Figure 31), select option "**02**" from the Main Menu.

```
MAPnnnn                        PALMETTO GBA
                    CLAIM AND ATTACHMENTS ENTRY MENU

                           CLAIMS ENTRY

                    INPATIENT                20
                    OUTPATIENT               22
                    SNF                      24
                    HOME HEALTH              26
                    HOSPICE                  28
                    NOE/NOA                  49
                    ROSTER BILL ENTRY        87

                           ATTACHMENT ENTRY

                    HOME HEALTH              41
                    DME HISTORY              54
                    ESRD  CMS-382 FORM       57

   ENTER MENU SELECTION:


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 31 – Claim and Attachments Entry Menu

Electronic UB-04 Claim Entry

When entering UB-04s, select the option from the Claim and Attachments Entry Menu that best describes your Medicare line of business:

- Inpatient.....20
- Outpatient.....22
- SNF 24
- Home Health 26
- Hospice 28
- Hospice Elections ...87

UB-04 Claim Entry – Page 1

After you select an option, page one of the UB-04 Claim Entry screen (Figure 32) will display. The screen will include the Provider Number, Type of Bill, and default Status/Location. You must enter the beneficiary information (name, address, date of birth, etc.) and any other information needed to process the claim. Field descriptions are provided in the table following Figure 32.

```
 MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 01
 XX                        CLAIM ENTRY                        SV:
 HIC               TOB     S/LOC S        OSCAR                 UB-FORM
NPI    TRANSFERING HOSPICE PROVIDER                PROCESS NEW HIC
PATIENT.CNTL#               TAX SUB:                TAXO.CD:
 STMT DATES FROM         TO         DAYS COV      N-C       CO      LTR
 LAST                           FIRST                 MI    DOB
 ADDR 1                                  2
      3                                  4
      5                                  6
ZIP           SEX   MS   ADMIT DATE        HR    TYPE   SRC   D HM      STAT
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01           02           03           04           05
              06           07           08           09           10
   SPAN CODES/DATES 01                  02                  03
04                  05                  06                  07
08                  09                  10                FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01                      02                      03
04                      05                      06
07                      08                      09
     PLEASE ENTER DATA
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV   PF8-NEXT
```

Figure 32 – UB-04 Claim Entry Screen, Page 1

Field Name	UB-04 X-Ref.	Description
SV		Suppress View: This field allows a claim to be suppressed.
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
STATUS		The Status code identifies the condition and of the claim within the system.
LOCATION		The Location code identifies where the claim resides within the system.
OSCAR	51	Displays the identification number of the institution that rendered services to the beneficiary/patient. The system will automatically pre-fill the Medicare Oscar number when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, CORF, ORF) the Medicare Oscar number must be changed to reflect the provider you wish to submit claims for. If the Medicare Oscar number is not changed for your sub-units, the claims will be processed under the incorrect Oscar number.
UB-FORM		Identifies the type of claim to be processed. All claims must be entered on the same form type. Valid values are: '9' = UB-92 'A' = UB-04
NPI		This field identifies the National Provider Identifier number.
TRANSFER-RING HOSPICE PROVIDER		Displays the identification number of the institution that rendered services to the beneficiary/patient. System-generated for external operators that are directly associated with one provider.

Field Name	UB-04 X-Ref.	Description
PROCESS NEW HIC	60	Identifies when the incorrect beneficiary health insurance claim number is present, and then the correct health insurance claim number can be keyed. Not applicable on new claim entries. Valid values include: Y = Incorrect HIC is present E = The new HIC number is in a cross-reference loop ***or*** the new HIC entered is cross-referenced on the Beneficiary file and this cross-referenced HIC is also cross-referenced. The chain continues for 25 HIC numbers. S = The cross-referenced HIC number on the Beneficiary file is the same as the original HIC number on the claim.
PATIENT CNTL#	3	The patient's unique number assigned by the provider to facilitate retrieval of individual patient records and posting of the payment.
FED. TAX NO/SUB	5	This field identifies the number assigned to the provider by the Federal Government for tax reporting purposes.
TAXO.CD	5	This field identifies a collection of unique alphanumeric codes. The code set is structured into three distinct "levels" including provider type, classification, and area of specialization.
STMT DATES	6	The statement covers (from and to) dates of the period covered by this bill (in MMDDYY format).
DAYS COV	7	Indicates the total number of covered days. This field is skipped on Home Health and Hospice claims. ♦ Enter the total number of covered days during the billing period (within the "From" and "Through" dates in UB-04 X-REF 6 - Statement Covers Period), which are applicable to the cost report, including lifetime reserve days elected (for which hospital requested Medicare payment). ♦ The numeric entry reported in this UB-04 X-REF should be the same total as the total number of covered accommodation units reported in UB-04 X-REF 46. ♦ Exclude any days classified as non-covered (see UB-04 X-REF 8 - Non-covered Days) and leave of absence days. ♦ Exclude the day of discharge or death (unless the patient is admitted and discharged the same day). Do not deduct days for payment made by another primary payer.
N-C	8	Indicates the total number of non-covered days. Enter the total number of non-covered days in the billing period. ♦ Enter the total number of covered days during the billing period (within the "From" and "Through" dates in UB-04 X-REF 6 - Statement Covers Period). These days are not covered Medicare payment days on the cost report and the beneficiary will not be charged utilization for Medicare Part A Services. ♦ The reason for non-coverage should be explained by occurrence codes (UB-04 X-REFs 32-35), and/or occurrence span code (UB-04 X-REF 36). Provide a brief explanation of any non-covered days not described via occurrence codes in UB-04 X-REF 84, "Remarks." (Show the number of days for each category of non-covered days, e.g., "5 leave days"). ♦ Day of discharge or death is not counted as a non-covered day. Do not deduct days for payment made by another primary payer.

Field Name	UB-04 X-Ref.	Description
CO	9	Co-Insurance Days are the inpatient Medicare hospital days occurring after the 60th day and before the 91st day. Enter the total number of inpatient or SNF co-insurance days.
LTR	10	Lifetime Reserve Days – This field only used for hospital inpatient stays. Enter the total number of inpatient lifetime reserve days the patient elected to use during this billing period.
LAST	12	Patient's last name at the time services were rendered.
FIRST	12	Patient's first name.
MI	12	Patient's middle initial.
DOB	14	The patient's date of birth (in MMDDYYYY format).
ADDR 1, 2, 3, 4, 5, 6	13	Patient's street address. Must input in fields 1 and 2. State is a 2-character field.
ZIP	13	Valid zip code (minimum of 5 digits).
DOB		The patient's date of birth in MMDDYYYY format.
SEX	15	The patient's sex. Refer to your UB-04 Manual for valid values.
MS	16	The patient's marital status. Not required. Refer to your UB-04 Manual for valid values.
ADMIT DATE	17	Enter date patient was admitted.
HR	18	Enter the hour the patient was admitted (for hospitals only).
TYPE	19	The type of admission. Enter the appropriate inpatient code that indicates the priority of the admission. (This is not required for SNFs or outpatient facilities.) Refer to your UB-04 Manual for valid values.
SRC	20	The source of admission. Enter appropriate code indicating the source of this admission. Refer to your UB-04 Manual for valid values.
D HM	21	Enter the time at which the patient was discharged from inpatient care (in HHMM format)
STAT	22	Indicates the patient's status at the ending service date in the period. Refer to your UB-04 Manual for valid values.
COND CODES	24-30	The condition codes are used to identify conditions relating to this bill that may affect claim processing, up to 30 occurrences. Refer to your UB-04 Manual for valid values.
OCC CDS/ DATE	32 – 35	The Occurrence Codes and Dates field consists of a two-digit alphanumeric code and a six-digit date in MMDDYY format. Report all appropriate occurrences, up to 30 occurrences. Refer to your UB-04 Manual for valid values.
SPANCODE/ DATES	36	Enter the appropriate Occurrence Span and Date code and associated beginning (From) and ending (Thru) dates defining a specific event relating to this billing period. Refer to your UB-04 Manual for valid values.
FAC.ZIP		This field identifies the provider or subpart nine-digit zip code.
DCN		The Document Control Number is not required when entering a new bill. Applicable only on adjustments, void/cancel TOB nn7 and nn8.
VALUE CODES-AMOUNTS-ANSI	39 - 41	The Value Codes and related dollar amount(s) identify monetary data necessary for the processing of a claim. ANSI is a 5-digit field made up of 2-digit Group Codes and 3-digit Reason (Adjustment) Code. This field is system-filled and will be used for sending ANSI information for the value codes to the Financial System for reporting on the remittance advice. Refer to your UB-04 Manual for valid values.

UB-04 CLAIM ENTRY – PAGE 2

Enter the following information on page two of the UB-04 Claim Entry screen:

- Revenue codes (in ascending numeric sequence)
- Dollar amounts (without decimal points)
- Revenue code 001 should be used in the final revenue code entry and correspond with the totals for "Total Charges" and "Non-covered Charges"
- List revenue codes in ascending numeric sequence
- Type in the dollar amounts without a decimal point (e.g., for $45.50, type "4550")
- Revenue code 001 should always be the final revenue code entry and correspond with the totals for "Total Charges" and "Non-covered Charges"
- To delete a revenue code line, type 4 zeros over the revenue code and press Enter, or type '**D**' in first position of field
- To insert a revenue code line, type it at the bottom of the list and press Enter, DDE will automatically re-sort the lines
- **[F2]** – a "jump key," when placed on a revenue code on MAP171A, allows you to scroll to the same revenue code line on MAP171A

There are additional revenue screens available. Press **[F6]** to page forward and **[F5]** to page back. To delete a revenue code line, type four zeros over the revenue code and press **[ENTER]**. To insert a revenue code line, type it at the bottom of the list and press **[ENTER]**. The system will re-sort the lines. See Figure 33 and the table describing the fields on the next page.

```
MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M   CLAIM PAGE 02
XX                          CLAIM ENTRY                 REV CD PAGE 01

HIC nnnnnnnnnA    TOB 111  S/LOC S B0100  PROVIDER nnnnnn

                                 TOT    COV
CL  REV  HCPC MODIFS       RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE SERV DT
 1
 2
 3
 4
 5
 6
 7
 8
 9
10
11
12
13
14

      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

Figure 33 – UB-04 Claim Entry Revenue Screen

Field Name	UB-04 X-Ref.	Description
CL		Identifies the claim line number of the Revenue Code. There are 13 revenue code lines per page with a total of 450 revenue code lines possible per claim. The system will input the revenue code line number when [F9] is pressed. It will be present for update and inquiry.
REV	42	The Revenue Code for a specific accommodation or service that was billed on the claim. Valid values are 0001 through 9999. ♦ List revenue codes in an ascending sequence and do not repeat revenue codes on the same bill if possible. ♦ To limit line item entries on each bill, report each revenue code only once, except when distinct HCPCS code reporting requires repeating a revenue code (e.g., laboratory services, revenue code 300, repeated with different HCPCS codes), or an accommodation revenue code that requires repeating with a different rate. ♦ Revenue code 001 (total charges) should always be the final revenue code entry. ♦ Some codes require CPT/HCPCS codes, units and/or rates.
HCPC	44	Enter the HCPCS code describing the service, if applicable. HCPCS coding must be reported for specific outpatient services including, but not limited to: ♦ Outpatient clinical diagnostic laboratory services billed to Medicare, enter the HCPCS code describing the lab service; ♦ Outpatient hospital bills for Medicare defined "surgery" procedure; ♦ Outpatient hospital bills for outpatient partial hospitalization; ♦ Radiology and other diagnostic services; ♦ Durable Medicare Equipment (including orthotics and prosthetics); ♦ ESRD drugs, supplies, and laboratory services; ♦ Inpatient Rehabilitation Facility (IRF) PPS claims, this HCPC field contains the submitted HIPPS/CMG code required for IRF PPS claims; and Other Provider services in accordance with CMS billing guidelines.
MODIFS		A 2-digit alphanumeric modifier (up to 2 occurrences).
RATE	44	Enter the rate for the revenue code if required.
TOT UNT	46	Total Units of Service indicates the total units billed. This reflects the units of service as a quantitative measure of service rendered by revenue category.
COV UNT	46	Covered Units of Service indicates the total covered units. This reflects the units of service as a quantitative measure of service rendered by revenue category.
TOT CHARGES	47	Report the total charge pertaining to the related revenue code for the current billing period as entered in the statement covers period.
NCOV CHARGES	48	Report non-covered charges for the primary payer pertaining to the related revenue code. Submission of bills by providers for all stays, including those for which no payment can be made, is required to enable the Intermediary and CMS to maintain utilization records and determine eligibility on subsequent claims. When non-covered charges are present on the bill, remarks are required in UB-04 X-REF 84.

Field Name	UB-04 X-Ref.	Description
SERV DT	45	The service date is required for every line item where a HCPCS code is required effective April 1, 2000, including claims where the "from" and "through" dates are equal. Inpatient Rehabilitation Facility (IRF) PPS claims, this field is not required on the Revenue Code 0024 line. However, if present on the Revenue Code 0024 line, it indicates the date the Provider transmitted the patient assessment. This date, if present, must be equal to or greater than the discharge date (Statement Cover To Date).

UB-04 Claim Entry – Page 2, Line Level Reimbursement (MAP171A)

This screen displays line item payment information and allows entry of more than two modifiers. Access the MAP171A screen (Figure 34) by pressing **[F2]** or **[F11]** on Page 2 MAP171. Field descriptions are provided in the table following Figure 34.

```
 MAPnnnA        M E D I C A R E  A  O N L I N E  S Y S T E M   CLAIM PAGE 02
 XX                         CLAIM ENTRY
 DCN                          HIC               RECEIPT DATE          TOB
 STATUS    LOCATION           TRAN DT           STMT COV DT           TO
   1                     SERV
  REV  HCPC MODIFIERS    DATE      RATE    TOT-UNT COV-UNT    TOT-CHRG     COV-CHRG

                          ANES CF           ANES BV         PC/TC IND
                DEDUCTIBLES           COINSURANCE         ESRD-RED/    VALCD-05/
             BLOOD        CASH     WAGE-ADJ     REDUCED   PSYCH/HBCF      OTHER
 PAT ->
 MSP ->                                              ANSI ->
                                                   OUTLIER ->               PAY/HCPC
             PAYER-1     PAYER-2      OTAF    DENIAL IND   OCE FLAGS        APC CD
 MSP ->                                                    1 2 3 4 5 6 7 8
  ID ->
             REIMB                    RESP       PAID
 PAT ->                                                          LABOR    NON-LABOR
PROV ->
 MED ->                             PRICER        PAY                        ASC
          ADJUSTMENT  ANSI        AMT    RTC    METHOD    IDE/NDC/UPC       GRP %
CONTR->
30715                                                        <== REASON CODES
 PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DN PF7-PRE PF8-NXT PF9-UPDT PF10-LT PF11-RT
```

Figure 34 – UB-04 Claim Entry, Page 2, Line Level Reimbursement

Field Name	UB-04 X-Ref.	Description
[Untitled]		This field identifies the Claim Line Number of the revenue code. There are 14 revenue code lines per page with a total of 450 revenue code lines per claim. In entry mode this field automatically fills when the claim is processed. The line number will be present for update and inquiry.
REV	42	The Revenue Code displays a code for a specific accommodation or service that was billed on the claim. This will be the revenue code selected on MAP1712.
HCPC	44	The Healthcare Common Procedure Code identifies certain medical procedures or equipment for special pricing, assigned by CMS.

Field Name	UB-04 X-Ref.	Description
MODIFIERS		This field will contain five 2-character HCPCS modifiers. The two modifiers entered on MAP1712 will be displayed and the user can enter any remaining modifiers.
SERV DATE	45	The date of service (in MMDDYY format) required for many outpatient bills. It will be the same as the line item selected on MAP1712.
RATE	44	Identifies the per-unit cost for a particular line item. This is the rate that was entered on MAP1712.
TOT-UNT	46	Total Units is a quantitative measure of services rendered by revenue category. The total units displayed on this screen are the same as that entered on MAP1712.
COV-UNT	46	Covered Units is a quantitative measure of services rendered by revenue category. The covered units displayed on this screen are the same as that entered on MAP1712.
TOT-CHRG	47	The total charges displayed on this page are the same as that entered on MAP1712.
COV-CHRG		This field identifies the covered units billed by revenue category.
ANES CF		This field identifies the anesthesia conversion factor.
ANES BV		This field identifies the anesthesia base values.
PC/TC IND		This field identifies the PC/TC Indicator that is added to the CORF services Supplemental Fee Schedule.
PAT BLOOD DEDUCTIBLE		The amount of Medicare Patient Blood Deductible applied to the line item. Blood deductible will be applied at the line level on revenue codes 380, 381 and 382. This field is system filled.
PAT CASH DEDUCTIBLE		The amount of Medicare Patient Cash Deductible applied to the line item. This field is system filled.
WAGE ADJ COINSURANCE		The amount of Patient Wage Adjustment Coinsurance applicable to the line based on the particular service rendered. The revenue and HCPCS code submitted define the service. For services subject to outpatient PPS (OPPS) in hospitals (TOB 12X, 13X and 14X) and in community mental health centers (TOB 76X), the applicable coinsurance is wage adjusted. Therefore, this field will have either a zero (for the services without applicable coinsurance) or a regular coinsurance amount (calculated on either charges or a fee schedule), unless the service is subject to OPPS. If the service is subject to OPPS, the national coinsurance amount will be wage adjusted, based on the MSA where the Provider is located or assigned as the result of a reclassification. CMS supplies the national coinsurance amount to the FIs, as well as the MSA by Provider. This field is system filled.
REDUCED COINSURANCE		For all services subject to OPPS (TOB 12n, 13n, 14n, and 76n) the amount of Patient Reduced Coinsurance applicable to the line for a particular coinsurance amount. Providers are only permitted to reduce the coinsurance amount due from the beneficiary for services paid under OPPS, and the reduced amount cannot be lower than 20% of the payment rate for the line. If the provider does not elect to reduce the coinsurance amount, the field will contain zeros.

Field Name	UB-04 X-Ref.	Description
ESRD-RED/PSYCH/ HBCF		The Patient End Stage Renal Disease Reduction/Psychiatric Reduction/Hemophilia Blood Clotting Factor will notate one of three values: ♦ ESRD reduction refers to the ESRD network reduction amount and is found on Claim Page 1 in Value Code 71. ♦ Psychiatric reduction applies to line items that have a "P" pricing indicator. The amount represents the psychiatric coinsurance amount (37.5% of covered charges). ♦ Hemophilia Blood Clotting Factor represents an additional payment to the DRG payment for hemophilia. The additional payment is based on the applicable HCPC. This payment add-on applies to inpatient claims.
VALCD-05/ OTHER		If Value Code 05 is present on the claim, this field will contain the portion of the value code 05 amount that is applicable to this line item. The value code 05 amount is first applied to revenue codes 96n, 97n and 98n, and then applied to revenue code lines in numeric order that are subject to deductible and/or coinsurance.
MSP BLOOD DEDUCTIBLE		This field identifies the Medicare Secondary Payer Blood Deductible amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
MSP CASH DEDUCTIBLE		This field identifies the Medicare Secondary Payer Cash Deductible amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
MSP COINSURANCE		This field identifies the Medicare Secondary Payer Coinsurance amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
ANSI ESRD-RED/PSYCH/ HBCF		This 2-character Group Code and 3-character Reason (Adjustment) Code is used to send ANSI information to the Financial System for reporting on the remittance advice for the ESRD Reduction/Psychiatric Coinsurance/ Hemophilia Blood Clotting Factor.
ANSI VALCD-05/OTHER		This 2-character Group Code and 3-character Reason (Adjustment) Code is used to send ANSI information to the Financial System for reporting on the remittance advice for the Value Code 05/Other amount.
MSP PAYER-1		The amount entered by the user (if available) or apportioned by MSPPAY as payment from the primary (Medicare Secondary Payer 1) payer. The MSPPAY module based on amount in the value code for the primary payer apportions this amount.
MSP PAYER-2		The amount entered by the user (if available) or apportioned by MSPPAY as payment from the secondary (Medicare Secondary Payer 2) payer. The MSPPAY module based on amount in the value code for the secondary payer apportions this amount.
OTAF		The Obligated to Accept in Full field contains the line item apportioned amount entered by the user (if available) or apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full. This field will be populated when value code 44 is present.

