Department of Health & Mental Hygiene
Medical Assistance

UB04
Medicare Advantage Plans
Crossover Billing Instructions

Revised 10/1/08

Medical Assistance Problem Resolution

Institutional Hotline: 410-767-5457

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INTRODUCTION

These instructions have been prepared to provide proper billing procedures and instructions for Medicare Advantage Plans for Maryland Medicaid providers who use the UB04 form.

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. Providers must use their unique 10-digit NPI number on all electronic transactions. When submitting paper claims, the NPI number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed properly. Details about placement of the NPI and the Medicaid provider number are contained within the form locator information in this manual.

When submitting claims to Medicare, please forward your taxonomy code as detailed in this manual under FL81, if applicable to your provider specialty. This information will assist in a successful crosswalk to Medicaid legacy provider number and reimbursement.

Additional information on NPI can be obtained from the CMS website at:

http://www.cms.hhs.gov/NationalProvIdentStand/
http://www.dhmh.state.md.us/mma/mmahome.html

COMPLETION OF UB-04 FOR HOSPITAL INPATIENT/OUTPATIENT MEDICARE ADVANTAGE PLAN CROSSOVER SERVICES

The uniform bill for institutional providers is known as the UB-04 and is the replacement for the UB-92 form. As of July 30, 2007 all institutional paper claims must use the UB-04; the UB-92 will no longer be acceptable, even when billing dates of service prior to July 30, 2007.

The instructions are organized by the corresponding boxes or "Form Locators" on the paper UB-04 and detail only those data elements required for Medical Assistance (MA) paper claim billing.

The UB-04 is a uniform institutional bill suitable for use in billing multiple third party liability (TPL) payers. When submitting the above claims, complete all items required by each payer who is to receive a copy of the form.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. **Please be aware that Maryland Medicaid has a maximum line item allowance on the UB04 of 50 lines per claim**.

The Maryland Medicaid statute of limitations for timely claim submission is as follows, effective for dates of service March, 2008 forward: Invoices for inpatient and outpatient services must be received within twelve (12) months of the date of discharge or date of service. If a claim is received within the 12 month limit but rejected, resubmission will be accepted within 60 days of the date of rejection, or within 12 months of the date of discharge or date of service, whichever is the longer period. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

For any claim initially submitted to Medicare and for which services have been approved or denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

All third-party resources, such as insurance or Worker's Compensation, should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 9-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payer makes payment later.

To ensure that claims are accurately cross-referenced to your Medicaid provider number, please notify the Claims Processing/Medicare Crossover Unit of your Medicare provider number and NPI number so all provider numbers can be properly linked in the Medicaid System. Requests to add, change, or delete information on the Medicare crossover file must be sent in writing to Mr. Jack Collins at the address below. If you have questions you may call 410-767-5559.

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203
Attn: Jack Collins

Completed Medicare Advantage Plan Crossover invoices are to be mailed to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

Invoices may be typed or printed. If printed, the entries must be legible. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected.

Adjustments should be completed when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" date(s); the bill has been **paid**; and a supplemental payment is needed. To submit an adjustment, a provider should complete a DHMH-4518A, Adjustment Form and mail that form to the address below:

Maryland Medical Assistance Program
Adjustment Section
P.O. Box 13045
Baltimore, MD 21203

MEDICARE PAPER CLAIM PROCEDURES

UB04 with Medicare EOMB Attachment

On the Medicare EOMB ***each individual claim*** is generally designated by two horizontal lines. Therefore, you should complete one UB-04 form per set of horizontal lines.

- ⇨ When billing Medical Assistance, the information on the UB-04 must be identical to the information that is ***between the two horizontal lines*** on the Medicare EOMB.
  - Dates of service must match
  - Revenue codes must match
  - Amount(s) in the total charges column (FL 47) of the UB-04 must match the "amount billed"

- ⇨ Claims that have more then 22 lines, write "1 of __" in FL 23 on each claim and total all the lines of the last UB-04 claim.

- ⇨ When submitting your Medicare claims for payment, the writing should be legible.

- ⇨ When attaching a copy of the Medicare EOMB, make sure of the following:

  - The EOMB is clear and that the entire EOMB, including the information on the top and the glossary, is included on the copy.

  - The EOMB must clearly indicate ***'Medicare', 'Part A Benefits', or 'Part B Benefits'***. In the absence of this identifying information, the provider must label the EOMB attachment "**MEDICARE EOMB**" to assure proper processing of the claim.

  - The UB-04 and the Medicare EOMB must be submitted.

  - **NOTE:** Medical Assistance will reimburse Medicare Advantage Plan co-payments, coinsurance and deductibles, with the following exception:

    - ⌧ We will not reimburse Medicare Advantage Plan claims for recipients identified on EVS as Specified Low Income Medicare Beneficiaries (SLMB I & SLMB II).