Field Name	UB-04 X-Ref.	Description
DENIAL IND		The Medicare Secondary Payer Denial Indicator field provides the user an opportunity to tell the MSPPAY module that an insurer primary to Medicare has denied this line item. Valid values are: ' ' = Blank D = Denied
OCE FLAGS		The Outpatient Code Editor flags identify eight fields that are returned by the OCE module via the APC return buffer. OCE flags are: Flag 1 = Service Flag 2 = Payment Flag 3 = Discounting Factor Flag 4 = Line Item Denial or Rejection Flag 5 = Packing Flag 6 = Payment Adjustment Flag 7 = Type of Bill Inclusion Flag 8 = Line Item Action
PAY/HCPC APC CD		**HCPC Ambulatory Patient Classification Code –** Identifies the APC (Payment Ambulatory Patient Classification Code) group number by line item. Payment for services under the OPPS is calculated based on grouping outpatient services into APC groups. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. Both APC codes appear on the claims file, but only one appears on the screen. If their values are different, this indicates a partial hospitalization item. In this case the payment APC code is displayed. When the item is not a partial hospitalization, the HCPC APC code is displayed. This data is read from the claims file. If an APC is not found, the value will default to '00000.' Claim page 31 displays the HIPPS code if different from what is billed. If medical changes the code, the new HIPPS code is displayed in the PAY/HCPC APC CD field and a value of 'M' is in the OCE flag 1 field. When a value of 'M' is in the OCE flag 1 field, the MR IND field is automatically populated with a 'Y.' If Pricer changes the code, the new HHRG is displayed in the PAY/HCPC APC CD field and a value of 'P' is in the OCE flag 1 field. If the HIPPS code was not changed, fields PAY/HCPC APC CD and OCE flag 1 are blank. For Home Health PPS claims, claim page 31 displays the HIPPS code if different from what is billed. If the Inpatient Rehabilitation Facility (IRF) PPS Pricer returns a HIPPS/CMG code different from what was billed, the new HIPPS/CMG code is displayed on the revenue code 0024 line in the PAY/HCPC/APC CD field and a value of 'I' is displayed in the OCE FLAG 1 field. If the IRF PPS pricer does not change the HIPPS/CMG code, these fields are blank.
MSP Payer-1 ID		This Medicare Secondary Payer Payer-1 ID code identifies the specific payer. If Medicare is primary, this field will be blank. Valid values are: 1 = Medicaid 2 = Blue Cross 3 = Other 4 = None A = Working Aged

Field Name	UB-04 X-Ref.	Description
		B = End Stage Renal Disease (ESRD) Beneficiary in 12-month coordination period with an employer group health plan C = Conditional Payment D = Auto No-Fault E = Workers' Compensation F = Public Health Service or other Federal Agency G = Disabled H = Black Lung I = Veterans Administration L = Liability
MSP Payer-2 ID		This Medicare Secondary Payer Payer-2 ID code identifies the specific payer. If Medicare is secondary, this field will be blank. Valid values are the same as for the MSP Payer-1 ID field.
PAT REIMB		The Patient Reimbursement amount is determined by the system to be paid to the patient on the basis of the amount entered by the Provider on claim page 3, in the "Due from Pat" field. This amount is the calculated line item amount.
PAT RESP		Patient Responsibility identifies the amount for which the individual receiving services is responsible. The amount is calculated as follows ♦ If the Payer-1 indicator is "C" or "Z," then the amount will equal Cash Deductible + Coinsurance + Blood Deductible. ♦ If the Payer-1 indicator is not "C" or "Z," then the amount will equal MSP Blood + MSP Cash Deductible + MSP Coinsurance.
PAT PAID		This is the patient paid amount calculated by the system. This amount is the lower of Patient Reimbursement + Patient Responsibility or the remaining Patient Paid (after the preceding lines have reduced the amount entered on Claim Page 3).
PROV REIMB		The Provider Reimbursement amount determined by the system. This is the calculated line item amount.
LABOR		Identifies the labor amount of the payment as calculated by the pricer.
NON-LABOR		Identifies the non-labor amount of the payment as calculated by the pricer.
MED REIMB		This is the total Medicare Reimbursement for the line item. It will be the sum of the Patient Reimbursement and the Provider Reimbursement.
CONTR ADJUSTMENT		The following calculation will be performed to obtain the total Contractual Adjustment: (Submitted Charges) – (Deductible) – (Wage Adjusted Coinsurance) – (Blood Deductible) – (Value Code 71) – (Psychiatric Reduction) – (Value Code 05/Other) – (Reimbursement Amount). For MSP claims, the MSP deductible, MSP blood deductible and MSP coinsurance are used in the above calculation in place of the deductible, blood deductible and coinsurance amounts.
ANSI		The ANSI Group-ANSI Adjustment Code consists of a 2-character group code and a 3-character reason (adjustment) code. It is used to send ANSI information to the Financial System for reporting on the remittance advice.
OUTLIER		Identifies the apportioned line level outlier amount returned from MSPPAYOL.
PRICER AMT		The Pricer Amount provides the line item reimbursement received from a pricer.

Field Name	UB-04 X-Ref.	Description
PRICER RTC		Identifies the Pricer Return Code from OPPS. Valid values include: *Describes how the bill was priced* 00 = Priced standard DRG payment 01 = Paid as day outlier/send to PRO for post payment review 02 = Paid as cost outlier/send to PRO for post payment review 03 = Paid as per diem/not potentially eligible for cost outlier 04 = Standard DRG, but covered days indicate day outlier but day or cost outlier status was ignored 05 = Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 = Pay per diem days only for transfers without an approved outlier 10 = Bad state code for SNF Rug Demo or Post Acute Transfer for Inpatient PPS Pricer DRG is 209, 210 or 211 12 = Post acute transfer with specific DRGs of 14,113,236, 263, 264, 429, 483 14 = Paid normal DRG payment with per diem days = or > average length of stay 16 = Paid as a Cost Outlier with per diem days = or > average length of stay 20 = Bad revenue code for SNF Rug Demo or invalid HIPPS code for SNF PPS Pricer 30 = Bad Metropolitan Statistical Area (MSA) Code *Describes why the bill was not priced* 50 = No Provider specific information found 52 = Invalid MSA in Provider file 53 = Waiver State – no calculated by PPS 54 = DRG not '001'-'468' or '471'-'910' 55 = Discharge date is earlier than Provider's PPS start date 56 = Invalid length of stay 57 = Review code not '00' – '07' 58 = Charges not numeric 59 = Possible day outlier candidate 60 = Review code '01' and length of stay indicates day outlier. Bill is not eligible as cost outlier 61 = Lifetime reserve days not numeric 62 = Invalid number of covered days (e.g., more than approved length of stay, non-numeric or lifetime reserve days greater than covered days) 63 = Review code of '00' or'03,' and bill is cost outlier candidate 64 = Disproportionate share percentage and bed size conflict on Provider specific file 98 = Cannot process bill older than 10/01/87

Field Name	UB-04 X-Ref.	Description
PAY METHOD		Identifies the method of payment (i.e., OPPS, LAB fee schedule, etc.) returned from OCE. Valid values include: 1 = Paid standard OPPS amount (service indicators 'S,' 'T,' 'V,' 'X,' or 'P') 2 = Services not paid under OPPS (service indicator 'A,' or no HCPCS code and certain revenue codes) 3 = Not paid (service indicators 'C' or 'E') 4 = Acquisition cost paid (service indicator 'F') 5 = Designated current drug or biological payment adjustment (service indicator 'G') 6 = Designated new device payment adjustment (service indicator 'H') 7 = Designated new drug or new biological payment adjustment (service indicator 'J') 8 = Not used at present 9 = No separate payment included in line items with APCS (service indicator 'N,' or no HCPCS code and certain revenue codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization program services)
IDE/NDC/UPC		This field contains IDE, NDC, or UPC. IDE- Investigational Device Exemption NDC Reserved for future use UPC Reserved for future use
ASC GRP		Identifies the Ambulatory Surgical Center Group code for the indicated revenue code.
ASC %		Identifies the Ambulatory Surgical Center Percentage used by the ASC Pricer in its calculation for the indicated revenue code.

UB-04 CLAIM ENTRY – PAGE 2 (MAP171D)

This page is a copy of core claim MAP103I, claim page 32. Providers may only view this page. No additions, modifications or deletions may be made here.

Field descriptions for this screen are provided in the table following Figure 35.

```
 MAPnnnD        M E D I C A R E  A  O N L I N E  S Y S T E M   CLAIM PAGE 02
 XX                            CLAIM ENTRY
 DCN                          HIC               RECEIPT DATE         TOB
 STATUS    LOCATION           TRAN DT           STMT COV DT          TO
 PROVIDER ID                  BENE NAME
 NONPAY CD     GENER HARDCPY       MR INCLD IN COMP          CL MR IND
 TPE-TO-TPE    USER ACT CODE       WAIV IND    MR REV URC    DEMAND
 REJ CD        MR HOSP RED         RCN IND     MR HOSP-RO   ORIG UAC
 MED REV RSNS
 OCE MED REV RSNS
         HCPC/MOD IN    SERV                              -----REASON-CODES------
  REV  HCPC MODIFIERS   DATE  COV-UNT   COV-CHRG   ADR
                                          FMR
 ORIG                      ORIG REV         MR      ODC
 OCE OVR      CWF OVR      NCD OVR      NCD DOC     NCD RESP NCD#   OLUAC
         NON       NON    DENIAL OVER ST/LC  MED  ------------ANSI------------
 LUAC  COV-UNT   COV-CHRG  REAS  CODE OVER   TEC  ADJ  GRP ------REMARKS------




 TOTAL                          LINE ITEM REASON CODES
30715                                                    <== REASON CODES
     PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

Figure 35 – UB-04 Claim Entry, Page 2 (MAP171D)

Field Name	UB-04 X-Ref.	Description
PROVIDER ID		Identifies the identification number of the Provider submitting the claim.
BENE NAME		The name of the Beneficiary (20 positions for the last name and 10 positions for the first name).
NON PAY CD		The Non-Pay Code identifies the reason for Medicare's decision not to make payment. Valid values include: B = Benefits exhausted C = Non-Covered Care (discontinued) E = First Claim Development (Contractor 11107) F = Trauma Code Development (Contractor 11108) G = Secondary Claims Investigation (Contractor 11109) H = Self Reports (Contractor 11110) J = 411.25 (Contractor 11111) K = Insurer Voluntary Reporting (Contractor 11106) N = All other reasons for non-payment P = Payment requested Q = MSP Voluntary Agreements (Contractor 88888) Q = Employer Voluntary Reporting (Contractor 11105) R = Spell of illness benefits refused, certification refused, failure to submit evidence, Provider responsible for not filing timely or Waiver of Liability T = MSP Initial Enrollment Questionnaire (Contractor 99999 or 11101) U = MSP HMO Cell Rate Adjustment (Contractor 55555) U = HMO/Rate Cell (Contractor 11103) V = MSP Litigation Settlement (Contractor 33333) V = Litigation Settlement (Contractor 11104) W = Workers Compensation X = MSP cost avoided

<table>
<tr><th>Field Name</th><th>UB-04 X-Ref.</th><th>Description</th></tr>
<tr><td></td><td></td><td>Y = IRS/SSA Data Match Project MSP Cost Avoided (Contractor 77777)
Y = IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102)
Z = System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed.
00 = COB Contractor (Contractor 11100)
12 = Blue Cross – Blue Shield Voluntary Agreements (Contractor 11112)
13 = Office of Personnel Management (OPM) Data Match (Contractor 11113)
14 = Workers' Compensation (WC) Data Match (Contractor 11114)</td></tr>
<tr><td>GENER HARDCPY</td><td></td><td>Instructs the system to generate a specific type of hard copy document. Valid values include:
2 = Medical ADR
3 = Non-Medical ADR
4 = MSP ADR
5 = MSP Cost Avoidance ADR
7 = ADR to Beneficiary
8 = MSN (Line Item) or Partial Benefit Denial Letter
9 = MSN (Claim Level) or Benefit Denial Letter</td></tr>
<tr><td>MR INCLD IN COMP</td><td></td><td>The Composite Medical Review Included in the Composite Rate field that identifies (for ESRD bills) if the claim has been denied because the service should have been included in the Comp Rate. Valid value is "Y" (the claim has been denied)</td></tr>
<tr><td>CL MR IND</td><td></td><td>This indicator identifies if all services on the claim received Complex Manual Medical Review. The value entered in this field automatically populates the MR IND field for all revenue code lines on the claim. Valid values are:
' ' = The services did not receive manual medical review (default)
Y = Medical records received. This service received complex manual medical review
N = Medical records were not received. This service received routine manual medical review</td></tr>
<tr><td>TPE-TO-TPE</td><td></td><td>Identifies the tape-to-tape flag (if applicable). The flag indicators across the top of the chart instruct the system to either perform or skip each of the four functions listed on the left of the chart below. The first indicator column represents a blank. If this field is blank, all functions are performed (as indicated on this chart).
<table>
<tr><th>Function</th><th>' '</th><th>Q</th><th>R</th><th>S</th><th>T</th><th>U</th><th>V</th><th>W</th><th>X</th><th>Y</th><th>Z</th></tr>
<tr><td>Transmit to CWF</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>N</td></tr>
<tr><td>Print on Remittance Advice</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>N</td><td>Y</td><td>Y</td><td>N</td></tr>
<tr><td>Include on PS&R</td><td>Y</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td></tr>
<tr><td>Include on Workload</td><td>Y</td><td>Y</td><td>N</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>N</td><td>N</td></tr>
</table></td></tr>
</table>

Field Name	UB-04 X-Ref.	Description
USER ACT CODE		The User Action Code is used for medical review and reconsideration only. The first position is the User Action Code and the second position is the Reconsideration Code. The reconsideration user action code will always be 'R.' When a reconsideration is performed on the claim, the user should enter a 'R' in the second position of the claim user action code, or in the line user action code field. This tells the system that reconsideration has been performed. Valid values include: *Medical Review* A = Pay per waiver - full technical. B = Pay per waiver - full medical. C = Provider liability - full medical - subject to waiver provisions. D = Beneficiary liability - full - subject to waiver provisions. E = Pay claim - line full. F = Pay claim - partial - claim must be updated to reflect liability. G = Provider liability - full technical - subject to waiver provisions. H = Full or partial denial with multiple liabilities. Claim must be updated to reflect liability. I = Full Provider liability - medical - not subject to waiver provisions. J = Full Provider liability - technical - not subject to waiver provisions. K = Full Provider liability - not subject to waiver provisions. M = Pay per waiver - line or partial line. N = Provider liability - line or partial line. O = Beneficiary liability - line or partial line. P = Open biopsy changed to closed biopsy. Q = Release with no medical review performed. R = CWF (Common Working File) denied but medical review was performed. Z = Force claim to be re-edited by Medical Policy. *Special Screening* 5 = Generates systematically from the reason code file to identify claims for which special processing is required. 7 = Force claim to be re-edited by Medical Policy edits in the 5XXXX range but not the 7XXXX range. 8 = A claim was suspended via an OCE MED review reason. 9 = Claim has been identified as 'First Claim Review.'
WAIV IND		Identifies whether the Provider has their presumptive waiver status. Valid values are: Y = The Provider does have their waiver status N = The Provider does not have their waiver status
MR REV URC		The Medical Review Utilization Review Committee Reversal field identifies whether an SNF URC Claim has been reversed. This indicator can be used for a partial or a full reversal. Valid values are: P = Partial reversal F = Full reversal, the system reverses all charges and days

Field Name	UB-04 X-Ref.	Description
DEMAND		The Medical Review Demand Reversal field identifies that an SNF demand claim has been reversed. Valid values are: P = Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal. F = Full reversal, the system reverses all charges and days.
REJ CD		The Reject Code identifies the reason code for which the claim is being denied.
MR HOSP RED		The Medical Review Hospice Reduced field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. Valid values are: ' ' = Not reduced Y = Reduced
RCN IND		The Reconsideration Indicator is used only for home health claims. Valid values include: A = Finalized count affirmed B = Finalized no adjustment count (pay per waiver) R = Finalized count reversal (adjustment) U = Reconsideration
MR HOSP-RO-REF		The Medical Review Regional Office Referred field identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. Valid values are: ' ' = Not referred Y = Referred
MED REV RSNS		The Medical Review Reasons field identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field displays medical review reasons specific to claim level. The system determines this by a "C" in the claim/line indicator on the reason code file. The medical review reasons must contain a "5" in the first position.
OCE MED REV RSNS		The OCE Medical Review field displays the edit returned from the OPPS version of OCE. Valid values include: 11 = Non-covered service submitted for review (condition code 20) 12 = Questionable covered service 30 = Insufficient services on day of partialization 31 = Partial hospitalization on same day as electro convulsive therapy or type T procedure 32 = Partial hospitalization claim spans 3 or less days with insufficient services, or electro convulsive therapy or significant procedure on at least one of the days 33 = Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services
UNTITLED		This Claim Line Number field identifies the line number of the revenue code. The line number is located above the revenue code on this map. To move to another revenue code, enter the new line number and press [ENTER].
REV		Identifies the Revenue Code for a specific accommodation or service that was billed on the claim. This information was entered on MAP1712. Valid values are 01 to 9999. To move to the next Revenue Code with a line level reason code, position the cursor in the page number field and press [F2].

Field Name	UB-04 X-Ref.	Description
HCPC/MOD IN		Identifies if the HCPC Code, Modifier or REV Code was changed. Valid values are: U = Up coding D = Down coding ' ' = Blank A "U" or "D" in this field opens the REV Code and HCPC/Mod fields to accept the changed code. Enter "U" or "D," tab down to the REV Code and HCPC/ MOD fields. After the new code is entered, the original Rev Code and HCPC/MOD fields move down to the ORIG REV or ORIG HCPC/MOD field.
HCPC		Identifies the HCPC code that further defines the revenue code being submitted. The information on this field was entered on MAP1712.
MODIFIERS		Identifies the HCPCS modifier codes for claim processing. This field may contain five-2 position modifiers.
SERV DATE		The line item date of service, in MMDDYY format, and is required for many outpatient bills. This information was entered on MAP1712.
COV-UNT		The number of covered units associated with the revenue code line item being denied.
COV-CHRG		The number of covered charges associated with the revenue code line item being denied.
ADR REASON CODES		Identifies the Additional Development Reason Codes that are present on the screen and allows the user to manually enter up to four occurrences to be used when an ADR letter is to be sent. The system reads the ADR code narrative to print the letter. The letter prints the reason code narrative as they appear on each revenue code line.
FMR REASON CODES		The Focused Medical Review Suspense Codes identify when a claim is edited in the system, based on a parameter in the Medical Policy Parameter file. The system generates the Medical Review code for the corresponding line item on the second page of the Denial/Non-Covered/Charges screen. The system assigns the same Focused Medical Review ID edits on lines that are duplicated for multiple denial reasons. The user may enter or overlay any existing Medical Review suspense codes. Claim level suspense codes should not apply to the line level. The Medical Policy reasons are defined by a "5" or "7" in the first position of the reason code.
ODC REASON CODES		This field identifies original denial reason codes.
ORIG		Identifies the original HCPC billed and modifiers billed, accommodating a 5-digit HCPC and up to 5 2-digit modifiers.
ORIG REV CD		Identifies the Original Revenue Code billed.
MR		This field indicates if the service received complex manual medical review. The valid values are: ' ' The services did not receive manual medical review (default value) 'Y' Medical records received. This service received complex manual medical review 'N' Medical records were not received. This service received routine manual medial review.

Field Name	UB-04 X-Ref.	Description
OCE OVR		The OCE Override is used to override the way the OCE module controls the line item. Valid values include: 0 = OCE line item denial or rejection is not ignored 1 = OCE line item denial or rejection is ignored 2 = External line item denial. Line item is denied even if no OCE edits 3 = External line item rejection. Line item is rejected even if no OCE edits
CWF OVR		The CWF Home Health Override field overrides the way the OCE module controls the line item.
NCD OVR		This Override Indicator identifies whether the line has been reviewed for medical necessity and should bypass the National Coverage Determination (NCD) edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. Valid values are: ' ' = Default value. The NCD edits are not bypassed. A blank in this field is set on all lines for resubmitted RTP'd claims. Y = The line has been reviewed for medical necessity and bypasses the NCD edits. D = The line has no covered charges and bypasses the NCD edits.
NCD DOC		The National Coverage Determination Documentation Indicator identifies whether the documentation was received for the necessary medical service. This indicator will not be reset on resubmitted RTP'd claims. Valid values are: Y = The documentation supporting the medical necessity was received. N = Default Value. The documentation supporting the medical necessity was not received.

Field Name	UB-04 X-Ref.	Description
NCD RESP		The National Coverage Determination Response Code that is returned from the NCD edits. Valid values include: ' ' = Set to space for all lines on resubmitted RTP'D claims, (default value.) 0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria. The line continues through the system's internal local medical necessity edits. 1 = The line continues through the system's internal local medical necessity edits, because: the HCPCS code was not applicable to the NCD edit table process, the date of service was not within the range of the effective dates for the codes, the override indicator is set to 'Y' or 'D', or the HCPCS code field is blank. 2 = None of the diagnoses supported the medical necessity of the claim (list 3 codes), but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. 3 = The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list 2 codes). The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to non-coverage by statute. 4 = None of the diagnosis codes on the claim support the medical necessity for the procedure (list 3 codes) and no additional documentation is provided. This line suspends as not medically necessary and will be denied. 5 = Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the FI will RTP the claim.
NCD #		National Coverage Determination Number: This field identifies the NCD number associated with the beneficiaries claim denial.
OLUAC		Identifies the original line user action code. It is only populated when there is a line user action code and a corresponding denial reason code in the Benefits Savings portion of claim page 32.
LUAC		The Line User Action Code identifies the cause of denial for the revenue line and a reconsideration code. The denial code (first position) must be present in the system and pre-defined in order to capture the correct denial reason. The values are equal to the values listed for User Action Codes. The reconsideration code (second position) has a value equal to "R," indicating to the system that reconsideration has been preformed. For the Revenue Code Total Line 0001, the system generates a value in the first two line occurrences of the LUAC field. These values indicate the type of total amount displayed on the total non-covered units and non-covered charges for the revenue code line 0001, only on MAP171D. These values do not apply to this field for any other revenue code line other than 0001. Valid values are: 1 = LUAC lines present on MAP171D 2 = Non-LUAC lines present on MAP171D

Field Name	UB-04 X-Ref.	Description
NON COV-UNT		Non-Covered Units identifies the number of days/visits that are being denied. Denied days/visits are required for those revenue codes that require units on Revenue Code file. The first line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines not containing a LUAC on MAP171D
NON COV-CHRG		Non-Covered Charges identifies the total number of denied/rejected/ non-covered charges for each line item being denied. The first line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines not containing a LUAC on MAP171D.
DENIAL REAS		The denial reason for the revenue code line. The denial code must be present in the system and pre-defined in order to capture the correct denial reason.
OVER CODE		The override code allows the operator to manually override the system generated ANSI codes taken from the Denial Reason Code file. Valid values are: ' ' = Default to system generated A = Override system generated ANSI Codes
ST/LC OVER		The Status/Location Override identifies the override of the reason code file status when a line item has been suspended. Valid values are: ' ' = Process claim with no override code D = Denied, for the reason code on the line R = Rejected, for the reason code on the line
MED TEC		Medical Technical Denial Indicator - This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. Valid values include: A = Home Health only - not intermittent care - technical and waiver was applied B = Home Health only - not homebound - technical and waiver was applied C = Home Health only - lack of physicians orders - technical deletion and waiver was not applied D = Home Health only - Records not submitted after the request - technical deletion and waiver was not applied M = Medical denial and waiver was applied S = Medical denial and waiver was not applied T = Technical denial and waiver was applied U = Technical denial and waiver was not applied

Field Name	UB-04 X-Ref.	Description
ANSI ADJ		The data for this ANSI Adjustment Reason Code field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the Reason Code file to assign the ANSI code to the denial screen. This code will occur once for each line item.
ANSI GRP		The data for this ANSI Group Code field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.
ANSI REMARKS		The data for this ANSI Remarks Code field is taken from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.
TOTAL		The total of all revenue code non-covered units and charges present on MAP171D.
LINE ITEM REASON CODES		The Line Item Reason Codes assigned out of the system for suspending the line item. There are a maximum of four (4) FISS reason codes that can be assigned to the line level.

UB-04 Claim Entry – Page 3

Enter the following information onto Page 3 of the Claim Entry screen (Figure 36):

- Payer Information
- Diagnoses Codes
- Attending Physician (UPIN, first and last name)

Field descriptions for Page 3 of the UB-04 Claim Entry screen are provided in the table following Figure 36.

```
 MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 03
 xx                          CLAIM ENTRY
 HIC nnnnnnnnnA    TOB      S/LOC S        PROVIDER nnnnnn
                             OFFSITE ZIPCD:
  CD  ID    PAYER                        OSCAR   RI AB  PRIOR PAY  EST AMT DUE
 A                                       nnnnnn
 B
 C
 DUE FROM PATIENT        0.00

 MEDICAL RECORD NBR                       COST RPT DAYS      NON COST RPT DAYS
 DIAGNOSIS CODES  1         2         3         4          5
                  6         7         8         9   END OF POA IND
 ADMITTING DIAGNOSIS           E CODE           HOSPICE TERM ILL IND
 IDE
 PROCEDURE CODES AND DATES  1                 2
  3                 4                 5                 6

 ESRD HOURS     ADJUSTMENT REASON CODE     REJECT CODE        NONPAY CODE
  ATT PHYS       NPI         LN                    FN           MI
  OPR PHYS       NPI         LN                    FN           MI
  OTH PHYS       NPI         LN                    FN           MI
30715                                                      <== REASON CODES
            PRESS PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Figure 36 – UB-04 Claim Entry, Page 3

Field Name	UB-04 X-Ref.	Description
OFF-SITE ZIPCD		This field identifies offsite Clinic/Outpatient department zip codes. It determines the claim line HPSA/PSA bonus eligibility.
CD	50 A, B, C	Use the following list of Primary Payer Codes when submitting electronic claims for payer identification. The following codes are for Medicare requirements only. Other payers require codes not reflected. Valid values are: 1 = Medicaid 2 = Blue Cross 3 = Other 4 = None A = Working-age - Employer Group Health Plan (EGHP) B = End Stage Renal Disease (ESRD) beneficiary in 30-month coordinated period with an Employer Group Health Plan C = Conditional payment D = Automobile no-fault E = Workers' compensation F = Public Health Service (PHS) or other federal agency G = Disabled - Large Group Health Plan (LGHP) H = Black lung (federal black lung program) I = Veteran's administration L = Liability Z = Medicare A
ID		Not required.
PAYER	50 A, B, C	Payer Identification lines: (A) Primary Payer – If Medicare is the primary payer, enter "**Medicare**" on line A. Enter Medicare indicates that the hospital developed for other insurance and determined that Medicare is the primary payer. If

Field Name	UB-04 X-Ref.	Description
		there are payer(s) of higher priority than Medicare, enter the name of the higher priority payer on line A. (B) Secondary Payer – If Medicare is the secondary payer, identify the primary payer on line A and enter "Medicare" on line B. (C) Tertiary Payer – If Medicare is the tertiary payer, identify the primary payer on line A, the secondary payer on line B and enter "Medicare" on line C.
OSCAR	51 A, B, C	Enter the Oscar Number assigned in Form Locator 50 A, B, C.
RI	52 A, B, C	The Release of Information Certification Indicator indicates whether the provider has on file, a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.
AB	53 A, B, C	The Assignment of Benefits Certification Indicator shows whether the provider has a signed form authorizing the third party payer to pay the provider.
PRIOR PAY	54 A, B, C	Enter the amount the provider has received from the indicated payer toward payment on the bill prior to the Medicare billing date.
EST AMT DUE	55 A, B, C	Not applicable.
DUE FROM PATIENT		The Due From Patient field is for outpatient services only. Enter the amount the provider has received from the patient toward payment.
MEDICAL RECORD NBR	23	Alphanumeric field used to enter patient's Medical Record Number.
COST RPT DAYS		The Cost Report Days identify the number of days claimable as Medicare patient days for inpatient and SNF types of bills (11n, 41n, 18n, 21n, 28n, and 51n) on the cost report. The system calculates this field and inserts the applicable data.
NON COST RPT DAYS		Identifies the number of Non-Cost Report Days not claimable as Medicare patient days for inpatient and SNF types of bills (11n, 18n, 21n, 28n, 41n, and 51n) on the cost report.
DIAGNOSIS CODE	67- 75	Used to enter the full ICD-9-CM Diagnosis Codes for the principal diagnosis code and up to eight additional conditions coexisting at the time of admission which developed subsequently, and which had an effect upon the treatment given or the length of stay.
END OF POA INDICATOR		This field identifies the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. The valid values are: 'Z' The end of POA indicators for principal and, if applicable, other diagnosis 'X' The end of POA indicators for principal and, if applicable, other diagnosis in special processing situations that may be identified by CMS in the future ' ' Not acute care, POA's do not apply
ADMITTING DIAGNOSIS	76	In the Admitting Diagnosis field, for inpatients, enter the full ICD-9-CM code for the principal diagnosis relating to condition established after study to be chiefly responsible for the admission.
E CODE	77	The External Cause of Injury Code field is used for E-codes should be reported in second diagnosis field Form Locator 68.
HOSPICE TERM ILL IND		Not required.

Field Name	UB-04 X-Ref.	Description
IDE		Identifies the Investigational Device Exemption (IDE) authorization number assigned by the FDA.
PROCEDURE CODES AND DATES	79 - 81	Enter the full ICD-9-CM, including all four-digit codes where applicable, for the principal procedure (first code). Enter the date (in MMDDYY format) that the procedure was performed during the billing period (within the "from" and "through" dates of services in Form Locator 6).
ESRD HOURS		Enter the number of hours a patient dialyzed on peritoneal dialysis.
ADJUSTMENT REASON CODE		Not required for new claim entry. Adjustment reason codes are applicable only on adjustments TOB nn7 and nn8.
REJECT CODE		Not required by provider. For Intermediary use only.
NON PAY CODE		Not required by provider. For Intermediary use only.
ATT PHYS	82	Enter the Unique Physician Identification Number (UPIN) and name of the attending physician for inpatient bills or the physician that requested the outpatient services. Inpatient Part A – Enter the UPIN and name of the clinician who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode. Enter the UPIN in the first six digits, followed by two spaces, the last name, one space, the first name, one space and middle initial. Outpatient and Other Part B – Enter the UPIN of the physician who requested the surgery, therapy, diagnostic tests, or the physician who has ordered Home Health, Hospice, or a Skilled Nursing Facility admission in the first six digits followed by two spaces, the physician's last name, one space, first name, one space and middle initial. Attending Physician I.D. – All Medicare claims require UPINs, e.g., including cases when there is a private primary insurer involved. Physicians not participating in the Medicare program may obtain UPINs. Additionally, for outpatient and other Part B, if there is more than one referring physician, enter the UPIN of the physician requesting the service with the highest charge.
NPI		This field identifies the National Provider Identifier number.
LN		This field identifies the last name of the attending physician.
FN		This field identifies the first name of the attending physician.
MI		This field identifies the middle initial of the attending physician.
OPER PHYS	83 A,B	Enter the UPIN and name of the physician who performed the principal procedure. Inpatient Part A Hospital - Enter the UPIN and name of the physician who performed the principal procedure. If no principal procedure is performed, leave blank. Outpatient Hospital - Enter the UPIN and name of the physician who performed the principal procedure. If there is no principal procedure, enter the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. Use the format for inpatient. Other bill types - Not required. Please note that if a surgical procedure is performed, and entry is necessary, even if the performing physician is the same as the admitting/attending physician.

Field Name	UB-04 X-Ref.	Description
NPI		This field identifies the National Provider Identifier number.
LN		This field identifies the last name of the operating physician.
FN		This field identifies the first name of the operating physician.
MI		This field identifies the middle initial of the operating physician.
OTH PHYS		This field identifies the name and/or number of the assisting licensed physician.
NPI		This field identifies the National Provider Identifier number.
LN		This field identifies the last name of the other physician.
FN		This field identifies the first name of the other physician.
MI		This field identifies the middle initial of the other physician.

UB-04 CLAIM ENTRY – PAGE 4

The Remarks Page (Figure 37) is used to transmit information submitted on automated claims, and it gives Palmetto GBA staff a mechanism to make comments on claims that need special consideration for adjudication. Providers may utilize Page 4 to:

- Justify claims filed untimely
- Justify adjustments to paid claims (required when using the "D9" Condition Code)
- Justify cancels to paid claims
- Justify other reasons that may delay claim adjudication

Field descriptions are provided in the table following Figure 37 on the next page.

```
 MAPnnnn        M E D I C A R E   A   O N L I N E   S Y S T E M    CLAIM PAGE 04
 xx                            CLAIM ENTRY         REMARK PAGE 01

 HIC               TOB      S/LOC S        PROVIDER

 REMARKS               ZIP:









 47  PACEMAKER     48  AMBULANCE     40  THERAPY     41  HOME HEALTH
 58  HBP CLAIMS (MED B)              E1  ESRD ATTACH
 ANSI CODES - GROUP:      ADJ REASONS:       APPEALS:

30715                                                    <== REASON CODES
 PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Figure 37 – UB-04 Claim Entry, Page 4

Field Name	UB-04 X-Ref.	Description
REMARKS	84	Maximum of 711 positions. Enter any remarks needed to provide information not reported elsewhere on the bill, but which may be necessary to ensure proper Medicare payment. This field carries the remarks information as submitted on automated claims, as well as provides internal staff with a mechanism to provide permanent comments regarding special considerations that played a part in adjudicating the claim, e.g., the Medical Review Department may use this area to document their rationale for the final medical determination or to provide additional information to the Waiver Employee to assist that individual with claim finalization. The remarks field is also used for Providers to furnish justification of late filed claims that override the Intermediary's existing reason code for timeliness. The following information must be entered on the first line. Additional information may be entered on the second and subsequent lines of the remarks section for further justification. Select one of the following reasons and enter the information exactly as it appears below: Justify: MSP involvement Justify: SSA involvement Justify: PRO Review involved Justify: Other involvement
ZIP		This field identifies the zip code.
[Attachments]		The following provides information on attachments: 47 = Pacemaker – No longer used. 48 = Ambulance – Not used. 40 = Therapy – Not used. 41 = Home Health – Not used. 58 = HBP Claims (Med B) – Not used. E1 = ESRD – Not used.
ANSI CODES - GROUP		Identifies the general category of payment adjustment. Used for claims submitted in an ANSI automated format only.
ADJ REASONS		Claim adjustment standard reason code that identifies appeals codes for inpatient or outpatient.
APPEALS		Identifies ANSI appeals codes for inpatient or outpatient.

UB-04 CLAIM ENTRY – PAGE 5

Page five of the UB-04 Claim Entry screen (Figure 38) is used to enter a patient's payer information. Field descriptions are provided in the table following Figure 38.

```
MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 05
xx                            CLAIM ENTRY
HIC               TOB      S/LOC S        PROVIDER
INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME   DOB   INS GROUP NUMBER
A

B

C

TREAT. AUTH. CODE


TREAT. AUTH. CODE


TREAT. AUTH. CODE


30715                                                  <== REASON CODES
           PRESS PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Figure 38– UB-04 Claim Entry, Page 5

Field Name	UB-04 X-Ref.	Description
INSURED NAME	58 A, B, C	Maximum of 25 digits; Last Name, First Name. On the same line that corresponds to the line on which Medicare payer information is reported, enter patient's name as reported on his/her Medicare health insurance card. If billing supplemental insurance, enter the name of the individual insured under Medicare on line A and enter the name of the individual insured under a supplemental policy on line B. Complete this section by entering the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare and the provider is requesting payment because: ♦ Another payer paid some of the charges and Medicare is secondarily liable for the remainder; ♦ Another payer denied the claim; or ♦ The provider is requesting conditional payment.
REL	59 A, B, C	On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is reported, enter the code indicating the relationship of the patient to the identified insured. The following codes are for Medicare requirements only. Other payers may require codes not reflected. Refer to your UB-04 Manual for valid values.
CERT.-SSN-HIC-ID	60 A, B, C	Enter the patient's Health Insurance Card Number (HICN) if Medicare is the primary payer.
SEX		The sex of the beneficiary/patient. Refer to your UB-04 Manual for valid values.

Field Name	UB-04 X-Ref.	Description
GROUP NAME	61 A, B, C	Enter the name of the group or plan through which that insurance is provided. Entry required, if applicable.
DOB		The insured's date of birth (in MMDDCCYY format).
INS GROUP NUMBER	62 A, B, C	Enter the Insurance Group identification number, control number, or code assigned by that health insurance company to identify the group under which the insured individual is covered. Entry required, if applicable. Enter the code that indicates whether the employment information given on the same line in items 72-75 applies to the insured, the patient, or the patient's spouse.
TREAT. AUTH CODE	63 A, B, C	The HHPPS Treatment Authorization Code identifies a matching key to the OASIS (Outcome Assessment Information Set) of the patient. This field is 2 8-digit dates (MMDDCCYYMMDDCCYY) followed by a 2-digit code (01-10). The first date comes from M0030 that is the Start of Care Date; the second date is from M0090 that is the Date Assessment Completed. The codes are from M0100 that is for the assessment currently being completed for the following reasons: 01 = Start of care – further visits planned 02 = State of care – no further visits planned 03 = Resumption of care (after inpatient stay) 04 = Rectification (follow-up) reassessment 05 = Other follow-up 06 = Transferred to an inpatient facility – patient not discharged from agency 07 = Transferred to an inpatient facility – patient discharged from agency 08 = Death at home 09 = Discharge from agency 10 = Discharge from agency – no visits completed after start/resumption of care assessment Entry required, if applicable.

UB-04 CLAIM ENTRY – PAGE 6

The following information can be found on Page 6 of the UB-04 Claim Entry screen (Figure 39):

- Medicare Secondary Payer (MSP) address
- Payment data (coinsurance, deductible, etc.)
- Pricer data (DRG, etc.).