Billing Provider Name and Address

2 Medicaid ICN – **Leave Blank**

3a PAT. CNTL. # / b. MED. REC. # — Patient Control Number

4 TYPE OF BILL — XXX

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH — Service Dates

7

8 PATIENT NAME

9 PATIENT ADDRESS

Patient Name: Last Name. First

10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES | 29 ACDT STATE | 30

Report when applicable

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

Report when applicable

	35 CODE	FROM	THROUGH
a	76	999999	999999
b			

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a					66	801 23
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
4-Digit Revenue Codes 0XXX	National Drug Code (NDC) (Rev Code 025X & 0637)	HCPCS (Freestanding Dialysis Facility outpatient only) Refer to instructions for specific conditions and requirements for reporting		Required	Required		
	PAGE ____ OF ____	CREATION DATE	Create Date	TOTALS			

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI — NPI Number

When applicable. DO NOT report Medicare payment

57 OTHER PRV ID — Medicaid Legacy 9-digit Provider #

58 INSURED'S NAME | 59 P REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

Patient'sMedical Assistance ID
*Should always be last entry in field

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX — Required

67 A B C D E F G H I J K L M N O P Q — Optional

68 — Optional

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE — PPS | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

Required

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

Optional

76 ATTENDING NPI — NPI - required | QUAL — 1D MA 9-digit Prov | LAST | FIRST

77 OPERATING NPI — NPI - required | QUAL — 1D MA 9-digit Prov | LAST | FIRST

78 OTHER NPI | QUAL | LAST | FIRST

79 OTHER NPI | QUAL | LAST | FIRST

80 REMARKS

Not Required - Optional

81CC a — B3 Taxonomy Code

b

c

d

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

The instructions that follow are keyed to the form locator number and headings on the UB-04 form.

FL 01 **Billing Provider Name, Address, and Telephone Number**

Required. Enter the name and service location of the provider submitting the bill.

Line 1 Enter the provider name filed with the Medical Assistance Program.

Line 2 Enter the street address to which the invoice should be returned if it is rejected due to provider error.

Line 3 Enter the City, State & full nine-digit ZIP Code

Line 4 Telephone, Fax, County Code (Optional)

Note: Checks and remittance advices are sent to the provider's address as it appears in the Program's provider master file.

FL 02 **Pay-to Name and Address**

Leave Blank – Internal Use Only

FL 03a **Patient Control Number**

Required. Enter the patient's unique alphanumeric control number assigned to the patient by the hospital. A maximum of 20 positions will be returned on the remittance advice to the provider.

FL 03b **Medical/Health Record Number**

Optional. Enter the medical/health record number assigned to the patient by the hospital when the provider needs to identify for future inquiries the actual medical record of the patient. Up to 13 positions may be entered.

FL 04 **Type of Bill**

Required. Enter the 3-digit code (**do not report leading zero**) indicating the specific type of bill. Entering the leading zero will cause your claim to deny. The third digit indicates the bill sequence for this particular episode of care and is referred to as a "frequency" code. All three digits are required to process a claim.

Type of Bill: Inpatient and Outpatient Designation

The matrix that follows contains general guidelines on what constitutes an "inpatient" or "outpatient" claim according to the first three digits of Type of Bill (TOB), minus the leading zero. **Only those "Types of Bills" highlighted in grey are acceptable by Medical Assistance**.

"Types of Bills" marked NOT USED will be denied by Medicaid. The usage of many data elements is based on the inpatient/outpatient bill type designation. For example, HCPCS are reported on outpatient bills while ICD-9-CM procedure codes are reported on inpatient bills.

The "x" in the Type of Bill column of the matrix represents a placeholder for the frequency code. A list of the frequency codes follows the matrix.

Exceptions and augmentations to the general guidelines that result from specific data element requirements are documented at the end of the matrix.

Type of Bill **Do NOT report leading zero**	**Description**	**Inpatient/Outpatient General Designation**
0**11x**	Hospital Inpatient (including Medicare Part A)	IP
0**12x**	Hospital Inpatient (Medicare Part B ONLY)	OP
0**13x**	Hospital Outpatient	OP
0**15x**	Chronic Hospitals, Chronic Rehabilitation Hospitals, Specialty Chronic Hospitals	IP
0**22x**	Skilled Nursing – Inpatient (Medicare Part B)	OP *Nursing Home Therapy*
0**33x**	Home Health – Outpatient (plan of treatment under Part A, including DME under Part A)	OP *Home Health Agency*
0**72x**	Clinic – Hospital Based or Independent Renal Dialysis Center	OP *Free-Standing Dialysis*

Type of Bill Frequency Codes:		
1	Admit Through Discharge Claims	The provider uses this code for a bill encompassing an entire inpatient confinement for which it expects payment from the payer.
2	Interim Billing - First Claim	This code is to be used for the first (admit) of an expected series of bills for the same confinement or course of treatment for which the provider expects payment from the payer. FL 17 should equal "30".
3	Interim Billing- Continuing Claim	This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted for which payment is expected from the payer. FL 17 should equal "30".
4	Interim Billing - Last Claim	This code is to be used for the last (discharge) of a series of bills for the same confinement or course of treatment for which payment is expected from the payer.

Type of Bill Frequency Codes:		
5	Late Charge(s) Only Claim	This code is to be used for submitting additional charges to the payer which were identified by the provider after the admit through discharge claim or the last interim claim has been submitted. This code is not intended for use in lieu of an adjustment claim or a replacement claim. *See note below for late charge billing.

FL 06 **Statement Covers Period (From - Through)**

Required (MMDDYY). Enter the "From" and "Through" dates covered by the services listed on the Explanation of Medicare Benefits (EOMB). The "Through" date equals the date through which we are paying for accommodations. Remember that Medical Assistance does not pay for accommodations for the date of death/discharge. The date of death/discharge should never be shown as the through date in this field.

NOTE A: For all services received on a single day both the "From" and "Through" dates will be the same. Only one date of service for outpatient charges may be billed on a single UB-04. (Continuing treatment must be billed on a day-to-day basis).

NOTE B: Medicare coinsurance and deductible amounts must be billed separately from non-Medicare covered regular charges.

NOTE C: Medicare Part A and Part B claims should include the "From" and "Through" dates as indicated on the Medicare payment listing or EOMB.

FL 08b **Patient Name**

Required. Enter the patient's name as it appears on the Medical Assistance card: last name, first name, and middle initial. (Please print this information clearly.)

FL 09, 1a-2e **Patient Address**

Optional. Enter the patient's complete mailing address, as follows:

Line 1a -- Enter the patient address – Street (or P.O. Box)
Line 2b -- Enter the patient address – City
Line 2c -- Enter the patient address – State
Line 2d -- Enter the patient address –Zip
Line 2e -- Enter the patient address –Country Code (Report if other than USA)

FL 10 **Patient Birth Date**

Required. Enter the month, day, and year of birth (MMDDYYYY). Example: 11223333

FL 12 **Admission/Start of Care Date**

Required. Enter the start date for this episode of care. For inpatient services, this is the date of admission. Enter the date as (MMDDYY).

FL 13 **Admission Hour**

Required on all inpatient claims except for bill type 021x. Optional for outpatient billing. Enter the code for the hour during which the patient was admitted for inpatient or outpatient care from the following table:

CODE STRUCTURE:

Code	Time	Code	Time
00	12:00-12:59 Midnight	12	12:00-12:59 Noon
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	09:00-09:59	21	09:00-09:59
10	10:00-10:59	22	10:00-10:59
11	11:00-11:59	23	11:00-11:59

FL 14 **Priority (Type) of Visit**

Required for inpatient billing only. Enter the code indicating priority of this admission.

Code Structure – Priority (Type of Visit)		
1	Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room
2	Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
5	Trauma Center	Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation. (Use Revenue Code 068x to capture trauma activation charges.)

FL 15 Source of Referral for Admission or Visit

Required for all inpatient admissions. Enter the code indicating the source of the referral for this admission or visit. Optional for outpatient claims.

Code Structure: Source of Referral for Admission or Visit		
1	Physician Referral	Inpatient: The patient was admitted to this facility upon the recommendation of his or her personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.
3	HMO Referral	Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. Outpatient: The patient was referred to this facility for outpatient, or referenced diagnostic services, by a health maintenance organization's physician.
4	Transfer from a Hospital (Different Facility*) *For transfers from Hospital Inpatient in the Same Facility, see Code D	Inpatient: The patient was admitted to this facility as a hospital transfer from a different acute care facility where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) a different acute care facility.
5	Transfer from a Skilled Nursing Facility	Inpatient: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was a resident. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the skilled nursing facility where he or she is a resident.

Code Structure: Source of Referral for Admission or Visit		
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) another health care facility where he or she is an inpatient.
7	Emergency Room	Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. Outpatient: The patient received services in this facility's emergency department.
8	Court/Law Enforcement	Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information not Available NOT USED	Inpatient: The means by which the patient was admitted to this hospital is not known. Outpatient: For Medicare outpatient bills this is not a valid code.

FL 17 Patient Discharge Status

Required for all inpatient claims. Enter a code from the code structure below indicating the patient's disposition or discharge status at the time of billing for that period of inpatient care.

Under Medicare's post acute care transfer policy (from 42 CFR 412.4), a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the qualifying diagnosis-related groups (DRGs) and the discharge is made under any of the following circumstances:

- To a hospital or distinct part of a hospital unit excluded from the inpatient prospective payment system (Inpatient Rehabilitation Facilities, Long Term Care Hospitals, psychiatric hospitals, cancer hospitals, and children's hospitals).
- To a skilled nursing facility (not swing beds).
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

Based on regulation, providers code these transfers with 62, 63, 65, 05, 03 and 06.

Code Structure: Patient Discharge Status	
01	Discharged to self or home care (routine discharge) Usage Notes: Includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care. Usage Notes: Medicare – Indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with approved swing bed arrangement, use Code 61 – Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.
04	Discharged/transferred to an intermediate care facility (ICF) Usage Notes: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.
05	**Definition effective 4/1/08:** Discharged/transferred to a Designated Cancer Center or Children's Hospital Usage Notes: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at: http://www3.cancer.gov/cancercenters/centerslist.html
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care. Usage Notes: Report this code when the patient is discharged/transferred to home with a written plan of care for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services.
07	Left against medical advice or discontinued care
09	Admitted as an Inpatient to this Hospital Usage Notes: For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.
20	Expired
30	Still a patient Usage Notes: Used when patient is still within the same facility; typically used when billing for leave of absence days or interim bills.

Code Structure: Patient Discharge Status	
43	Discharge/Transferred to a Federal Healthcare Facility Usage Notes: Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration's nursing facility.
50	Hospice – Home
51	Hospice – Medical Facility (Certified) Providing Hospice Level of Care
61	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed Usage Notes: Medicare – used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
62	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged/Transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric distinct Part Unit of a Hospital
66	Discharged/Transferred to a Critical Access Hospital (CAH)
70	Effective **4/1/08**: **NOT USED** Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List (see Code 05)

FL 31-34 a b Occurrence Codes and Dates

Required when there is an Occurrence Code that applies to this claim. Enter the code and associated date defining a significant event relating to this bill that may affect payer processing. Enter all dates as MMDDYY.

The Occurrence Span Code fields can be utilized to submit additional Occurrence Codes when necessary by leaving the THROUGH date blank in FL 35-36. As a result, up to 12 Occurrence Codes may be reported.

Report Occurrence Codes in alphanumeric sequence (numbered codes precede alphanumeric codes) in the following order: FL 31a, 32a, 33a, 34a, 31b, 32b, 33b, 34b. If there are Occurrence Span Code fields available, fields 35a FROM, 36a FROM, 35b FROM and 36b FROM may then be used as an overflow. After all of these fields are exhausted, FL 81 (Code-Code field) can be used with the appropriate qualifier (A2) to report additional codes and dates (see FL 81 for additional information).