Field descriptions are provided in the table following Figure 39.

```
MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 06
xx                          CLAIM ENTRY

HIC               TOB      S/LOC S        PROVIDER
            MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
                CITY                   ST     ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
                CITY                   ST     ZIP

                           PAYMENT DATA
DEDUCTIBLE              COIN           CROSSOVER IND    PARTNER ID
PAID DATE          PROVIDER PAYMENT              PAID BY PATIENT
REIMB RATE          RECEIPT DATE         PROVIDER INTEREST
CHECK/EFT NO              CHECK/EFT ISSUE DATE           PAYMENT CODE
                            PRICER DATA
DRG      OUTLIER AMT               TTL BLNDED PAYMT            FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT              NET INL
TECH PROV DAYS      TECH PROV CHARGES
 OTHER INS ID             CLINIC CODE
30715                                                  <== REASON CODES
PRESS PF3-EXIT  PF7-PREV PAGE  PF9-UPDT  ENTER-CONTINUE
```

Figure 39 – UB-04 Claim Entry, Page 6

Field Name	Description
INSURER'S ADDRESS 1 AND 2	Enter the address of the insurance company that corresponds to the line on which Medicare payer information is reported FL58 A, B, C.
CITY 1 AND 2	Enter the specific city of the insurance company.
ST 1 AND 2	Enter the specific state of the insurance company.
ZIP 1 AND 2	Enter the specific zip code of the insurance company.

Payment Data – This information is available for viewing in Detail Claim Inquiry (Option 12) immediately after the claim is updated/entered on DDE.

Field Name	Description
PAYMENT DATA	
DEDUCTIBLE	Amount applied to the beneficiary's deductible payment.
COIN	Amount applied to the beneficiary's co-insurance payment.
CROSSOVER IND	**The Crossover Indicator** identifies the Medicare payor on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. Valid values are: 1 = Primary 2 = Secondary 3 = Tertiary
PARTNER ID	Identifies the Trading Partner number.
PAID DATE	This is the actual date that claim was processed for payment consideration.
PROVIDER PAYMENT	This is the actual amount that provider was reimbursed for services.
PAID BY PATIENT	This is the actual amount reimbursed to beneficiary. Not utilized in DDE.
REIMB RATE	Provider's specific reimbursement rate (PPS).
RECEIPT DATE	Date claim was first received in the FISS system.

Field Name	Description
PROVIDER INTEREST	Interest paid to the provider.
CHECK/EFT NO	Displays the identification number of the check or electronic funds transfers.
CHECK/EFT ISSUE DATE	Displays the date the check was issued or the date the electronic funds transfer occurred.
PAYMENT CODE	Displays the payment method of the check or electronic funds transfer. Valid values are: ACH = Automated Clearing House or Electronic Funds Transfer CHK = Check NON = Non-payment data
PRICER DATA	
DRG	The Diagnostic Related Grouping Code assigned by the pricer's calculation.
OUTLIER AMOUNT	The Outlier Amount qualified for outlier reimbursement.
TTL BLNDED PAYMENT	Not utilized in DDE.
FED SPEC	Not utilized in DDE.
GRAMM RUDMAN ORIG REIM. AMT	The Gramm Rudman Original Reimbursement Amount.
NET INL	Not utilized in DDE.
TECHNICAL PROV DAYS	The number of days for which the provider is liable.
TECHNICAL PROV CHARGES	The dollar amount for which the provider is liable.
OTHER INS ID	Not utilized in DDE.
CLINIC CODE	Not utilized in DDE.

Roster Bill Entry

To access the Roster Bill Entry page, open the Claim and Attachments Entry Menu (select option 02 from the Main Menu) and then select option 87. The DDE Roster Bill page (Figure 40) will display. This page allows providers to enter their pneumococcal pneumonia and flu shots in a roster bill format. After typing roster bill information, press **[F9]** to transmit the claim.

When completing the roster bill, providers should observe the following points

- Only one date of service per roster page
- A maximum of ten patients per roster page may be reported on a DDE roster page

Field descriptions are provided in the table following Figure 40.

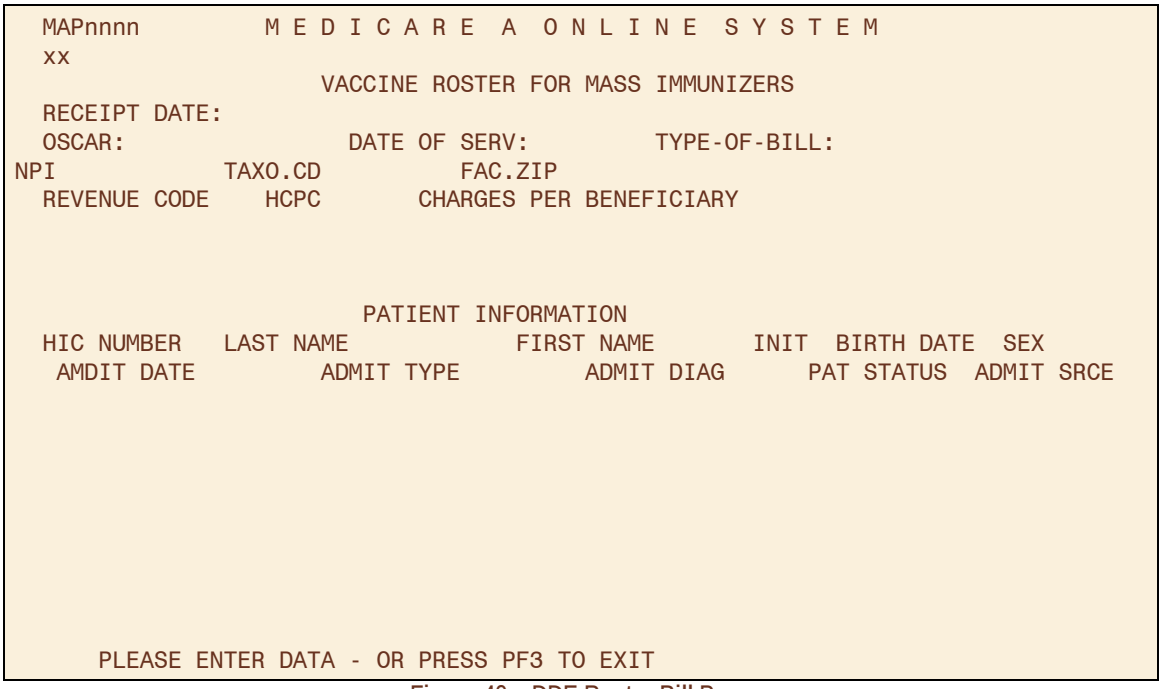


Figure 40 – DDE Roster Bill Page

Field Name	Description
RECEIPT DATE	The system date that the claim was received by the Intermediary.
OSCAR	The identification number of the institution that rendered services to the beneficiary/patient. **Note:** The system will auto-fill the Medicare provider number used when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, Home Health, Inpatient, etc.) the Medicare OSCAR number must be changed to reflect the OSCAR number you wish to submit claims for. If the Medicare OSCAR number is not changed for your sub-units, the claims will be processed under the incorrect OSCAR number.
DATE OF SERVICE	The date the service was rendered to the beneficiary (in MMDDYYYY format).
TYPE-OF-BILL	Type the type of bill for the submitted roster bill.
NPI	This field identifies the National Provider Identifier number.
TAXO.CD	This field identifies a collection of unique alpha numeric codes. The code set is structured into here distinct "levels" including Provider Type, Classification,, and Area of Specialization.
FAC.ZIP	This field identifies the provider or subpart nine-digit zip code.
REVENUE CODE	Enter the specific accommodation or service that was billed on the claim. This should be done by line item. Valid values are 0636 ***or*** 0770.
HCPC	Healthcare Common Procedure Coding System (HCPCS) applicable to ancillary services. Valid values are G0008, Q0124 and 90724.
CHARGES PER BENEFICIARY	Enter the charges per revenue code being charged to the beneficiary.
Patient Information	
HIC	The health insurance claim number assigned when a beneficiary becomes eligible for Medicare.
LAST NAME	Enter the last name of the patient as it appears on the patient's Health Insurance Card or other Medicare notice.

Field Name	Description
FIRST NAME	Enter the first name of the patient as it appears on the patient's Health Insurance Card or other Medicare notice.
INIT	Enter the middle initial of the patient.
BIRTH DATE	Enter the patient's date of birth (in MMDDYYYY format).
SEX	Enter the sex of the patient. Refer to your UB-04 Manual for valid values.
RTP	This field identifies whether the claim was returned to provider. The valid value is: "Y"
ADMIT DATE	This field identifies the date of the patient's admission.
DISC DATE	This field identifies when the patient was discharged.
ADMIT TYPE	This field identifies the code indicating the priority of admission. The valid values are: '1' Emergency '2' Urgent '3' Elective '4' Newborn '5' Trauma Center
ADMIT DIAG	This field identifies the diagnosis code describing the inpatient condition at the time of the admission.
PAT STATUS	This field identifies the code indicating the patient's status at the ending service date in the period.
ADMIT SRCE	This field identifies the way a patient was referred to the hospital for admission. The valid values are: '1' Physician referral '2' Clinical referral '3' HMO referral '4' Transfer from hospital '5' Transfer from SNF '6' Transfer from another health care facility '7' Emergency room '8' Court/law enforcement '9' Information not available 'A' Transfer from CAH 'B' Transfer from another Home Health Agency 'C' Readmission to the same Home Health Agency

ESRD CMS-382 Form

The ESRD attachment form allows ESRD providers to inquire, update, and enter an ESRD method selection data. Select option "**57**" from the Claim and Attachments Entry Menu. Enter a HIC number and function.

Choose one of the following functions:

- E = Entry
- U = Update
- I = Inquiry

Press **[ENTER]** to access the additional fields for entry. If a beneficiary is currently on file when you enter an "**E**" for the method selection form, the system will automatically enter the beneficiary's last name, first name, middle initial, date of birth, and sex based on the information stored on the beneficiary file. In addition, the system should allow access to the provider number, dialysis type, and selection or change fields.

Field descriptions for the ESRD CMS-382 Inquiry screen are provided in the table following Figure 41.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M     OP:
xx                     ESRD  CMS-382  INQUIRY                    DT:

HIC:                 METHOD:    382 EFFECTIVE DATE:         FUNCTION:

LN                       FN             MI    DOB         SEX

PROV:                  NPI:        TAXO.CD
                       FAC.ZIP

DIALYSIS TYPE:       NEW SELECTION(=Y) OR CHANGE(=N):    OPTION YR:

CWF ICN#:                            CONTRACTOR:

CWF TRANS DT:          CWF MAINT DT:          TIMES TO CWF:     CWF DISP CD:

REMARK NARRATIVE:         382-EFFECTIVE DATE:          TERM DATE:




     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 41 – ESRD CMS-382 Inquiry Form

Field Name	Description
OP	The Operator Code identifies the last operator to update this record.
DT	The last date that this record was processed.
HIC	The beneficiary's Health Insurance Card number.
METHOD	The method of home dialysis selected by the beneficiary. Valid values are: 1 = Method I – Beneficiary receives all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claims for their services. 2 = Method II – Beneficiary deals directly with one supplier and is responsible for submitting their own claim
382 EFFECTIVE DATE	Identifies the date the Beneficiary's ESRD Method Selection becomes effective on the (HCFA-382) form.
FUNCTION	Three valid functions include: E = Entry U = Update I = Inquiry
LN	Last name of the beneficiary at the time the method selection occurred.
FN	First name of the beneficiary.
MI	Middle Initial of the beneficiary.
DOB	Beneficiary's date of birth.
SEX	Sex of the beneficiary. Refer to your UB-04 Manual for valid values.
PROV	Enter the ESRD Provider number or the facility for which you are entering the ESRD attachment. The Medicare Provider number will system fill with the Provider number you used to log onto the DDE system. Therefore, if you have sub-units (multiple ESRD facilities) you will need to change the Provider number to reflect the ESRD facility for which the attachment information is being entered.
NPI	This field identifies the provider National Provider Identifier number.

Field Name	Description
TAXO.CD	Taxonomy Code: This field identifies a collection of unique alphanumeric codes. The code set is structured in three distinct "levels" including provider type, classification, and area of specialization.
FAC.ZIP	This field identifies the provider or subpart nine-digit zip code.
DIALYSIS TYPE	Valid types of dialysis include: 1 = Hemodialysis 2 = Continuous ambulatory peritoneal dialysis (CAPD) 3 = Continuous cycling peritoneal dialysis (CCPD) 4 = Peritoneal Dialysis
NEW SELECTION OR CHANGE	Indicates an exception to other ESRD data. Valid values are: Y = Selection – Entered on initial selection or for exceptions such as when the option year is equal to the year of the select date N = Change – Entered for a change in selection, e.g., option year is one year greater than the year of select date
OPTION YR	Identifies the year that a beneficiary selection or change is effective. A selection change becomes effective on January 1 of the year following the year the ESRD beneficiary signed the selection form.
CWF ICN#	Common Working File (CWF) Internal Control Number (ICN). FISS inserts this number on the ESRD Remarks screen to ensure the correction is being made to the appropriate ESRD Remark segment.
CONTRACTOR	Identifies the carrier or Intermediary responsible for a particular ESRD Maintenance file.
CWF TRANS DT	The date that information was transmitted to the CWF.
CWF MAINT DT	Identifies the date that a CWF response was applied to a particular ESRD record.
TIMES TO CWF	Number of times the record was transmitted to the CWF.
CWF DISP CD	The CWF Disposition Code. Valid values include: 01 = Debit accepted, no automated adjustment 02 = Debit accepted, automated adjustment 03 = Cancel accepted 04 = Outpatient history only accepted 50 = Not in file (NIF) 51 = True NIF on HCFA Batch System 52 = Mater record housed at another CWF site 53 = Record in HCFA alpha match 55 = Name/personal character mismatch 57 = Beneficiary record archived, only skeleton exists 58 = Beneficiary record blocked for cross reference 59 = Beneficiary record frozen for clerical correction 60 = Input/output error on data 61 = Cross-reference database problem AB = Transaction caused CICS abnormal end of job (abend) BT = History claim not present to support spell CI = CICS processing error CR = Crossover reject ER = Consistency edit reject UR = Utilization reject RD = Transaction Error
REMARK NARRATIVE	Valid Remark Narrative types include: M1 = Method I M2 = Method II

Field Name	Description
382 EFFECTIVE DATE	The method effective date. Valid values are: Y = The 382 effective date is equal to the 382 signature date N = The 382 effective date will be January 1 of the following year
TERM DATE	Projected date of termination of dialysis coverage.

SECTION 6 – CLAIM CORRECTION

The Claim and Attachments Correction Menu displays (Figure 42) when "**03**" is chosen from the Main Menu.

```
MAPnnnn                      PALMETTO GBA
                  CLAIM AND ATTACHMENTS CORRECTION MENU

                         CLAIMS CORRECTION
                  INPATIENT                21
                  OUTPATIENT               23
                  SNF                      25
                  HOME HEALTH              27
                  HOSPICE                  29
                         CLAIM ADJUSTMENTS    CANCELS
                  INPATIENT                30       50
                  OUTPATIENT               31       51
                  SNF                      32       52
                  HOME HEALTH              33       53
                  HOSPICE                  35       55
                         ATTACHMENTS
                  PACEMAKER                42
                  AMBULANCE                43
                  THERAPY                  44
                  HOME HEALTH              45
   ENTER MENU SELECTION:


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 42 – Claim and Attachments Correction Menu

Claim correction allows you to:

- Correct Return To Provider (RTP) claims
- Suppress RTP claims that you do not wish to correct
- Adjust claims
- Cancel claims

Note: The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, the user will need to change the provider number to inquire or input information. **[TAB]** to the PROVIDER field and type in the correct provider number.

Online Claims Correction

If a claim receives an edit (FISS reason code), a Return to Provider (RTP) is issued. An RTP is generated after the transmission of the claim. The claim is returned for correction. Until the claim is corrected via DDE or hardcopy, it will not process. When an RTP is received, the claim is given a Status/Location code beginning with the letter "T" and routed to the Claims Summary Inquiry screen. Claims requiring correction are located on the Claim Summary screen the day after claim entry. It is not possible to correct a claim until it appears on the summary screen. Providers are permitted to correct **only** those claims appearing on the summary screen with status "T." Claims that have been given "T" status have not yet been processed for payment consideration, so it is important to review your claims daily and correct them in order to avoid delays in payment.

CLAIM SUMMARY INQUIRY

Once an option is chosen from the Claim and Attachments Correction Menu, the Claim Summary Inquiry screen (Figure 43) will display.

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
XX                       CLAIM SUMMARY INQUIRY
                           NPI
      HIC               PROVIDER nnnnnn         S/LOC T        TOB
 OPERATOR ID            FROM DATE         TO DATE           DDE SORT
 MEDICAL REVIEW SELECT
      HIC            PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS









    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Figure 43 – Claim Summary Inquiry

Certain information is already completed, including the provider number, the status/location where RTP claims are stored (T B9997), and the first two digits of the type of bill. To narrow the selection, enter any or all of the information in the following table.

Field Name	Description
DDE SORT	Allows multiple sorting of displayed information. Valid values include: " " = TOB/DCN (Current default sorting process, S/LOC, Name) M = Medical Record number sort (Ascending order, HIC) N = Name sort (Alpha by last name, first initial, Receipt Date, MR#, HIC) H = HICN sort (Ascending order, Receipt Date, MR#) R = Reason Code sort (Ascending Order, Receipt Date, MR#, HIC) D = Receipt Date sort (Oldest Date displaying first, MR#, HIC)
MEDICAL REVIEW SELECT	Used to narrow the claim selection for inquiry. This will provide the ability to view pending or returned claims by medical review category. Valid values include: " " = Selects all claims 1 = Selects all claims 2 = Selects all claims excluding Medical Review 3 = Selects Medical Review only

To see a list of the claims that require correction, press **[ENTER]**. The selection screen will then display all claims that have been returned for correction (status/location T). To narrow the scope of the claims viewed, enter one of the following selection criteria, type of bill, from date, to date, and HIC number. If the claim you are looking for does not display on the screen, do the following:

- Verify the HIC number that you typed.
- Verify the "from" and "through" dates.

- Verify that the type of bill (TOB) is the same as the TOB on the claim you originally submitted. If not, **[TAB]** to the TOB field and enter the first two digits of the TOB for the claim you are trying to retrieve.
- If you still cannot find the claim, back out of Claims Correction (press **[F3]**) all the way to the Main Menu. Choose Inquiry (option 01), then Claims (option 12), and select the claim. Check the status/location (S/LOC). **Only claims in status location T B9997 can be corrected.** Status locations that cannot be corrected include:
  P B9997 – This claim has paid. An adjustment is required in order to change a paid claim.
  P 09998 – This claim was paid but due to its age, it has been moved to off-line history. Timeliness of filing will not allow you adjust this claim.
  P B9996 – This claim is waiting to be released from the 14-day payment floor (not showing on the RA). No correction allowed.
  R B9997 – This claim was rejected. Submit a new claim or an adjustment.
  D B9997 – This claim was denied and may not be corrected or adjusted.

CLAIMS CORRECTION PROCESSING TIPS

- The Revenue Code screen has multiple sub-screens. If you have more Revenue Codes than can fit on one screen, press **[F6]** to go the next sub-screen. Press **[F5]** to go back to the first screen.
- You can also get from page to page by entering the page number in the top right hand corner of the screen (Claim Page).
- Reason codes will display at the bottom of the screen to explain why the claim was returned. Up to 10 reason codes can appear on a claim.
  - Pressing **[F1]** will access the reason code file.
  - Press **[F3]** to return to the claim.
- The reason codes can be accessed from any claim screen.
- The inquiry screen can be accessed by typing the option number in the "SC" field in the upper left hand corner of the screen, for instance "10" for Beneficiary information. Press **[F3]** to return to the claim.

CORRECTING REVENUE CODE LINES

To delete an entire Revenue Code line:

- **[TAB]** to the line and type zeros over the top of the Revenue Code to be deleted or type "D" in the first position.
- Press **[HOME]** to go to the Page Number field. Press **[ENTER]**. The line will be deleted.
- Next, add up the individual line items and correct the total charge amount on Revenue Code line (0001).

To add a Revenue Code line:

- Tab to the line below the total line (0001 Revenue Code).
- Type the new Revenue Code information.
- Press **[HOME]** to go to the Page Number field. Press **[ENTER]**. The system will resort the Revenue Codes into numerical order.
- Correct the total charge amount of Revenue Code line (0001).

Changing total and non-covered charge amounts:

- **[TAB]** to get to the beginning of the total charge field on a line item.
- Press **[END]** to delete the old dollar amount. It is very important ***not*** to use the spacebar to delete field information. Always use **[END]** when clearing a field.
- Type the new dollar amount without a decimal point. Example: for $23.50 type "2350."
- Press **[ENTER]**. The system will align the numbers and insert the decimal point.
- Correct the totals line, if necessary.

- To exit without transmitting any corrections, press **[F3]** to return to the selection screen. Any changes made to the screen will not be updated.
- Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom of the screen. Continue the correction process until the system takes you back to the claim correction summary.

  The on-line system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check (S B2500, unless otherwise set in the System Control file). The claim will continue forward when nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will appear at the bottom of the screen: '`PROCESS COMPLETED – ENTER NEXT DATA.`'

RTP Selection Process

Select the claim to be corrected by tabbing to the "SEL" field for the first line of the claim to be corrected. Type a "U" or "S" and press **[ENTER]**. The patient's original UB-04 claim will display. (This will be MAP 1711, the first page of the claim).

Type Information:

- Use the Function keys listed at the bottom of the screen to move through the claim (i.e., [F8] to go to the next screen, **[F7]** to back up a screen).
- The Revenue Code screen has multiple sub-screens. If you have more revenue codes than can fit on one screen, press **[F6]** to go the next sub-screen. Press **[F5]** to go back to the first screen.
- You can also get from page to page by entering the page number in the top right hand corner of the screen (Claim Page).

Reason Codes will appear at the bottom of the screen (Figure 44) to explain why the claim was returned. Up to ten reason codes can appear on a claim.