Enter the appropriate codes and dates from the table below.

Note A: Occurrence Codes should be entered in alphanumeric sequence. However, report any Occurrence Codes required to process your Maryland Medicaid claim first; then continue to report other Occurrence Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 12 Occurrence Codes, including those reported in FL 81.

Note B: Any hospital inpatient Type of Bill (TOB) with frequency codes 1or 4 must report occurrence Code 42 - Date of Death/Discharge.

Code Structure – Occurrence Codes & Dates:		
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from any insurer.
25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
42	Date of Discharge	Use only when "Through" date in FL 6 (Statement Covers Period) is not the actual discharge date and the frequency code in FL 4 is that of a final bill (1 or 4).

FL 35-36a b Occurrence Span Codes and Dates

Required when there is an Occurrence Span Code that applies to this claim. These codes identify occurrences that happened over a span of time. Enter the code and associated beginning and ending dates defining a specific event relating to this billing period. Enter all dates as MMDDYY.

Report Occurrence Span Codes in alphanumeric sequence (numbered codes precede alphanumeric codes) in the following order: FL 35a & 36a, 35b & 36b. After all of these fields are exhausted, FL 81 (Code-Code field) can be used with the appropriate qualifier (A3) to indicate that Occurrence Span overflow codes are being reported. The third column in FL 81 is 12 positions, which accommodates both the FROM and THROUGH date in a single field (see FL 81 for more information).

Code Structure - Occurrence Span Codes and Dates:		
76	Patient Liability (Spend-down Amount Dates) **Replaces Code 80 as of 7/31/07**	The from/through dates for a period of non-covered care for which the hospital is permitted to charge the beneficiary. Enter the from/through dates indicated as the "begin" and "expiration" dates on the DHMH 4233, Notice of Eligibility letter. Indicate patient resources in FL 39-41 a,b,c, or d. Use **Value Code 66** and indicate the resource shown on the DHMH 4233, Notice of Eligibility letter

FL 39-41 a-d Value Codes and Amounts

Required when there is a Value Code that applies to this claim. A code structure to relate amounts or values to data elements necessary to process this claim as qualified by the payer organization.

FLs 39a - 41a must be completed before the 'b' fields, etc. Whole numbers or non-dollar amounts are right justified to the left of the dollars/cents delimiter. Do not zero fill the positions to the left of the delimiter. Negative numbers are not allowed except in FL 41.

If all the Value Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A4) to indicate that a Value Code is being reported (see FL 81 for more information).

Note: Value Codes should be entered in alphanumeric sequence. However, report any Value Codes required to process your Maryland Medicaid claim first; then continue to report other Value Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 6 Value Codes, including those reported in FL 81.

Code Structure – Value Codes and Amounts:		
66	Medicaid Spend Down Amount **Replaces Code D3 as of 7/31/07**	The dollar amount that was used to meet the recipient's spend down liability for this claim. For Maryland Medicaid inpatient only enter the amount of the patient's spend down amount as indicated on the DHMH 4233, Notice of Eligibility letter.

FL 42 Revenue Codes

Required. Line 1-23. Enter the appropriate four-digit numeric revenue code from the enclosed Revenue Code Matrix to identify specific accommodation and/or ancillary charges.

On a multiple page UB04, all of the claim level information is repeated on each page; only the line items in the revenue code section will vary. The 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

The appropriate revenue code must be entered to explain each charge in FL 47.

- For inpatient services involving multiple services for the same item providers should combine the services under the assigned revenue code and then report the total number of units that represent those services.
- For outpatient services providers should report the corresponding HCPCS code for the service along with the date of service and the revenue code. HCPCS are required only for those outpatient revenue codes listed under FL 44.

- If multiple services are provided on the same day for like services, that is, those with the same revenue code, the provider should combine the like services for each day and report the rate along with the number of units provided.

To assist in bill review, revenue codes should always be listed in ascending numeric sequence, by date of service (outpatient). The exception is Revenue Code 0001, which is used on paper claims only and is reported on Line 23 of the last page of the claim. On inpatient claims, accommodations must be entered first on the bill and in revenue code sequence. Revenue codes must not be repeated on the same bill.

NOTE: Detail beyond 0 level code in fourth digit field is not required unless specified in the **Revenue Code Matrix Table**, which you will find included in these Instructions.

FL 43 National Drug Code (NDC) - Medicaid Drug Rebate Reporting

Required on outpatient claims (type of bill 131/135) when reporting revenue codes within series 025X and revenue code 0637.

For claims submitted on or after September 1, 2008 for dates of service on or after July 1, 2008.

Format

1) Report **the NDC Qualifier** of "N4" in the first two (2) positions, left justified
2) Followed immediately by **the 11-Character NDC Number** in the 5-4-2 format **(**do not report hyphens**).**
3) Followed immediately by **the Unit of Measurement Qualifier** (listed below).
   F2 -International Unit
   GR-Gram
   ML-Milliliter
   UN- Unit
4) Followed immediately by **the Unit Quantity** with a floating decimal for fractional units limited to three (3) digits to the right of the decimal point. Any spaces unused for the quantity field are left blank.
   Notes:
   - ⇨ Enter the actual metric decimal quantity (units) administered to the patient.
   - ⇨ A maximum of seven (7) positions to the left of the floating decimal may be reported.
   - ⇨ When reporting a whole number, do not key the floating decimal.
   - ⇨ When reporting fractional units, you must enter the decimal as part of the entry.