```
 MAPnnnn        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 01
 XX                        CLAIM ENTRY                        SV:
 HIC nnnnnnnnnA    TOB 131  S/LOC S B0100  OSCAR nnnnnn         UB-FORM
  NPI  TRANSFERING HOSPICE PROVIDER              PROCESS NEW HIC
PATIENT.CNTL#                       TAX SUB:              TAXO.CD:
 STMT DATES FROM 042502  TO 043002  DAYS COV 005  N-C       CO      LTR
 LAST SMITH                    FIRST JOHN            MI    DOB 03031940
 ADDR 1 1000 LOCUS ST                    2 NEWTOWN, SC
      3                                  4
      5                                  6
ZIP 290000000 SEX M MS M ADMIT DATE 042502 HR 00 TYPE 3 SRC 1 D HM 00   STAT 01
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01           02           03           04           05
              06           07           08           09           10
   SPAN CODES/DATES 01                  02                   03
04                  05                  06                   07
08                  09                  10        FAC.ZIP
  DCN
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 01      525.00        02 A1     1000.00 PR 1   03 A3    14800.03
04 12     5250.00 CO 71  05                       06
07                       08                       09
14624                                                    <== REASON CODES
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT   PF9-UPDT
```

Figure 44 – UB-04 Claim Entry, Page One

Press **[F1]** to access the Reason Code file (Figure 45). The system automatically pulls up the first reason code with its message. The message will identify the fields that are in error and will suggest corrective action. Press **[F3]** to return to the claim, or type in an additional reason code and press **[ENTER]**.

```
 MAPnnnn       M E D I C A R E  A  O N L I N E  S Y S T E M    OP:
 xx                       REASON CODES INQUIRY                 DT:
PLAN REAS  NARR   EFF      MSN      EFF      TERM    EMC    HC/PRO  PP   CC
IND  CODE  TYPE   DATE     REAS     DATE     DATE   ST/LOC  ST/LOC  LOC  IND

 TPTP A    B    NPCD A    B     HD CPY A    B   NB ADR     CAL DY     C/L
--------------------------------NARRATIVE-------------------------------------
AN INPATIENT, OUTPATIENT, OR SNF CLAIM HAS SERVICE DATES EQUAL TO OR
OVERLAPPING A HOSPICE ELECTION PERIOD.  THEREFORE, NO MEDICARE PAYMENT CAN BE
MADE.  IF BILLING IS FOR THE TREATMENT OF A NON-TERMINAL CONDITION FOR THE
HOSPICE PATIENT, PLEASE RESUBMIT CLAIM WITH THE APPROPRIATE CONDITION CODE.









      PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
 PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
```

Figure 45 – Reason Codes Inquiry Screen

Type Information:

- The reason codes may be accessed from any claim screen.
- The Inquiry screen can be accessed by typing the option number in the "SC" field in the upper left hand corner of the screen, for instance "15" for DX/PROC Codes. Press **[F3]** to return to the claim.

Press **[F3]** to return to the selection screen. Any changes made to the screens will not be updated. Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom of the screen. Continue the correction process until the system takes you back to the Claim Correction Summary.

Note: The online system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check. The claim will continue forward when the nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the **corrected** claim has been successfully updated, the claim will disappear from the screen. The following message will display at the bottom of the screen `PROCESS COMPLETED - ENTER NEXT DATA`.

SUPPRESSING RTP CLAIMS

A feature exists within DDE that allows a claim to be suppressed because RTP claims do not purge from the FISS for 60 days. This is a helpful function for RTP claims filling up unnecessary space under the Claim Correction Menu option. This action will hide from view the claims in the Claim Correction Menu option; however, all claims will continue to display through the Inquiry Menu option until they purge from the system.

Type a "**Y**" in the SV field located in the upper right hand corner of page 1 and then press **[F9]**. The system will return you to the Claim Summary Inquiry screen.

NOTE: This action CANNOT be reversed.

CLAIMS SORT OPTION

DDE claims are normally displayed in type of bill order depending on the two-digit number selected from the Claim and Attachments Correction Menu. The claim sort option allows a provider to choose the sort order. To sort the DDE claims, type one of the following values in the DDE SORT field and press **[ENTER]**:

M = Displays claims in Medical Record Number order. The dual-purpose field labeled PROV/MRN will display the provider number unless you choose this sort option.

N = Displays claims in the beneficiary last name order.

H = Displays claims in Health Insurance Claim (HIC) number order.

R = Displays claims in Reason Code order.

D = Displays claims in Receipt Date order.

Claims and Attachments Corrections

ADJUSTMENTS

When claims are keyed and submitted through DDE for payment consideration, the user can sometimes make entry mistakes that are not errors to the DDE/FISS system. As a result, the claim is processed through the system to a final disposition and payment. To change this situation, the on-line claim adjustment option can be used to submit adjustments for previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter "P" and is recorded on the claim status inquiry screen.

A claim cannot be adjusted unless it has been finalized and is reflected on the remittance advice.

Providers must be very careful when creating adjustments. If you go into the adjustment system and update a claim without making the right corrections, the adjustment will still be created and process through the system. Errors could cause payment to be taken back unnecessarily.

No adjustments can be made on the following claims:

- **R** = Rejected claims
- **T** = RTP claims
- **D** = Medically denied claims
- Type of Bill nnP (PRO adjustment) or nnI (intermediary adjustment)

If a claim has been denied with a full or partial medical denial, the provider cannot submit an adjustment. Any attempted adjustments will reject with Reason Code 30904 (a provider is not permitted to adjust a partially or fully medically denied claim).

To access the claim and make the adjustment:

1. Select the option on the Claim and Attachments Correction Menu for the type of claim to be adjusted and press **[ENTER]**. End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB.
2. Enter the HIC number and the FROM and TO dates of service, and then press **[ENTER]**. The system will automatically default the TOB frequency to an nn7. The HIC number field is now protected and may no longer be changed.
3. Indicate why you are adjusting the claim by entering the claim change condition code, on Page 01 of the claim and a valid Adjustment Reason Code on Page 03. Valid Adjustment Reason Codes can be

found typing '**16**' in the '**SC**' field in the upper right hand corner of the screen and pressing **[ENTER]** or see below.

4. Give a short explanation of the reason for the adjustment in the remarks section on Page 04 of the claim.
5. To back out without transmitting the adjustment, press **[F3]**. Any changes made to the screens will not be updated.
6. Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. Claims being adjusted will still show on the claim summary screen. Always check the inquiry claim summary screen (#12) to affirm location of the claim being adjusted.
7. Check the remittance advice to ensure that the claim adjusted properly.

CLAIM VOIDS/CANCELS

Using the Claim Cancels option, providers can cancel previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter "**P**" and is recorded on the claim status inquiry screen. **A claim cannot be voided (canceled) unless it has been finalized and is reflected on the remittance advice.**

Providers must be very careful when creating cancel claims. If you go into the adjustment system and update a claim without making the right corrections, the cancel will still be created and process through the system. Errors could cause payment to be taken back unnecessarily. In addition, once a claim has been voided (canceled), no other processing can occur on that bill.

Important notes on cancels:

- All bill types can be voided except one that has been denied with full or partial medical denial.
- Do not cancel TOB XXP (PRO adjustments) or XXI (Intermediary Adjustments).
- A cancel bill must be made to the original paid claim.
- Providers may not reverse a cancel. Errors will cause payment to be taken back by the Intermediary.
- Provider cannot cancel an MSP claim. Provider must submit an adjustment even if the claims are being changed into a "no-pay" claim.
- Providers may/should add remarks on Claim Page 04 to document the reason for the cancel.
- After the cancel has been "stored," the claim will appear in Status/Location S B9000.
- Cancels do not appear on provider weekly monitoring reports; therefore, use the Claim Summary Inquiry to follow the status/location of a cancel.

To access the claim and cancel it:

1. Select the option on the Claim and Attachments Correction Menu for the type of claim to be canceled and press **[ENTER]**. End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB.
2. Enter the HIC number and the FROM and TO dates of service, and then press **[ENTER]**.
3. Select the claim to be canceled by typing an '**S**' in the '**SEL**' field beside the first line of the claim and then press **[ENTER]**. The HIC number field is now protected and may no longer be changed.
4. Indicate why you are voiding/canceling the claim by entering the claim change condition code (see list below) on Page 01 of the claim.
5. Give a short explanation of the reason for the void/cancel in the remarks section on Page 04 of the claim.

6. To back out without transmitting the void/cancel, press **[F3]**. Any changes made to the screens will not be updated.
7. Press **[F9]** to update/enter the cancel claim into DDE for reprocessing and payment retraction.
8. Check the remittance advice to ensure the claim canceled properly.

VALID CLAIM CHANGE CONDITION CODES

Adjustment condition code will be needed to indicate the primary reason for initiating an on-line claim adjustment or void/cancel. Valid code values include:

D0 = Changes to service dates
D1 = Changes to charges – **Note**: When there are multiple changes to a claim in addition to changes to charges, the D1 "changes to charges" code value will take precedence.
D2 = Changes to Revenue Codes/HCPCS
D3 = Second or subsequent interim PPS bill
D4 = Change in GROUPER input
D5 = Cancel only to correct a HICN or Provider identification number – **For nn8 TOB only**
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill) – **For nn8 TOB only**
D7 = Change to make Medicare the secondary payer
D8 = Change to make Medicare the primary payer
D9 = Any other change
E0 = Change in patient status

SECTION 7 – ONLINE REPORTS

The Online Reports View function allows viewing of certain provider specific reports by the Direct Data Entry Provider. The purpose of the reports is to inform the providers of the status of claims submitted for processing and provide a monitoring mechanism for claims management and customer service to use in determining problem areas for providers during their claim submission process.

As reports are viewed on-line, it will be necessary to scroll (or toggle) between the left view (Scroll L) and the right view (Scroll Right). Use the **[F11]** key to move to the right and the **[F10]** key to return to the left.

To access the online reports, choose menu selection 04 from the DDE Main Menu. The Online Reports Menu will display (Figure 46).

```
MAPnnnn                        PALMETTO GBA
                            ONLINE REPORTS MENU


                          R1    SUMMARY OF REPORTS

                          R2    VIEW A REPORT









   ENTER MENU SELECTION:


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Figure 46 – Online Report Menu

The most frequently viewed provider reports are the Claims Returned to Provider Report (050); Pending, the Processed and Returned Claims Report (201); and the Errors on Initial Bills Report (316).

050 The **Claims Returned to Provider Report** lists the claims that are being returned to the provider for correction. The claims on the report are in status/location T B9998. The main difference between this report and the 201 is that it contains the description of the Reason Code(s) for the claim being returned.

201 The **Pending, Processed and Returned Claims Report** lists claims that are pending claims returned to the provider for correction and claims processed, but not necessarily shown as paid on a remittance advice. This report will exclude Medicare Choices, ESRD Managed Care and plan submitted HMO (Encounter) claims.

316 The **Errors on Initial Bills Report** is a listing, by provider, of errors received on new claims (claims which were entered into the system for the present cycle.)

From the Online Reports Menu, you can select R1 for a summary of reports from which you can select one (Figure 47) or R2 view a report by entering the report number (Figure 48).

```
MAPnnnn          M E D I C A R E  A  O N L I N E  S Y S T E M
                          ONLINE REPORTS SELECTION
REPORT NO

SEL REPORT NO.  FREQUENCY  DESCRIPTION

       201      WEEKLY     CLAIM PENDING REPORT









      PROCESS COMPLETED  ---   NO MORE DATA THIS TYPE
     PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
```

Figure 47 – R1-Summary of Reports, Online Reports Selection

Field Name	Description
REPORT NO	Type in the desired report to view on-line.
SEL	The Selection field is used to select the report to be viewed. Type an 'S' before the desired report.
REPORT NO	Indicates the report number.
FREQUENCY	Reflects the frequency of the report. Valid values are Daily, Weekly and Monthly.
DESCRIPTION	Identifies the name or title of the report.

```
MAPnnnn    REPORT      FREQUENCY    SCROLL
KEY                       PAGE         SEARCH









PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF11-RIGHT
```

Figure 48 – R2-View A Report

050 Report – Claims Returned to Provider

The Claims Returned to Provider Report lists the claims that are being returned to the Provider for correction. The claims on the report are in status/location T B9997. It is primarily used by providers who are not on DDE to identify the Reason Code(s) for the returned claims. This report includes the Reason Code(s) by number and narrative (Figures 49 and 50).

```
MAPnnnn    REPORT 050  FREQUENCY D  SCROLL L
KEY nnnnnn               PAGE 000001  SEARCH
REPORT:                                        MEDICARE PART A - 00
 CYCLE DATE:                                 CLAIMS RETURNED TO PRO
 PROVIDER:                                    FOR CYCLE DATE nn/nn
          FOR PROVIDER


 HIC/CERT/SSNO   PCN/DCN           TYPE BILL  PROVIDER      NAME


              C7080  OUTPATIENT CLAIMS DATES OF SERVICE ARE EQUAL OR OV
                          FROM DATE AND THRU DATES OF THE ADMISSION FOR INPA
                          PROVIDERS.
                          REFUND ANY COLLECTED PART B
                          DEDUCTIBLE AND/OR COINSURANCE AND BILL THE INPATIE
                          SERVICES. (IF SERVICE DATES ARE INCORRECT, CORRECT

TOTAL RETURNED CLAIMS
            ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF11-RIGHT
```

Figure 49 – 050 Claims Returned to Provider, Scroll Left View

```
MAPnnnn    REPORT 050  FREQUENCY D  SCROLL R
KEY nnnnnn               PAGE 000001  SEARCH
 REPORT: 050          |101                              PAGE:
 CYCLE DATE: nn/nn/nn|VIDER                             FREQUENCY:
 PROVIDER: 000000    |/98                               RUN TIME:   3:15
          FOR PROVIDE|
          -----------|
                     |E THE SERVICES WERE
                     |              ADMIT  COV FM  COV TO    TOTAL CHGS
                     |               -----  ------  ------    ----------
 nnnnnnnnnA     nnnnn|ONE           nnnnnn  nnnnnn nnnnnn     1,332.76
                nnnnn|
                     |ERLAP OR ARE WITHIN THE
                     |TIENT FOR DIFFERENT
                     |
                     |NT PROVIDER FOR THESE
                     | AND RESUBMIT.
                     |
                     |T WITH OCCURRENCE SPAN CODE
                     |M IN WHICH THIS OUTPATIENT
                     |
 TOTAL RETURNED CLAIM |nn,nnn.nn
                     |
              ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF10-LEFT
```

Figure 50 – 050 Claims Returned to Provider, Scroll Right View

Field Name	Description
REPORT	Identifies the unique number assigned to the Claims Returned to Provider report.
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
SEARCH	Allows searching for specific information contained in report fields by using [F2].
REPORT	Identifies the unique number assigned to the Claims Returned to Provider report.
PAGE	The specific page you are viewing within the report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
FREQUENCY	The frequency the report is run.
PROVIDER	Identifies the facility that rendered services for the claims being returned.
RUN TIME	The time of the production cycle that produced the reports.
FOR PROVIDER	The provider name and address for report remittance. This information is taken from the Provider File and is a total of 4 lines of 31 characters each.
HIC/CERT/SSNO	Identifies the Health Insurance Claim Number submitted by the provider for the beneficiary listed in the name field.
PCN/DCN	The Document Control Number identifies the returned claim.
TYPE OF BILL	Identifies the type of facility, type of care, source and frequency of this claim in a particular period of care.
PROVIDER	Identifies the facility listed on the claim.
NAME	Lists the beneficiary's last and first name as submitted by the provider of the patient who received the services.
ADMIT DATE	The date (in MMDDYY format) that the beneficiary was admitted for inpatient services or the beginning of the outpatient, home health or hospice services.
COV FM	Identifies the beginning date (in MMDDYY format) of services rendered to the beneficiary as indicated on the claim.
COV TO	Identifies the ending date of services rendered to the beneficiary as indicated on the claim.
TOTAL CHGS	Displays the total charges as submitted by the provider.
[Reason Code and Narrative]	Displays the reason code(s) and narrative for the returned claim. There is a maximum of 150 occurrences for each reason code/narrative.
TOTAL RETURNED CLAIMS	The total number of reported claims being returned to the provider listed in the Provider field.
TOTAL RETURNED CHARGES	The total amount of charges for claims returned to the provider listed in the Provider field.