Sample NDC:

Whole Number Unit:

N	**4**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**	**1**	**U**	**N**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	

Fractional Unit:

N	**4**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**	**1**	**U**	**N**	**1**	**2**	**3**	**4**	**.**	**5**	**6**	**7**

General NDC Reporting Notes:

1) If the NDC reported is not eligible for the rebate, the line item charges will be denied by Maryland Medicaid.
2) Do not enter a revenue code description in the field.
3) Do not enter a space between the qualifier and NDC.
4) Do not enter hyphens or spaces within the NDC number.
5) The NDC number submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.
6) Enter the NDC unit of measurement code and numeric quantity administered to the patient.
7) The Description Field on the UB04 is 24-characters in length (refer to the sample NDC above).

Reporting Multiple NDC's

You may report multiple line items of revenue codes and NDC codes within series 025X or revenue code 0637, following the guidelines below:

1) Each line item must reflect a revenue code within series 025X or revenue code 0637.
2) Each line item must reflect a valid NDC per the NDC format.
3) Each NDC reported must be unique or the revenue code line item will deny as a duplicate against the Revenue Code and NDC line item that matches it.

Maryland hospitals approved by DHMH under the 340B Program are exempt from reporting the NDC and must continue to submit pharmacy revenue codes as single line items to avoid duplicate denials.

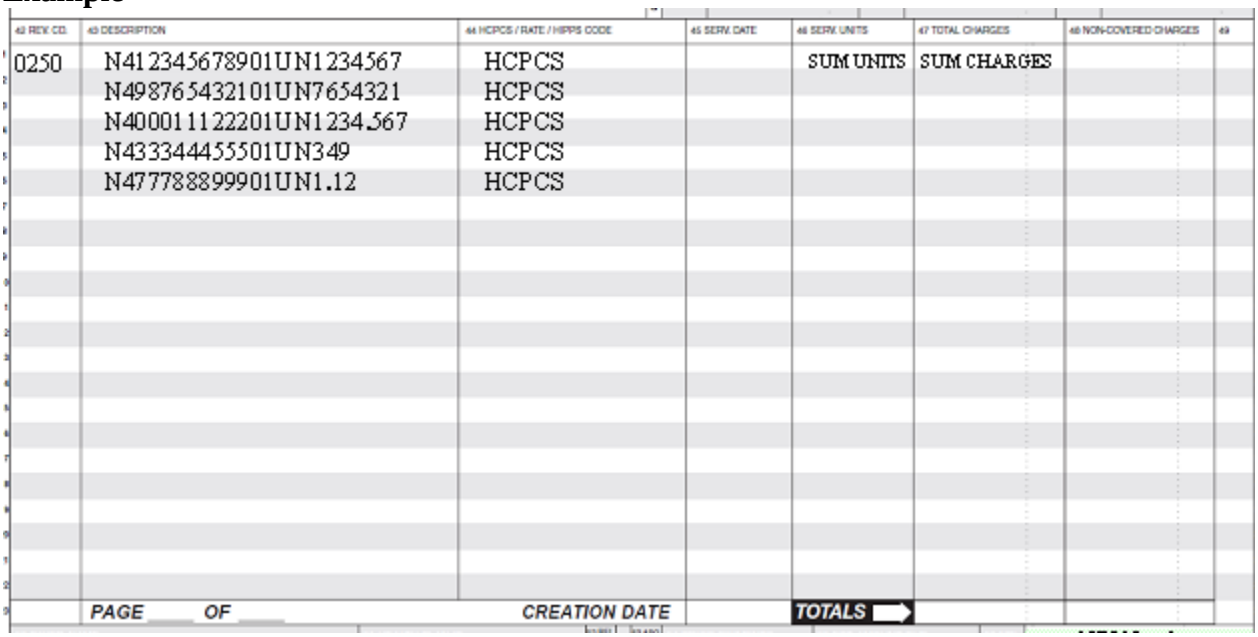
Reporting Compound Drugs

When reporting compound drugs, a maximum of 5 lines are allowed.

Line 1: Report the revenue code, NDC, HCPCS, and sum the total units and total charges for all line items included in the compound drug.

Lines 2-4: Report only the NDC and HCPCS correlating to the compound drug.

Example



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	N412345678901UN1234567	HCPCS		SUM UNITS	SUM CHARGES		
	N498765432101UN7654321	HCPCS					
	N400011122201UN1234.567	HCPCS					
	N433344455501UN349	HCPCS					
	N477788899901UN1.12	HCPCS					
	PAGE ___ OF ___	CREATION DATE		TOTALS			

FL 44 **HCPCS/Accommodation Rates/HIPPS Rate Codes**

Required for freestanding dialysis facility billing only. The field contains 5 positions for the base code, plus 8 positions for up to 4 HCPCS modifiers and must be submitted in the following circumstances:

HCPCS:
When the following surgical revenue codes listed below are billed:

Revenue Codes: 025X, 270X

FL 45 **Service Date**

Line 1-22: **Required – Freestanding Dialysis Facilities only**. Enter the date (MMDDYY) the outpatient service was provided.

Line 23: Enter Creation Date (MMDDYY)

Required. Enter the date the bill was created or prepared for submission. Creation Date on Line 23 should be reported on all pages of the UB04.

FL 46 **Units of Service**

Required. Enter the total number of ***covered*** accommodation days, ancillary units of service, or visits, where appropriate and defined by revenue code requirements. There must be a unit of service for every revenue code except 0001.

FL 47 Total Charges

Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period (FL 06).

Line Item Charges
Required - Lines 1-22. Line items allow up to nine numeric digits (0,000,000.00); 7 positions for dollars, 2 positions for cents.

Total (Summary) Charges
Required - Line 23 of the final claim page using Revenue Code 0001.

The 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

NOTE: Total charges must match the Medicare Explanation of Benefits (EOMB)

FL 53 a,b,c Assignment of Benefits Certification Indicator

Required. Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

N	No
W	Not Applicable (Use code 'W' when the patient refuses to assign benefits.)
Y	Yes

FL 54 a,b,c Prior Payments - Payer

Required when the indicated payer has paid an amount to the provider towards this bill. Enter the amount the provider has received (to date) by the health plan toward payment of this bill. DO NOT REPORT MEDICARE PRIOR PAYMENTS IN THIS FIELD.

FL 56 National Provider Identifier (NPI) – Billing Provider

Required. The unique identification number assigned to the provider submitting the bill; NPI is the10-digit national provider identifier. Beginning on the Medical Assistance NPI compliance date of July 30, 2007, when the Billing Provider is an organization health care provider, the organization health care provider will report its 10-digit NPI or its subpart's NPI in FL 56.

Note: Organizational health care providers must continue to report proprietary legacy identifiers necessary for Maryland Medicaid to identify the Billing Provider entity in FL 57 Lines a-c.

FL 57 a,b,c Other (Billing) Provider Identifier - Legacy

Required. A unique identification number assigned to the provider submitting the bill by the health plan. Enter the Maryland Medicaid Legacy 9-digit provider number.

FL 60 a,b,c **Insured's Unique ID**

Required. Enter the 11-digit Medical Assistance number of the insured as it appears on the Medical Assistance card.

If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field.

REMINDER:

Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification System/Interactive Voice Response (EVS/IVR) line:

Toll-Free Number for the entire State: **1-866-710-1447**

The Eligibility System User Guide can be downloaded by visiting our website at www.dhmh.state.md.us. Click on the **Medical Care Programs** tab and once you are on that page, click on the Eligibility Verification System Brochure link.

WebEVS: Providers may verify a patient's current Medical Assistance eligibility by using the new web-based eligibility services available for providers who are enrolled in EMedicaid. To access this service, click on: www.emdhealthchoice.org

FL 67 **Principal Diagnosis Code and Present on Admission Indicator**

Principal Diagnosis Code

Required. Enter the 5-digit ICD-9-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB-04.

Follow the official guidelines for ICD reporting. Refer to the Official ICD-9-CM Guidelines for Coding and Reporting for additional information.

The ICD-9-CM codes will be used for inpatient and outpatient services.

NOTE A: The principal diagnosis code will include the use of "V" codes. The "E" codes are not acceptable for principal diagnosis.

FL 67 a-q **Other Diagnosis Codes**

Required. Enter the 5-digit ICD-9-CM diagnoses codes corresponding to all conditions that co-exist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.

Enter the appropriate ICD-9-CM diagnosis code (co-morbidity) in FL 67a that determines the DRG selected.

Completion of FL 67 c-q are currently optional as our data processing system will accept one principal and three co-existing diagnoses.

NOTE A: Other diagnoses codes will permit the use of "V" codes and "E" codes where appropriate.

FL 76 **Attending Provider Name and Identifiers**

Required. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Line 1 Inpatient: **Required.** Enter the 10-digit NPI number assigned to the physician attending an inpatient. This is the physician primarily responsible for the care of the patient from the beginning of this hospitalization.

Line 1 Outpatient: **Required.** Enter the 10-digit NPI number assigned to the physician referring the patient to the hospital. When a patient is not referred or has no private physician, the attending physician is the staff member to whom the patient is assigned.

Line 1 Secondary Identifier Qualifiers: **Required**

1D Enter the Attending Physician's 9-digit Maryland Medicaid Provider Number.

Note: If the Attending Physician's 9-digit Maryland Medicaid Provider number is not known/unavailable, enter "999995700".

Line 2 Attending Physician Name
Not required. Last name, First name

FL 80 **Remarks**

Not required. Area to capture additional information necessary to adjudicate the claim.

FL 81 a-d **Code-Code Field**

Situational. To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Where applicable, providers should use taxonomy codes as noted.

Left Column:	Middle Column:	Right Column:
1 field (Code Qualifier)	1 field (Code)	1 field (Number or Value)

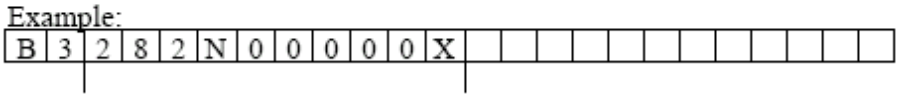
B3 **Required.** Health Care Provider Taxonomy Code.

Used for Billing Provider only. For provider types listed below, use the taxonomy code accompanying your specialty. You must submit the accompanying designated taxonomy code listed below to assure appropriate reimbursement from the Medical Assistance Program.

Medicaid Provider Specialty/Taxonomy Code Table			
Specialty	**Bill Type(s)**	**Subspecialties**	**Taxonomy Code**
Acute General Hospital	IP: **111,** 112, 113, 114, 115, 121 OP: **131**, 135	Only the acute hospital taxonomy code should be billed on an acute hospital claim.	282N00000X
Acute Rehabilitation Hospital	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Medicaid Stand-Alone Rehab Hospital	283X00000X
Acute Rehabilitation Hospital	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Medicaid General Acute Hospital with Rehab Unit	273Y00000X
Chronic Rehabilitation Hospital	IP: **151,** 152, 153, 154, 155		282E00000X
Chronic Hospital	IP: **151,** 152, 153, 154, 155		281P00000X
Special Other Acute Hospitals	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Pediatric Inpatient	282NC2000X
Special Other Chronic Hospitals	IP: **151,** 152, 153, 154, 155	Pediatric Inpatient	281PC2000X

All positions fully coded in the middle column; the right-hand column is left blank.