201 Report – Pended, Processed and Returned Claims

Figures 51 and 52 show the Left view and right view of the Pended, Processed and Returned Claims report. The fields described in the table following the Figures, display for Inpatient, Outpatient and Lab Pended Claims.

```
MAPnnnn    REPORT 201  FREQUENCY W  SCROLL L
KEY nnnnnn               PAGE 000001  SEARCH
REPORT: 201                                          MEDICARE PART A - 00
 CYCLE DATE: nn/nn/nn                              SUMMARY OF PENDED CLAIM
BLUE CROSS CODE:                                         INPATIENT
                                                       RECD    ADMIT
NAME                  MED REC NUMBER        HIC NUMBER      DATE     DATE
BENEFICIARY, A        nnnnnnnnn             nnnnnnnnnD    12/20/02 12/02/02 1
     PAT CONTROL NBR: Rnnnnnnnnnn
BENEFICIARY, B        nnnnnnnnn             nnnnnnnnnA    12/20/02 12/06/02 1
     PAT CONTROL NBR: Rnnnnnnnnnn
BENEFICIARY, C        nnnnnnnnn             nnnnnnnnnA    12/20/02 11/21/02 1
     PAT CONTROL NBR: Rnnnnnnnnnn
BENEFICIARY, D                              nnnnnnnnnA    06/12/03 07/14/03 0
     PAT CONTROL NBR: DDE
                             (MED)            (MSP)          (CWFR)
                           MEDICAL              MSP          CWF REGULAR
CLAIMS        COUNT           0                  0               51
                                                       RECD    ADMIT
NAME                  MED REC NUMBER        HIC NUMBER      DATE     DATE
       TOTAL CHARGES            0.00             0.00     2,398,255.18
ADJUSTMENTS   COUNT            0                  0               0
       TOTAL CHARGES            0.00             0.00            0.00
              ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF11-RIGHT
```

Figure 51 – 201 Pended, Processed and Returned Claims, Scroll Left View

```
MAP1661    REPORT 201  FREQUENCY W  SCROLL R
KEY nnnnnn               PAGE 000001  SEARCH
REPORT: 201          |380                              PAGE:      1
 CYCLE DATE: 10/31/0 |S                            FREQUENCY: WEEKLY
BLUE CROSS CODE:     |                          PROVIDER NUMBER: 420018
                     | FROM     THRU   ADJ    LAST    SUB SUSP    TOTAL
NAME                 | DATE     DATE   IND    TRAN    IND TYPE    CHARGES  ADS
BENEFICIARY, A       |2/02/02 12/14/02     12/23/02   A  CWFR     75,063.91
     PAT CONTROL NBR|
BENEFICIARY, B       |2/06/02 12/11/02     12/23/02   A  CWFR     14,387.21
     PAT CONTROL NBR|
BENEFICIARY, C       |1/21/02 12/13/02     12/23/02   A  CWFR    236,040.85
     PAT CONTROL NBR|
BENEFICIARY, D       |7/14/03 07/23/03     07/07/03   A  CWFR     34,659.95
     PAT CONTROL NBR|
                     |   (CWFD)           (SUSP)
                     | CWF DELAYED        SUSPENSE            TOTAL
CLAIMS        COUNT  |       0                9                  60
                     | FROM     THRU   ADJ    LAST    SUB SUSP    TOTAL
NAME                 | DATE     DATE   IND    TRAN    IND TYPE    CHARGES  ADS
       TOTAL CHARGES|        0.00       538,596.86     2,936,852.04
ADJUSTMENTS   COUNT  |       0                0                  0
       TOTAL CHARGES|        0.00             0.00               0.00
              ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF10-LEFT
```

Figure 52 – 201 Pended, Processed and Returned Claims, Scroll Right View

Field Name	Description
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
FREQUENCY	The frequency under which the report is run. Valid values are D (Daily), W (Weekly) or M (Monthly).

Field Name	Description
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
PAGE	The specific page you are viewing within the report.
SEARCH	Allows searching for a particular type of claim or summary count information. Cycles through Inpatient/Outpatient/Lab/Other category.
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
TITLE OF REPORT	The Report title changes as the user cycles through the available Type of Bills (e.g., Pending, Processed or Returned).
BLUE CROSS CODE	The BCBS identification number assigned to a particular provider/facility.
TYPE OF CLAIM	Identifies the type of claim being reflected on the report (e.g., Inpatient/Outpatient/ Lab/Other).
NAME	The Beneficiary's Last Name/First Name.
MED REC NUMBER	The unique number assigned to the beneficiary at the medical facility.
HIC NUMBER	Identifies the unique Health Insurance Claim Number assigned to the beneficiary by CMS. This number is to be used on all correspondence and to facilitate the payment of claims.
RECD DATE	The date on which the Intermediary received the claim from the provider (in MMDDYY format).
ADMIT DATE	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care (in MMDDYY format).
PROVIDER NUMBER	The Provider Number of the Medicare provider rendering services to the beneficiary.
FROM DATE	The beginning date of service for the period included on the claim (in MMDDYY format).
THRU DATE	The ending date of service for the period included on the claim (in MMDDYY format).
ADJ IND	Indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain an asterisk, otherwise it will be blank.
LAST TRAN	Identifies the date of the most recent transaction on this claim (in MMDDYY format).
SUB IND	Identifies the mode of submission of the claim. If the UBC is a '7' or '8' (hard copy indicator), this will be a 'P' (paper claim); otherwise, it will contain an 'A' (automated claim).
SUSP TYPE	The suspense location where the claim resides within the system. Valid values are: MED = (Medical) Location code positions 2 & 3 is '50' MS = Location code positions 2 & 3 is '80' or '85' CWFR = Location code positions 2 & 3 is '90,' CWF = (Regular) Location code position 4 is not 'B,' 'F,' 'J,' 'L' or 'M' CWFD = Location code positions 2 & 3 is '90,' CWF = (Delayed) Location code position 4 IS 'B,' 'F,' 'J,' 'L' or 'M' SUSP = (Suspense) Any suspended claim (Status 'S') that does not fall into any of the categories listed above.
TOTAL CHARGES	Reflects total charges by beneficiary line item.

Field Name	Description
ADS	Addition Development System identifies if the claim has been to or currently resides in ADR. If Location code positions 2 & 3 have ever equaled 60, this field will contain a 'Y'; otherwise, it will be blank.
PAT CONTROL NBR	Unique number assigned to the beneficiary at the medical facility.
ADS REASON CODES	Identifies contains up to 10 5-digit reason codes requesting specific information from the provider on claims for which the ADS indicator is 'Y.'
(MED) MEDICAL	The total charges of the medical suspense category. Location code positions 2 & 3 - '50.'
(MSP) MSP	Medicare Secondary Payer identifies the category heading identifying counts, by Type of Bill, of adjustment records meeting the following criteria: Adjustment requester ID - 'H' (hospital) or 'F' (Fiscal Intermediary), and the adjustment reason code - 'AU,' 'BL,' 'DB,' 'ES,' 'LI,' 'VA,' 'WC' or 'WE.' Location code positions 2 & 3 - '80' or '85'
(CWFR) CWF REGULAR	The total charges of the CWF category. Location code positions 2 & 3 - '90,' Location code position 4 **is not** 'B,' 'F,' 'J,' 'L' or 'M.'
(CWFD) CWF DELAYED	The total charges of the CWF category. Location code positions 2 & 3 - '90,' Location code position 4 **is** 'B,' 'F,' 'J,' 'L' or 'M.'
(SUSP) SUSPENSE	The total charges of all suspended claims (Status - 'S'), which do not fall into any of the other listed categories, e.g., MED, MSP, CWFR, CWFD.
CLAIMS COUNT	The total number of claims pending (not processed) at the end of the processing cycle for this Provider.
TOTAL CHARGES	The total charges by suspense category for pending claims or adjustments at the end of the processing cycle.
ADJUSTMENTS COUNT	Identifies by suspense category the total number of adjustments pending (not processed) at the end of the processing cycle for this Provider.
TOTAL CHARGES	Identifies by suspense category the total charges for pending claims or adjustments at the end of the processing cycle.

316 – Errors on Initial Bills

The Errors on Initial Bills report (Figures 53 and 54) lists (by Provider) errors received on new claims (claims entered into the system for the present cycle). The purpose of this report is to provide a monitoring mechanism for claims management and customer service to use in determining problem areas for Providers during their claim submission process.

```
MAPnnnn    REPORT 316  FREQUENCY W  SCROLL L
KEY nnnnnn               PAGE 000001  SEARCH
REPORT: 316                                          MEDICARE PART A - 00
CYCLE DATE:  10/31/03                                ERRORS ON INITIAL BI
                                                   PROVIDER:  nnnnnn
REASON        INPAT        SNF         HHA        OUTPAT   HOSP-ESRD    LCF-E
CODE        H/C  AUTO   H/C  AUTO   H/C  AUTO   H/C  AUTO   H/C  AUTO   H/C
E94G2         0     0     0     0     0     0     1     0     0     0     0
13599         0     0     0     0     1     0     0     0     0     0     0
15331         0     0     0     0     0     0     1     0     0     0     0
15431         0     0     0     0     0     0     1     0     0     0     0
16602         0     0     0     0     0     0     1     0     0     0     0
16603         0     0     0     0     0     0     1     0     0     0     0
30924         0     0     0     0     1     0     1     0     0     0     0
31023         0     0     0     0     0     0     1     0     0     0     0
31616         0     0     0     0     0     0     1     0     0     0     0
32300         1     0     0     0     0     0     1     0     0     0     0
32303         0     0     0     0     0     0     1     0     0     0     0
32402         0     0     0     0     0     0     2     0     0     0     0
37151         0     0     0     0     0     0     1     0     0     0     0
37192         0     0     0     0     0     0     2     0     0     0     0
39700         0     0     0     0     0     0     1     0     0     0     0
              ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF11-RIGHT
```

Figure 53 – 316 Errors on Initial Bills, Scroll Left View

```
MAPnnnn    REPORT 316  FREQUENCY W  SCROLL R
KEY nnnnnn               PAGE 000001  SEARCH
REPORT: 316          |380                              PAGE:      1
CYCLE DATE:  10/31/0|LLS                           FREQUENCY:   WEEKLY
                    |
REASON        INPAT |SRD       CORF       HOSPICE     ANC/OTH       TOTAL
CODE        H/C  AUT|AUTO   H/C  AUTO   H/C  AUTO   H/C  AUTO   H/C  AUTO
E94G2         0     |   0     0     0     0     0     1     0     2     0
13599         0     |   0     0     0     0     0     0     0     1     0
15331         0     |   0     0     0     0     0     0     0     1     0
15431         0     |   0     0     0     0     0     0     0     1     0
16602         0     |   0     0     0     0     0     0     0     1     0
16603         0     |   0     0     0     0     0     0     0     1     0
30924         0     |   0     0     0     0     0     0     0     2     0
31023         0     |   0     0     0     0     0     0     0     1     0
31616         0     |   0     0     0     0     0     0     0     1     0
32300         1     |   0     0     0     0     0     0     0     2     0
32303         0     |   0     0     0     0     0     0     0     1     0
32402         0     |   0     0     0     0     0     0     0     2     0
37151         0     |   0     0     0     0     0     1     0     2     0
37192         0     |   0     0     0     0     0     0     0     2     0
39700         0     |   0     0     0     0     0     0     0     1     0
              ENTER NEW KEY DATA OR
PRESS PF2-SEARCH PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF10-LEFT
```

Figure 54 – 316 Errors on Initial Bills, Scroll Right View

Field Name	Description
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
FREQUENCY	The frequency under which the report is run. Valid values are D (Daily), W (Weekly) or M (Monthly).

Field Name	Description
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
PAGE	The specific page you are viewing within the report.
SEARCH	Allows searching for a particular type of claim or summary count information. Cycles through Inpatient/ Outpatient/Lab/Other category.
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
PAGE	Identifies the specific page within the report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
TITLE OF REPORT	The report title changes as the user cycles through the available Type of Bills (e.g., Pending, Processed or Returned).
PROVIDER	Identifies the Medicare Provider rendering services to the beneficiary.
REASON CODE	The reason code for a specific error reason condition, existing. The first position indicates the type and location of the reason code. Valid values include: 1 = CMS Unibill 2 = Reserved for future use 3 = Fiscal Intermediary Standard System 4 = File maintenance 5 = State (site) specific 6 = Post payment A-X = Miscellaneous errors Positions 2-5 indicate either a file or application error. If position 2 contains an alpha character, it is file related; otherwise, it is application related.
INPAT	Reflects all claims/adjustments with a Type of Bill 11X or 41X.
SNF	Reflects all SNF claims/adjustments with a Type of Bill 18X, 21X, 28X or 51X.
HHA	Reflects all HHA claims/adjustments with a Type of Bill 32X, 33X or 34X.
OUTPAT	Reflects all outpatient claims/adjustments with a Type of Bill 13X, 23X, 43X, 53X, 73X or 83X.
HOSP-ESRD	Reflects all Hospital End Stage Renal Disease claims with a Type of Bill 72X.
LCF-ESRD	Reflects all claims with a Long Term Care Facility End Stage Renal Disease Type of Bill 72X and a provider number greater than XX299 and less than XX2500 (XX represents the state code).
CORF	Reflects all CORF claims/adjustments with a Type of Bill 75X.
HOSPICE	Reflects all Hospice claims/adjustments with a Type of Bill 81X or 82X.
ANC/OTHER	Reflects all Ancillary and Other claims with a Type of Bill 12X, 14X, 22X, 24X, 42X, 44X, 52X, 54X, 71X, 74X or 79X.
TOTAL	The total of all claims printed on this report for each specific Reason Code.
H/C	Claims by bill type, which are produced on paper and submitted to the Intermediary designated by a Uniform Bill Code less than 8.
AUTO	Claims by bill type, which are submitted to the Intermediary in an electronic mode, designated by a Uniform Bill Code greater than 7.

SECTION 8 – HEALTH INSURANCE QUERY ACCESS

The Health Insurance Query Access (HIQA) gives Medicare providers direct access to the CMS's CWF Host database. Providers may query a Beneficiary's Master Record. The beneficiary's record contains Medicare entitlement, hospice benefit information, health maintenance organization (HMO) information, and other payer information. Each beneficiary record is located at one of nine CWF Host sites.

CWF edits claims for validity, entitlement, remaining benefits, and deductible status. A reply from CWF will be returned the following day. The majority of claims will be accepted by CWF for remittance. Others will reject, open for recycle at a later date, or suspend for investigative action.

The objectives of the CWF are to provide:

- Complete beneficiary information to Medicare contractors as—
  - Entitlement data
  - Utilization data
  - Claim history
- Information in a timely manner via an online process
- Accurate initial claims processing with—
  - Deductible access
  - Coinsurance access
  - Part A and Part B benefits paid comparison
  - Check editing prepayment (so contractor's approval equals CMS acceptance)
  - Duplicate payments prevention
  - Efficient implementation of future benefits and enhancements changes

Part A CWF Send Process

The Intermediary or satellite uses its best available information on beneficiary eligibility and remaining benefits to fully adjudicate claims. Every claim has been grouped, priced, and evaluated for Medicare Secondary Payer involvement and has its final reimbursement (including interest) before it is sent. High Speed ***bulk data transfer*** transmits the intermediary paid claim to the host for approval. Prior to ***SEND***, Intermediary converts adjudicated claims from in-house format to CWF format. This is known as the ***best shot*** approach for bill payment. Claims awaiting CWF transmission reside in status/location **S B9000.**

Part A Response Process

Palmetto GBA maintains a holding file containing claims awaiting an initial CWF response (**S B9099**). No manual transaction can be made against these claims. Claims cannot be finally adjudicated until a definitive response is received from CWF, unless a manual function instructs the system to process the claim without being transferred to CWF. Responses aid in processing and proper adjudication of Medicare claims. The responses Palmetto GBA receives from the CWF are:

- CWF Edit Error codes that tell us a CWF response is ready to be worked (a 5-digit code appears in the lower left corner of the UB04 screen).
- A CWF Disposition Code, a 2-digit category or status of claim, that indicates:
  - Claim is approved
  - Claim is rejected
  - Claims will be retrieved from history
- Alert codes, CWF requests for investigation of overlapping benefits and eligibility status.

- Approved claims, Intermediary produced provider check and remittance advice.
- Rejected claims that require further investigation. Intermediary reviews these claims, makes corrections, and resubmits them to CWF.
- Recycled claims, which recycle automatically back to CWF. The FISS status/location definitions are:
  S B90_0 = 1st transmission
  S B90_1 = 2nd transmission
  S B90_2 = additional transmissions

CWF Host Sites

The Centers for Medicare & Medicaid Services maintains centralized files on each Medicare beneficiary with minimal eligibility and utilization data. Contractors query this file to process claims. **CWF** disperses the beneficiary files into **nine regional host sites**.

GL – Great Lakes	MA – Mid-Atlantic	SE – Southeast	GW – Great Western	
Illinois	Indiana	Alabama	Idaho	North Dakota
Michigan	Maryland	Mississippi	Iowa	Oregon
Minnesota	Ohio	North Carolina	Kansas	South Dakota
Wisconsin	Virginia	South Carolina	Missouri	Utah
	West Virginia	Tennessee	Montana	Washington
			Nebraska	Wyoming

PA – Pacific	SO – South	KS – Keystone	NE – Northeast	SW – Southwest
Alaska	Florida	Delaware	Connecticut	Arkansas
Arizona	Georgia	New Jersey	Maine	Colorado
California		New York	Massachusetts	Louisiana
Hawaii		Pennsylvania	New Hampshire	New Mexico
Nevada			Rhode Island	Oklahoma
			Vermont	Texas

HIQA Inquiry Screen

Once you have successfully logged onto the HIQA function, the CWF beneficiary inquiry area will display (Figure 55). To access a beneficiary's CWF Master Record, enter information into this screen. Field definitions and completion requirements are provided in the table following Figure 55.

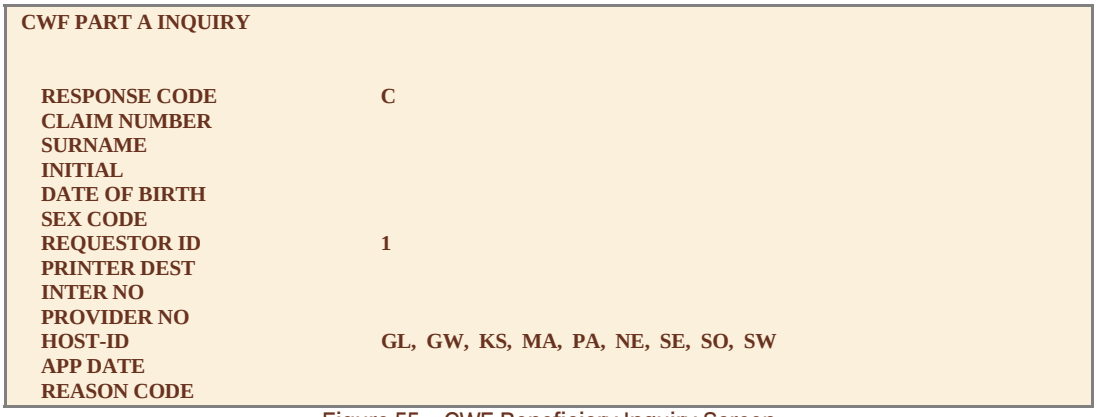


Figure 55 – CWF Beneficiary Inquiry Screen

Field Name	Description
Response Code	Data in this field (a "C" for Display on CRT) is automatically inserted by the system.

Field Name	Description
Claim Number	Enter the beneficiary's Medicare number in this field.
Surname	Enter the first six (6) letters of the beneficiary's last name.
Initial	Enter the first initial of the beneficiary's first name.
Date of Birth	Enter the beneficiary's date of birth in MMDDCCYY format.
Sex Code	Enter the beneficiary's sex. Valid values are: F = Female M = Male
Requestor ID	Identifies person submitting the inquiry or person requesting printed output. Enter "1" in this field.
Printer Dest	Printer device that the response will be directed to if a "P" or "E" is typed in the Response Code field. Leave this field blank (system default printer).
Inter No	Identifies the intermediary processing the claim. Enter "00380," Palmetto GBA's Intermediary Number.
Provider No	The number assigned by Medicare to the provider rendering medical service to the beneficiary. Enter the facility's six-digit Medicare provider number.
Host-ID	Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations: GL = Great Lakes MA = Middle Atlantic SE = Southeast GW = Great West PA = Pacific SO = South KS = Keystone NE = Northeast SW = Southwest
App Date	Date the beneficiary was admitted to the hospital in MMDDYY format. Leave this field blank.
Reason Code	Indicates the reason for the inquiry. Valid codes are: 1 = Status Inquiry 2 = Inquiry relating to an admission A "1" is automatically inserted in this field by the system.