Example:



UB04
REVENUE CODE MATRIX

Units of service are required for every revenue code except 0001 - Total Charge.

Each revenue code may only be used once. The last revenue code on line 23 of the last page of the claim must be 0001 - Total Charge.

The table on the next page lists the only revenue codes recognized by the Maryland Medical Assistance Program. Use of any other codes will result in either rejection or return of the invoice or non-payment of the individual revenue code.

The table also indicates that some of the codes are not used (NU), not payable (NP), or not covered (NC).

Finally, the table indicates the revenue codes which must be reported at a greater than zero level. Non -payable subheadings are identified - National non-assigned subheadings have not been included.

Medicaid Revenue Code Matrix Table

Revenue Code	Detail Greater Than Zero Level Required
001X	X
002X	NP
010X	
011X	X
012X	X
013X	X
014X	NP
015X	X
016X	
017X	X
018X	NU
019X	NU
020X	X
021X	
022X	X
023X	NP
024X	
025X	
026X	
027X	
028X	
029X	X
030X	
031X	
032X	
033X	X
034X	
035X	
036X	
037X	
038X	
039X	

Revenue Code	Detail Greater Than Zero Level Required
054X	X
055X	NP
056X	NP
057X	NP
058X	NP
059X	NP
060X	NP
061X	
062X	
063X	
064X	NP
065X	
066X	NP
067X	NP
068X	NP
070X	
071X	
072X	
073X	
074X	
075X	
076X	
077X	NP
078X	NP
079X	
080X	X
081X	
082X	Freestanding Dialysis Only
083X	Freestanding Dialysis Only
084X	Freestanding Dialysis Only
085X	Freestanding Dialysis Only
088X	X

Medicaid Revenue Code Matrix Table

Revenue Code	Detail Greater Than Zero Level Required
040X	
041X	
042X	
043X	
044X	
045X	
046X	
047X	
048X	
049X	
050X	X
051X	
052X	NC
053X	

Revenue Code	Detail Greater Than Zero Level Required
090X	
091X	X
092X	X
093X	NC
094X	X
095X	NC
096X	X
097X	X
098X	X
099X	NP
100X	NC
210X	NC
310X	NC

NC = Not Covered NP = Not Payable NU – Not Used

0001 **Total Charge**

On the paper UB04 report the total for all revenue codes as indicated in FL47 Total Charges and FL48 Non-covered Charges on Line 23 of the last page of the UB04.
For electronic transactions, report the total charge in the appropriate data segment/field.

001X **Reserved for Internal Payer Use**

002X **Health Insurance – Prospective Payment System (HIPPS) - NOT PAYABLE**

This revenue code is used to denote that a HIPPS rate code is being reported in FL44.

	Subcategory	Standard Abbreviation
2	Skilled Nursing Facility – PPS **(Not Payable)**	SNF PPS (RUG)
3	Home Health – PPS **(Not Payable)**	HH PPS (HRG)
4	Inpatient Rehab Facility – PPS **(Not Payable)**	REHAB PPS (CMG)

003X to 009X **RESERVED – NOT USED**

010X **All Inclusive Rate**

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

Revenue codes 0100 and 0101 may not be used by Maryland general hospitals.

	Subcategory	Standard Abbreviation
0	All Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All Inclusive Room and Board (Use this code if you bill ancillaries separately from room and board)	ALL INCL R&B

011X **Room & Board – Private (One Bed)**

Requires condition code 39 (Private Stay Medically Necessary), Justification Required on Form 3808. Routine service charges for single bedrooms.

Rational: Most third party payers require that private rooms be separately identified.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/PVT
2	Obstetrics (OB)	OB/PVT
3	Pediatric	PEDS/PVT
4	Psychiatric	PSYCH/PVT
5	Hospice (Not Payable)	HOSPICE/PVT
6	Detoxification	DETOX/PVT
7	Oncology	ONCOLOGY/PVT
8	Rehabilitation	REHAB/PVT
9	Other (written description required)	OTHER/PVT

012X **Room & Board - Semi-Private (Two Beds)**

Routine service charges incurred for accommodations in a semi-private room (2 beds).

Rationale: Most third party payers require that semi-private rooms be identified.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/SEMI
2	Obstetrics (OB)	OB/SEMI-PVT
3	Pediatric	PEDS/SEMI-PVT
4	Psychiatric	PSYCH/SEMI-PVT
5	Hospice (**Not Payable**)	HOSPICE/SEMI-PVT
6	Detoxification	DETOX/SEMI-PVT
7	Oncology	ONCOLOGY/SEMI-PVT
8	Rehabilitation	REHAB/SEMI-PVT
9	Other (written description required)	OTHER/SEMI-PVT

013X **Room & Board - Three and Four Beds**

Routine service charges for rooms containing three and four beds.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/3&4 BED
2	Obstetrics (OB)	OB/3&4 BED
3	Pediatric	PEDS/3&4 BED
4	Psychiatric	PSYCH/3&4 BED
5	Hospice (**Not Payable**)	HOSPICE/3&4 BED
6	Detoxification	DETOX/3&4 BED
7	Oncology	ONCOLOGY/3&4 BED
8	Rehabilitation	REHAB/3&4 BED
9	Other (written description required)	OTHER/3&4 BED

014X **Room & Board – Deluxe Private - NOT PAYABLE**

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

015X **Room & Board - Ward**

Routine service charge for accommodations with five or more beds.