HIQA PAGE 1

Field descriptions for Page 1 of the HIQA screen are provided in the table following Figure 56.

```
HIQACRO                          CWF PART A INQUIRY REPLY              PAGE 01 OF 06

IP-REC      CN nnnnnnnnnA      NM DOE            IT J       DB 01011911      SX M      IN  nnnnn
PN nnnnnn        APP          REAS 1              DATETIME 97049  122129          REQ 1
DISP-CODE  02      MSG       UNCONDITIONAL ACCEPT
CORRECT   nnnnnnnnnA              NM                IT       DB               SX        DBCEN  9
A-ENT 020180  A-TRM 000000  B-ENT  020180   B-TRM 000000   DOD 000000   LRSV 60   LPSY 190
DAYS  LEFT  FULL-HOSP  CO-HOSP  FULL-SNF  CO-SNF  IP-DED  BLOOD  DOEBA   DOLBA
CURRENT      58           30        20        80       000       0     013195   020295
PRIOR        52           30        20        80       000       0     050691   051491
PARTB  YR 97  DED-TBM  10000  BLD 3  YR 96  DED-TBM  00000  BLD 3       DI  0000000000
FULL-NAME  DOE.JOHN.Q
HMO      CURR ID   00000     OPT 0    ENR  000000     TERM  000000
PER 0    PRIOR ID  00000     OPT 0    ENR  000000     TERM  000000
PART A   YR     BLD  3
CATASTROPHIC A  DED-TBM   BLOOD    CO-SNF    FULL-SNF    DOEBA    DOLBA    DED-APL
YEAR       89     0000000     02       008       142       120489    120889    0056000

ESRD     CODE-1     EFF DATE              CODE-2        EFF DATE
PF1=INQ SCREEN  PF3/CLEAR=END        PF8=NEXT
```

Figure 56 – CWF Part A Inquiry Reply Screen, Page 1

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.

Field Name	Description
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex code.
IN	**Intermediary Number** – The provider's intermediary.
PN	**Provider Number** – The agency's Medicare provider number.
APP	**Applicable Date** – Used for spell determination.
REAS	**Reason Code** – Indicates the reason for the inquiry.
DATETIME	**Date and Time Stamp** – Julian date.
REQ	**Requestor ID**
Disposition Code	Indicates a condition on a CABLE response. Valid values are: 01 = Part A Inquiry approved 02 = Part A Inquiry approved 03 = Part A Inquiry rejected 20 = Qualified approval but may require further investigation 25 = Qualified approval 50 = Not in file 51 = Not in file on CMS batch system 52 = Master record housed at another HOST site 53 = Not in file in CMS but sent to CMS's alpha-reinstate 55 = Does not match a master record ER = Consistency edit reject UR = Utilization edit CR = A/B crossover edit CI = CICS processing problem SV = Security violation
MSG	**Message** – The verbiage pertaining to the disposition code.
CORRECT	**Correct Claim Number** – Use only if HIC number is incorrect.
NM	**Corrected Name** – Used only if the name is not consistent with CMS's record.
IT	**Corrected Initial** – Used only if the initial is not consistent with CMS's record.
DB	**Corrected Date of Birth** – Used only if the date of birth entered is different than CMS's beneficiary record.
SX	**Corrected Sex Codes** – Used only if sex code is not consistent with CMS's record.
DBCEN	**Date of Birth Century** – Valid values are: 8 = 1800 9 = 1900
A-ENT	**Part A Entitlement** – Date of entitlement to Part A benefits. This is in a MMDDYY format.
A-TRM	**Part A Termination** – Indicates date of termination of Part A entitlement. This is in a MMDDYY format.
B-ENT	**Part B Entitlement** – Date of entitlement to Part B benefits in MMDDYY format.
B-TRM	**Part B Termination** – Indicates date of termination of Part B entitlement in MMDDYY format.
DOD	**Date of Death** – If the beneficiary is alive, the field will be all zeros.
LRSV	**Lifetime Reserve** – Shows the number of lifetime reserve days remaining.
LPSY	**Lifetime Psychiatric** – Shows the number of psychiatric days remaining.
FULL-HOSP	**Full Hospital Days Remaining** – Indicates the inpatient days remaining to be paid at full benefits.
CO-HOSP	**Co-Hospital Days Remaining**
FULL-SNF	**Full SNF Days Remaining** – Number of SNF days remaining to be paid at coinsurance benefits.

Field Name	Description
IP-DED	**Inpatient Deductible** – Amount of inpatient deductible remaining.
BLOOD	**Blood Deductible** – Number of pints blood deductible remaining.
DOEBA	**Date of Earliest Billing Action** – For spell of illness.
DOLBA	**Date of Latest Billing Action** – For this spell of illness.
PART B YR	**Most Recent Part B Year** – From the applicable date input field.
DED-TBM	**Deductible To Be Met –** Amount of the Part B cash deductible remaining to be met.
BLD	**Blood** – Part B blood deductible pints remaining to be met.
YR	**Year** – Next most recent Part B year.
DED-TBM	**Deductible to be Met**.
DI	**Data Indicators**. A. State Buy-In 0 = Does not apply 1 = State buy-in involved B. Alien Indicator 0 = Does not apply 1 = Alien non payment provision may apply C. Psychiatric Pre-entitlement 1 = Psychiatric pre-entitlement reduction applied D. Reason for entitlement 0 = Normal 1 = Disability 2 = End Stage Renal Disease (ESRD) 3 = Has or had ESRD, but has current DIB 4 = Old age, but has or had ESRD 8 = Has or had ESRD and is covered under premium Part A 9 = Covered under premium Part A
CURR ID	**HMO Identification Code** – Valid values are: 1 = H 2 & 3= state code 4 & 5= HMO number within the state
OPT	**HMO Option Code** – Describes the beneficiary's relationship with the HMO. Valid values are: 2 = HMO to process bills only for directly provided services and for service from providers with whom the HMO has effective arrangements. Palmetto GBA processes all other bills. C = HMO to process all bills.
ENR	**HMO Enrollment Date**
TERM HMO	**HMO Termination Date**
PER	**HMO Period of Enrollment** – Code which indicates that the individual has had 1, 2, or 3 periods of enrollment in an HMO.
PRIOR HMO	Information pertaining to Inpatient.

HIQA PAGE 2

Field descriptions for Page 2 of the HIQA screen are provided in the table following Figure 57.

```
HIQA/HIQACOP                    CWF PART A INQUIRY REPLY                PAGE 02 OF 06

IP-REC      CN nnnnnnnnnA       NM DOE          IT J      DB 010111      SX M
PAP                               PAP DATE   00000
MAMM                              TECH/PROF      1 0000/0000    2 0000/0000    3 0000/0000
IMMUNO/TRANSPLANT DATA            COV. IND.      TRANS. IND.    DISCH. DATE    00000
                                                                             00000
                                                                             00000
HOSPICE DATE    PERIOD 4    OWNER CHANGE 4      PERIOD 3    OWNER CHANGE 3
START DATE1     000000      000000              000000      000000
TERM DATE1      000000      000000
PROV1

INTER 1
DOEBA DATE      000000      000000
DOLBA DATE      000000      000000
DAYS USED       000                             000
START DATE2     000000      000000              000000      000000
PROV2
INTER2
REVOCATION IND

 PF1=INQ SCREEN  PF3/CLEAR=END  PF7=PREV  PF8=NEXT
```

Figure 57 – CWF Part A Inquiry Reply Screen, Page 2

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's date of birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
PAP	**PAP Risk Indicator** – Valid values are: 1 = Yes 2 = No
PAP DATE	Date PAP performed.
MAM	**Mammo Risk Indicator** – Valid values are: 1 = Yes 2 = No
TECH/PROF	**Mammography Technical Professional Component Date** – The date the technician/ professional claims were presented for x-rays used for mammography screening.
IMMUNO/ TRANSPLANT DATA COV IND	Indicates Medicare transplant surgery coverage available to the beneficiary. Valid values are: 1 = Space – No Coverage 2 = Transplant Coverage
TRANS IND	**Transplant Type Indicator** – Indicates the type of transplant surgery performed on the beneficiary. Valid values are: 1 = Allograft bone marrow - transplant from another person. 2 = Autograft bone marrow - transplant from beneficiary H = Heart transplant K = Kidney transplant L = Liver transplant
DISCH DATE	**Discharge Date** – The date that the beneficiary was discharged from a hospital stay during which the indicated transplant occurred.
HOSPICE DATA	Indicates if a beneficiary has or had elected the Medicare hospice benefit.

Field Name	Description
START DATE 1	The elected start date of a beneficiary's hospice benefit period.
TERM DATE 1	The termination of the first hospice benefit period. May be listed as the end of the benefits for the hospice period indicated, or the revocation of hospice benefits.
PROV1	**First Provider** – First provider the beneficiary has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1 NUMBER	**First Intermediary Number** – Indicator as to the Medicare Intermediary that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period. Period 1 = 1-90 days Period 2 = 1-90 days Unlimited number of subsequent 60-day benefit periods
START DATE2	Lists second start date if a beneficiary elects to change hospices during a benefit period.
PROV2 NUMBER	Indicates the Second Intermediary to process hospice claims for second provider number.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary has not revoked hospice benefits 1 = Beneficiary has revoked hospice benefits.

HIQA PAGE 3

Field descriptions for Page 3 of the HIQA screen are provided in the table following Figure 58.

```
HIQA/HIQACOP                    CWF PART A INQUIRY REPLY                PAGE 03 OF 06

IP-REC      CN  nnnnnnnnA       NM  DOE          IT  J       DB  010111        SX  M
PAP                                 PAP DATE   00000
MAMM                                TECH/PROF      1 0000/0000      2 0000/0000      3 0000/0000
IMMUNO/TRANSPLANT DATA              COV. IND.      TRANS. IND.      DISCH. DATE      00000
                                                                                    00000
                                                                                    00000
HOSPICE DATE     PERIOD 2     OWNER CHANGE 2          PERIOD 1     OWNER CHANGE 1
START DATE1      000000       000000                  000000       000000
TERM DATE1       000000       000000
PROV1

INTER 1
DOEBA DATE       000000       000000
DOLBA DATE       000000       000000
DAYS USED        000                                  000
START DATE2      000000       000000                  000000       000000
PROV2
INTER2
REVOCATION IND

 PF1=INQ SCREEN   PF3/CLEAR=END   PF7=PREV   PF8=NEXT
```

Figure 58 – CWF Part A Inquiry Reply Screen, Page 3

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's Date of Birth.

Field Name	Description
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
PAP	**PAP Risk Indicator** – Valid values are: 1 = Yes 2 = No
PAP DATE	Date PAP performed.
MAM	**Mammo Risk Indicator** – Valid values are: 1 = Yes 2 = No
TECH/PROF	This is the date that the technician/professional claims were presented for x-rays used for mammography screening.
IMMUNO/ TRANSPLANT DATA COV IND	Indicates Medicare transplant surgery coverage available to the beneficiary. Valid values are: 1 = Space – No Coverage 2 = Transplant Coverage
TRANS IND	**Transplant Type Indicator** – Indicates the type of transplant surgery performed on the beneficiary. Valid values are: 1 = Allograft bone marrow – transplant from another person 2 = Autograft bone marrow – transplant from beneficiary H = Heart transplant K = Kidney transplant L = Liver transplant
DISCH DATE	**Discharge Date** – The date the beneficiary was discharged from a hospital stay during which the indicated transplant occurred.
HOSPICE DATA	Indicates if the beneficiary elected the Medicare hospice benefit.
START DATE1	The elected start date of a beneficiary's period of hospice coverage.
TERM DATE 1	Indicates the termination of the first hospice benefit period. May be listed as the end of the benefits for the hospice period indicated, or the revocation of hospice benefits.
PROV1	**First Provider** – first provider the beneficiary has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1 NUMBER	**First Intermediary Number** – Indicator as to the Medicare Intermediary that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period.
START DATE2	Lists second start date if a beneficiary elects to change hospices during a benefit period.
PROV2 NUMBER	Indicates the Second Intermediary to process hospice claims for second provider number.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary has not revoked hospice benefits. 1 = Beneficiary has revoked hospice benefits.

HIQA PAGE 4

Field descriptions for Page 4 of the HIQA screen are provided in the table following Figure 59.

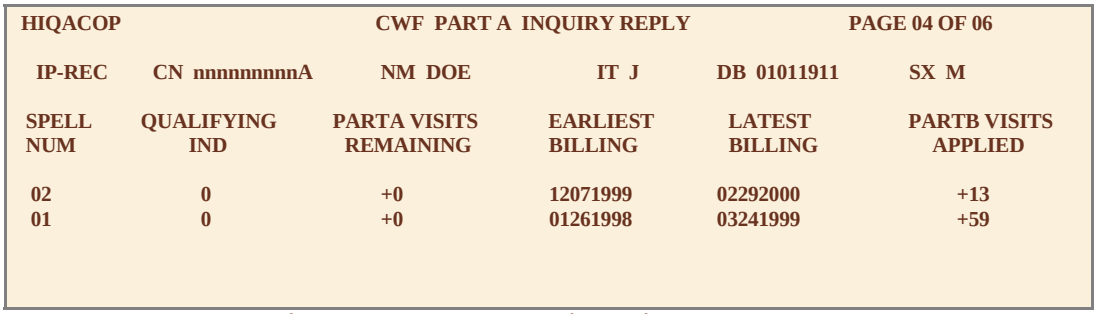


Figure 59 – CWF Part A Inquiry Reply Screen, Page 4

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
SPELL NUM	**Spell of Illness Number** – This number reflects the current home health spell of illness.
QUALIFYING IND	**Qualifying Stay Indicator** – This is a numeric field used to identify a qualifying A/B split hospitalization. Valid values are: 0 = No 1 = Yes
PART A VISITS REMAINING	The number of Part A visits remaining in the benefit period. Medicare Part A pays for the first 100 visits if a patient has a qualifying hospital stay, and if a patient is admitted to home health within 14 days of discharge. Medicare Part B pays for the remaining visits. In addition, Medicare Part B pays for all visits if there is no qualifying hospital stay (the patient must have Medicare Part B for Part B to reimburse for the services). If a beneficiary has Medicare Part A only, then Part A will pay for all of their services.
EARLIEST BILLING	The date of the first bill submitted during the benefit period.
LATEST BILLING	The date of last bill submitted during the benefit period.
PARTB VISITS APPLIED	The number of visits reimbursed by Medicare Part B.

HIQA PAGE 5

Field descriptions for Page 5 of the HIQA screen are provided in the table following Figure 60.

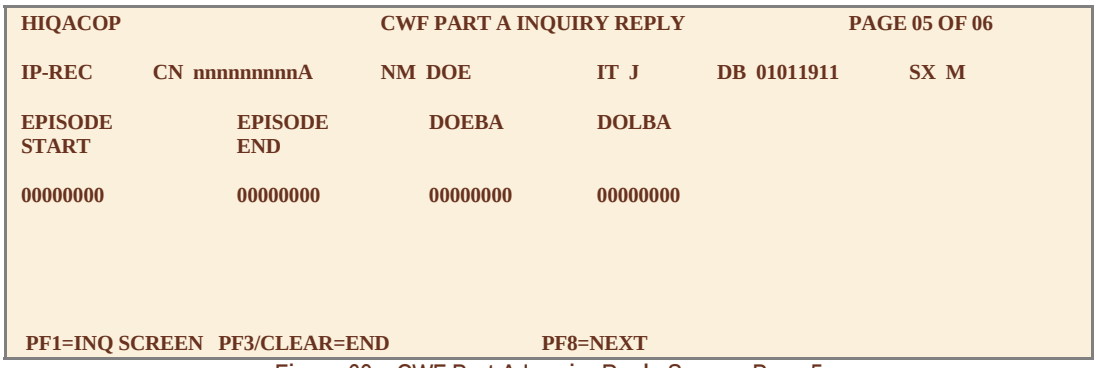


Figure 60 – CWF Part A Inquiry Reply Screen, Page 5

Field Name	Description
IP-REC CN	Claim number being investigated.
NM	Last name of the beneficiary. Up to six characters may be used in this field.
IT	First initial of the beneficiary.
SX	Sex of the beneficiary.
EPISODE START	The start date of an episode.
EPISODE END	The end date of an episode.
DOEBA	**Date of Earliest Billing Action** - the first service date of the HHPPS period.
DOLBA	**Date of Last Billing Action** - the last service date of the HHPPS period.

HIQA PAGE 6

Field descriptions for Page 6 of the HIQA screen are provided in the table following Figure 61.

```
HIQA/HIQACOP                CWF PART A INQUIRY REPLY              PAGE 06 OF 06

IP-REC      CN  nnnnnnnnnA      NM  DOE          IT  J       DB  01011911      SX  M

PROCEDURE          DESCRIPTION
      HCPCS        TECH
      CODE         PROF    RICK          MOST RECENT DATES OF SERVICE




PF1=INQ SCREEN  PF3/CLEAR=END                PF8=NEXT
```

Figure 61 - CWF Part A Inquiry Reply Screen, Page 6

Field Name	Description
IP-REC CN	Claim number being investigated.
NM	Last name of the beneficiary. Up to six characters may be used in this field.
IT	First initial of the beneficiary.
SX	Sex of the beneficiary.
PROCEDURE DESCRIPTION	
HCPCS Code	Healthcare Common Procedure Coding System (HCPCS) code for Mammography.
TECH	Technical Service of Mammography
PROF	Professional Service of Mammography
RISK	Not Used
Most Recent Dates Of Service	Date of service for the HCPCS Technical and Professional codes.

SECTION 9 – HEALTH INSURANCE QUERY FOR HHA

The Health Insurance Query for HHAs (HIQH) allows different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility based on available claims data. Since beneficiaries often move from home health to hospice care, both HHAs and hospices can employ HIQH as their single CWF inquiry transaction. HIQH, which includes the information made available in HIQA, gives Medicare providers direct access to the CMS's CWF Host database. Providers may query a Beneficiary's Master Record. The beneficiary's record contains Medicare entitlement, hospice benefit information, health maintenance organization (HMO) information, and other payer information. Each beneficiary record is located at one of nine CWF Host sites.

CWF edits claims for validity, entitlement, remaining benefits, and deductible status. A reply from CWF will be returned the following day. The majority of claims will be accepted by CWF for remittance. Others will reject, open for recycle at a later date, or suspend for investigative action.

The objectives of the CWF are to provide:

- Complete beneficiary information to Medicare contractors as—
  - Entitlement data
  - Utilization data
  - Claim history
- Information in a timely manner via an online process
- Accurate initial claims processing with—
  - Deductible access
  - Coinsurance access
  - Part A and Part B benefits paid comparison
  - Check editing prepayment (so contractor's approval equals CMS acceptance)
  - Duplicate payments prevention
  - Efficient implementation of future benefits and enhancements changes

Part A CWF Send Process

The Intermediary or satellite uses its best available information on beneficiary eligibility and remaining benefits to fully adjudicate claims. Every claim has been grouped, priced, and evaluated for Medicare Secondary Payer involvement and has its final reimbursement (including interest) before it is sent. High Speed ***bulk data transfer*** transmits the intermediary paid claim to the host for approval. Prior to ***SEND***, Intermediary converts adjudicated claims from in-house format to CWF format. This is known as the ***best shot*** approach for bill payment. Claims awaiting CWF transmission reside in status/location **S B9000.**

Part A Response Process

Palmetto GBA maintains a holding file containing claims awaiting an initial CWF response (**S B9099**). No manual transaction can be made against these claims. Claims cannot be finally adjudicated until a definitive response is received from CWF, unless a manual function instructs the system to process the claim without being transferred to CWF. Responses aid in processing and proper adjudication of Medicare claims. The responses Palmetto GBA receives from the CWF are:

- CWF Edit Error codes that tell us a CWF response is ready to be worked (a 5-digit code appears in the lower left corner of the UB04 screen).
- A CWF Disposition Code, a 2-digit category or status of claim, that indicates:

- Claim is approved
- Claim is rejected
- Claims will be retrieved from history

♦ Alert codes, CWF requests for investigation of overlapping benefits and eligibility status.

♦ Approved claims, Intermediary produced provider check and remittance advice.

♦ Rejected claims that require further investigation. Intermediary reviews these claims, makes corrections, and resubmits them to CWF.

♦ Recycled claims, which recycle automatically back to CWF. The FISS status/location definitions are:
S B90_0 = 1st transmission
S B90_1 = 2nd transmission
S B90_2 = additional transmissions

CWF Host Sites

The Centers for Medicare & Medicaid Services maintains centralized files on each Medicare beneficiary with minimal eligibility and utilization data. Contractors query this file to process claims. **CWF** disperses the beneficiary files into **nine regional host sites**.

GL – Great Lakes	MA – Mid-Atlantic	SE – Southeast	GW – Great Western	
Illinois	Indiana	Alabama	Idaho	North Dakota
Michigan	Maryland	Mississippi	Iowa	Oregon
Minnesota	Ohio	North Carolina	Kansas	South Dakota
Wisconsin	Virginia	South Carolina	Missouri	Utah
	West Virginia	Tennessee	Montana	Washington
			Nebraska	Wyoming
PA – Pacific	**SO – South**	**KS – Keystone**	**NE – Northeast**	**SW – Southwest**
Alaska	Florida	Delaware	Connecticut	Arkansas
Arizona	Georgia	New Jersey	Maine	Colorado
California		New York	Massachusetts	Louisiana
Hawaii		Pennsylvania	New Hampshire	New Mexico
Nevada			Rhode Island	Oklahoma
			Vermont	Texas

HIQH Inquiry Screen

Once you have successfully logged onto the HIQH function, the CWF beneficiary inquiry area will display (Figure 62). To access a beneficiary's CWF Master Record, enter information into this screen. Field definitions and completion requirements are provided in the table following Figure 62.

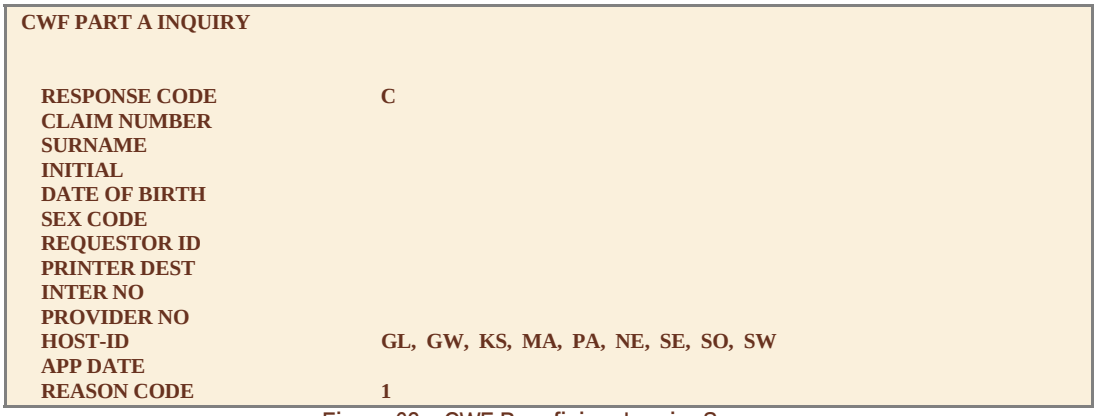


Figure 62 – CWF Beneficiary Inquiry Screen

Field Name	Description
Response Code	Data in this field (a "C" for Display on CRT) is automatically inserted by the system.
Claim Number	Enter the beneficiary's Medicare number in this field.
Surname	Enter the first six (6) letters of the beneficiary's last name.
Initial	Enter the first initial of the beneficiary's first name.
Date of Birth	Enter the beneficiary's date of birth in MMDDCCYY format.
Sex Code	Enter the beneficiary's sex. Valid values are: F = Female M = Male
Requestor ID	Identifies person submitting the inquiry or person requesting printed output. Enter "1" in this field.
Printer Dest	Printer device that the response will be directed to if a "P" or "E" is typed in the Response Code field. Leave this field blank (system default printer).
Inter No	Identifies the intermediary processing the claim. Enter "00380," Palmetto GBA's Intermediary Number.
Provider No	The number assigned by Medicare to the provider rendering medical service to the beneficiary. Enter the facility's six-digit Medicare provider number.
Host-ID	Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations: GL = Great Lakes MA = Middle Atlantic SE = Southeast GW = Great West PA = Pacific SO = South KS = Keystone NE = Northeast SW = Southwest
App Date	If left blank, the last two episode periods will display. To search for a specific episode period, enter the date in the MMDDYY format.
Reason Code	Indicates the reason for the inquiry. Valid codes are: 1 = Status Inquiry 2 = Inquiry relating to an admission A "1" is automatically inserted in this field by the system.

HIQH PAGE 1

Field descriptions for Page 1 of the HIQH screen are provided in the table following Figure 63.

```
HIQHCRO                    CWF HOME HEALTH INQUIRY REPLY          PAGE 01 OF 07

IP-REC      CN  nnnnnnnnnA      NM  DOE          IT  J      DB  01011911      SX  M      IN   nnnnn
PN nnnnnn         APP            REAS 1           DATETIME  97049   122129          REQ  1
DISP-CODE   02      MSG        UNCONDITIONAL ACCEPT

CORRECT     nnnnnnnnnA              NM                IT       DB              SX          DBCEN   9
A-ENT  020180   A-TRM  000000     B-ENT    020180       B-TRM   000000     DOD   000000
PARTB    YR  03   DED-TBM   00000
FULL-NAME   DOE.JOHN.Q




PF1=INQ SCREEN   PF3/CLEAR=END          PF8=NEXT
```

Figure 63 – CWF Part A Inquiry Reply Screen, Page 1

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex code.
IN	**Intermediary Number** – The provider's intermediary.
PN	**Provider Number** – The agency's Medicare provider number.
APP	**Applicable Date** – Used for spell determination.
REAS	**Reason Code** – Indicates the reason for the inquiry.
DATETIME	**Date and Time Stamp** – Julian date.
REQ	**Requestor ID**
Disposition Code	Indicates a condition on a CABLE response. Valid values are: 01 = Part A Inquiry approved 02 = Part A Inquiry approved 03 = Part A Inquiry rejected 20 = Qualified approval but may require further investigation 25 = Qualified approval 50 = Not in file 51 = Not in file on CMS batch system 52 = Master record housed at another HOST site 53 = Not in file in CMS but sent to CMS's alpha-reinstate 55 = Does not match a master record ER = Consistency edit reject UR = Utilization edit CR = A/B crossover edit CI = CICS processing problem SV = Security violation
MSG	**Message** – The verbiage pertaining to the disposition code.
CORRECT	**Correct Claim Number** – Use only if HIC number is incorrect.
NM	**Corrected Name** – Used only if the name is not consistent with CMS's record.
IT	**Corrected Initial** – Used only if the initial is not consistent with CMS's record.
DB	**Corrected Date of Birth** – Used only if the date of birth entered is different than CMS's beneficiary record.

Field Name	Description
SX	**Corrected Sex Codes** – Used only if sex code is not consistent with CMS's record.
A-ENT	**Part A Entitlement** – Date of entitlement to Part A benefits. This is in a MMDDYY format.
A-TRM	**Part A Termination** – Indicates date of termination of Part A entitlement. This is in a MMDDYY format.
B-ENT	**Part B Entitlement** – Date of entitlement to Part B benefits in MMDDYY format.
B-TRM	**Part B Termination** – Indicates date of termination of Part B entitlement in MMDDYY format.
DOD	**Date of Death** – If the beneficiary is alive, the field will be all zeros.
PART B YR	**Most Recent Part B Year** – From the applicable date input field.
DED-TBM	**Deductible To Be Met –** Amount of the Part B cash deductible remaining to be met.

HIQH PAGE 2

Field descriptions for Page 2 of the HIQH screen are provided in the table following Figure 64.

```
HIQHCOP                    HOME HEALTH BENEFIT PERIOD              PAGE 02 OF 07

 HH-REC    CN nnnnnnnnnA      NM DOE          IT J      DB 01011911      SX M

SPELL      QUALIFYING      PARTA VISITS      EARLIEST      LATEST      PARTB VISITS
NUM          IND           REMAINING         BILLING       BILLING       APPLIED

 02           0               +82          07/15/2003    09/12/2003        +0
 01           0               +46          9/19/2003     03/20/2001        +0



PF1=INQ SCREEN   PF3/CLEAR=END   PF7=PREV   PF8=NEXT
```

Figure 64 – CWF Part A Inquiry Reply Screen, Page 2

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
SPELL NUM	**Spell of Illness Number** – This number reflects the current home health spell of illness.
QUALIFYING IND	**Qualifying Stay Indicator** – This is a numeric field used to identify a qualifying A/B split hospitalization. Valid values are: 0 = No 1 = Yes
PART A VISITS REMAINING	The number of Part A visits remaining in the benefit period. Medicare Part A pays for the first 100 visits if a patient has a qualifying hospital stay, and if a patient is admitted to home health within 14 days of discharge. Medicare Part B pays for the remaining visits. In addition, Medicare Part B pays for all visits if there is no qualifying hospital stay (the patient must have Medicare Part B for Part B to reimburse for the services). If a beneficiary has Medicare Part A only, then Part A will pay for all of their services.
EARLIEST BILLING	First bill submitted during the benefit period.
LATEST BILLING	The last bill submitted during the benefit period.

Field Name	Description
PARTB VISITS APPLIED	The number of visits reimbursed by Medicare Part B.

HIQH PAGE 3

Field descriptions for Page 3 of the HIQH screen are provided in the table following Figure 65.

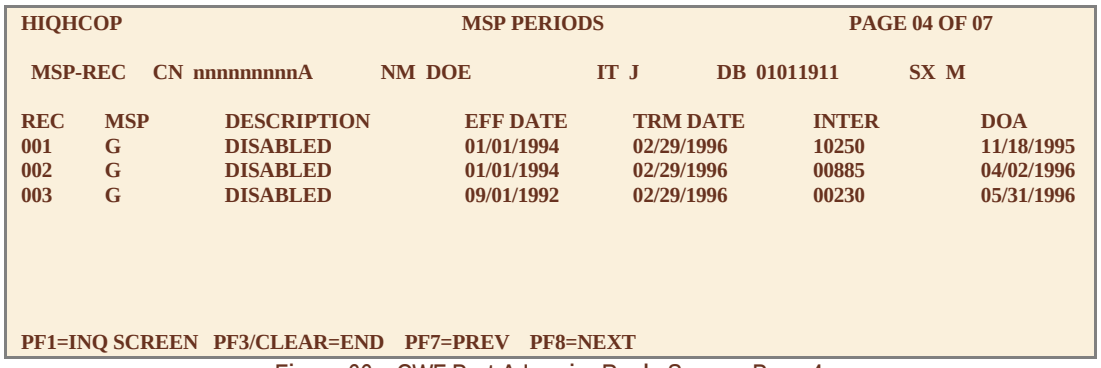
```
HIQHCOP                    HOME HEALTH PPS INQUIRY REPLY              PAGE 04 OF 05

 HH-REC    CN  nnnnnnnnnA        NM  DOE          IT  J        DB  01011911        SX  M

   START      END        INTER       PROV       DOEBA        DOLBA        PATIENT
   DATE       DATE        NUM        NUM                                  STAT  IND

   9/13/2003  11/11/2003  00380      nnnnnn     000000000    000000000    30    0

   07/15/2003 09/12/2003  00380      nnnnnn     07/15/2003   09/12/2003   30    0



PF1=INQ SCREEN  PF3/CLEAR=END  PF7=PREV  PF8=NEXT
```

Figure 65 – CWF Part A Inquiry Reply Screen, Page 3

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
START DATE	**Start Date** – Shows the start date of the home health episode.
END DATE	**End Date** – Indicates end date of the home health episode.
INTER NUM	**Inter Num** – Medicare Intermediary number that processed the claim.
PROV NUM	**Provider Number**- The provider number of the home health agency that submitted the claim.
DOEBA	**Date of Earliest Billing Action** - the first service date of the HHPPS period.
DOLBA	**Date of Last Billing Action** - the last service date of the HHPPS period.
PATIENT STAT	**Patient Status Code** – the patient status code submitted in field 22 of the claim.
PATIENT IND	**Patient Indicator** – Valid values are: 1 = RAP auto cancelled 2 = RAP not cancelled

HIQH PAGE 4

Field descriptions for Page 4 of the HIQH screen are provided in the table following Figure 66.



```
HIQHCOP                          MSP PERIODS                    PAGE 04 OF 07

 MSP-REC    CN  nnnnnnnnnA        NM  DOE          IT  J        DB  01011911        SX  M

REC    MSP    DESCRIPTION        EFF DATE        TRM DATE        INTER        DOA
001    G      DISABLED           01/01/1994      02/29/1996      10250        11/18/1995
002    G      DISABLED           01/01/1994      02/29/1996      00885        04/02/1996
003    G      DISABLED           09/01/1992      02/29/1996      00230        05/31/1996




PF1=INQ SCREEN   PF3/CLEAR=END   PF7=PREV   PF8=NEXT
```

Figure 66 – CWF Part A Inquiry Reply Screen, Page 4

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
REC	**Record Number**
MSP	This code is used to differentiate how information is located, followed by an explanation for investigation. **Note:** MSP codes may not be available with all inquiries. Valid values are: A = Claims Processing B = IRS/SSA/CMS Data Match C = First claim development D = Mass Mailing E = Black Lung (DOL) F = Veterans (VA) G = Other data matches H = Workers compensation I = Notified by beneficiary J = Notified by provider K = Notified by insurer L = Notified by employer M = Notified by attorney N = Notified by EGHP/Primary payer
DESCRIPTION	Name of Insurance (EGHP, Workers Comp, etc.)
EFF DATE	**Effective Date**
TRM DATE	**Termination Date**
INTER	**Intermediary Number**
DOA	**Date of Accretion** – date record was set up.

HIQH PAGE 5

Field descriptions for Page 5 of the HIQH screen are provided in the table following Figure 67.

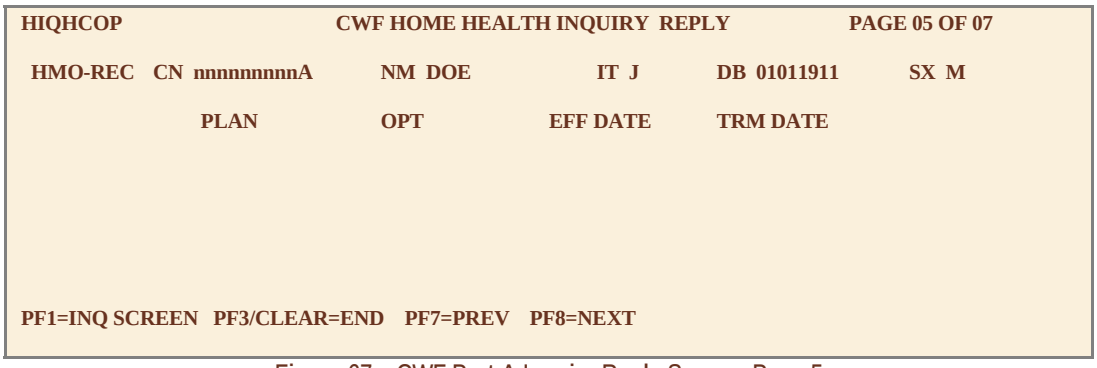


Figure 67 – CWF Part A Inquiry Reply Screen, Page 5

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
PLAN	**HMO Identification Code** – Valid values are: 1 = H 2 & 3 = State Code 4 & 5 = HMO Number within the state
OPT	**HMO Option Code –**Describes the beneficiary's relationship with the HMO. Valid values are: 2 = HMO to process bills only for directly provided services and for service from provider with whom the HMO has effective arrangements. Palmetto GBA processes all other bills. C = HMO to process all bills.
EFF DATE	**HMO Effective Date**
TRM DATE	**HMO Termination Date**

HIQH PAGE 6 & PAGE 7

Field descriptions for Page 6 & Page 7 of the HIQH screen are provided in the table following Figure 68.

```
HIQHCOP                          CWF HOSPICE PERIODS                  PAGE 06OF 07

HOSP REC    CN  nnnnnnnnA        NM  DOE          IT  J      DB  010111      SX  M

HOSPICE DATE      PERIOD 2      OWNER CHANGE 2              PERIOD 1      OWNER CHANGE 1
START DATE1       000000        000000                      000000        000000
TERM DATE1        000000        000000
PROV1

INTER 1
DOEBA DATE        000000        000000
DOLBA DATE        000000        000000
DAYS USED         000                                       000
START DATE2       000000        000000                      000000        000000
PROV2
INTER2
REVOCATION IND

 PF1=INQ SCREEN   PF3/CLEAR=END   PF7=PREV   PF8=NEXT
```

Figure 68 – CWF Part A Inquiry Reply Screen, Page 6 & 7

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname.
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's Date of Birth.
SX	**Sex** – Beneficiary's sex. Valid values are: M = Male F = Female
HOSPICE DATA	Indicates if the beneficiary elected the Medicare hospice benefit.
START DATE1	The elected start date of a beneficiary's period of hospice coverage.
TERM DATE 1	Indicates the termination of the first hospice benefit period. May be listed as the end of the benefits for the hospice period indicated, or the revocation of hospice benefits.
PROV1	**First Provider** – first provider the beneficiary has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1 NUMBER	**First Intermediary Number** – Indicator as to the Medicare Intermediary that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period.
START DATE2	Lists second start date if a beneficiary elects to change hospices during a benefit period.
PROV2 NUMBER	Indicates the Second Intermediary to process hospice claims for second provider number.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary has not revoked hospice benefits. 1 = Beneficiary has revoked hospice benefits.

APPENDIX – ACRONYMS

Acronym	Description
A	
ADR	Additional Development Request
ADJ	Adjustment
ASC	Ambulatory Surgical Center
ANSI	American National Standards Institute
B	
C	
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
CWF	Common Working File
D	
DCN	Document Control Number
DDE	Direct Data Entry
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
E	
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
F	
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
FMR	Focused Medical Review
FQHC	Federally Qualified Health Centers
G	
H	
HCFA	Health Care Financing Administration (now CMS)
HCPC	Healthcare Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HMO	Health Maintenance Organization
I	
IDE	Investigational Device Exemption
IEQ	Initial Enrollment Questionnaire
IME	Indirect Medical Education
IRS	Internal Revenue Service

Acronym	Description
J	
K	
L	
M	
MCE	Medicare Code Editor
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N	
NDC	National Drug Code
O	
OCE	Outpatient Code Editor
OMB	Office of Management and Budget
OTAF	Obligated To Accept in Full
P	
PHS	Public Health Service
PPS	Prospective Payment System
PRO	Peer Review Organization
Q	
R	
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return To Provider
S	
SNF	Skilled Nursing Facility
SSA	Social Security Administration
T	
U	
UPIN	Unique Physician Identification Number
URC	Utilization Review Committee
V	
W	
X	
Y	
Y2K	Year 2000
Z	