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

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/WARD
2	Obstetrics (OB)	OB/WARD
3	Pediatric	PEDS/WARD
4	Psychiatric	PSYCH/WARD
5	Hospice (**Not Payable**)	HOSPICE/WARD
6	Detoxification	DETOX/WARD
7	Oncology	ONCOLOGY/WARD
8	Rehabilitation	REHAB/WARD
9	Other (written description required)	OTHER/WARD

016X **Room & Board - Other**

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	R&B
4	Sterile Environment **(Not payable)**	R&B/STERILE
7	Self Care **(Not payable)**	R&B/SELF
9	Administrative Days	R&B/ADMIN DAYS

017X **Nursery**

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

Rationale: Provides a breakdown of various levels of nursery care. Tertiary care is a level of care between premature and regular nursery care.

	Subcategory	Standard Abbreviation
1	Newborn – Level I (Newborn Nursery)	NURSERY/LEVEL I
2	Newborn – Level II (Continuing Care)	NURSERY/LEVEL II
3	Newborn – Level III (Intermediate Care)	NURSERY/LEVEL III
4	Newborn – Level IV (Intensive Care)	NURSERY/LEVEL IV
9	Other Nursery	NURSERY - OTHER

Note: The levels of care correlate to the intensity of medical care provided to an infant and NOT the NICU facility certification level assigned by the state.

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

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

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

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

018X **Leave of Absence - NOT PAYABLE UNDER HOSPITAL PROGRAM**

Charges for holding a room while the patient is temporarily away from the provider.

	Subcategory	Standard Abbreviation
0	General Classification	Leave of Absence or LOA
2	Patient Convenience	LOA/PT CONV
3	Therapeutic Leave	LOA/THERAPEUTIC
5	Nursing Home (for Hospitalization)	LOA/NURS HOME
9	Other LOA (Written documentation required)	LOA/OTHER

019X **Subacute Care - NOT PAYABLE UNDER HOSPITAL PROGRAM**

Accommodation charges for subacute care to inpatients or skilled nursing facilities.

	Subcategory	Standard Abbreviation
0	General Classification	SUBACUTE
1	Subacute Care – Level I	SUBACUTE – LEVEL I
2	Subacute Care – Level II	SUBACUTE – LEVEL II
3	Subacute Care – Level III	SUBACUTE – LEVEL III
4	Subacute Care – Level IV	SUBACUTE – LEVEL IV
9	Other Subacute Care (Written documentation required)	SUBACUTE /OTHER

020X **Intensive Care Unit**

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

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

	Subcategory	Standard Abbreviation
1	Surgical	ICU/SURGICAL
2	Medical	ICU/MEDICAL
3	Pediatric	ICU/PEDS
4	Psychiatric	ICU/PSYCH
6	Intermediate ICU	ICU/INTERMEDIATE
7	Burn Care	ICU/BURN CARE
8	Trauma	ICU/TRAUMA
9	Other Intensive Care (written documentation required)	ICU/OTHER

021X **Coronary Care Unit**

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

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

	Subcategory	Standard Abbreviation
0	General Classification	CORONARY CARE
1	Myocardial Infarction	CCU/MYO INFARC
2	Pulmonary Care	CCU/PULMONARY
3	Heart Transplant	CCU/TRANSPLANT
4	Intermediate-CCU	CCU/INTERMEDIATE
9	Other Coronary Care (written description required)	CCU/OTHER

022X **Special Charges**

Charges incurred during an inpatient stay or on a daily basis for certain services.

	Subcategory	Standard Abbreviation
1	Admission Charge	ADMIT CHARGE

023X **Incremental Nursing Charge - NOT PAYABLE UNDER HOSPITAL PROGRAM**

Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit.

024X **All Inclusive Ancillary - NOT TO BE USED BY MARYLAND HOSPITALS**

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only when authorized by the host states Medicaid Agency.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

	Subcategory	Standard Abbreviation
0	General Classification	ALL INCL ANCIL
9	Other Inclusive Ancillary (written description required)	ALL INCL/ANCIL/OTHER

025X **Pharmacy (**Must report NDC Code on outpatient claims for dates of service 1/1/2008 forward**)**

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.

	Subcategory	Standard Abbreviation
0	General Classification	PHARMACY
1	Generic Drugs	DRUGS/GENERIC
2	Non-Generic Drugs	DRUGS/NONGENERIC
3	Take Home Drugs **(Not covered)**	DRUGS/TAKEHOME
4	Drugs Incident to Other Diagnostic Services **(Not covered)**	DRUGS/INCIDENT OTHER DX
5	Drugs Incident to Radiology **(Not covered)**	DRUGS/INCIDENT RAD
6	Experimental Drugs **(Not covered)**	DRUGS/EXPERIMT
7	Non-Prescription Drugs	DRUGS/NONPSCRPT
8	IV Solutions	IV SOLUTIONS
9	Other Pharmacy (written description required)	DRUGS/OTHER

026X **IV Therapy**

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

	Subcategory	Standard Abbreviation
0	General Classification	IV THERAPY
1	Infusion Pump	IV THER/INFSN PUMP
2	IV Therapy/Pharmacy Svcs (**Not payable**)	IV THER/PHARM SVC
3	IV Therapy/Drug/Supply Delivery (**Not payable**)	IV THER/DRGU/SUPPLY/DEL
4	IV Therapy/Supplies (**Not payable**)	IV THER/SUPPLIES
9	Other IV Therapy (written description required)	IV THERAPY/OTHER

027X **Medical/Surgical Supplies and Devices (Also see 062X, an extension of 027X)**

Charges for supply items required for patient care.

	Subcategory	Standard Abbreviation
0	General Classification	MED-SUR SUPPLIES
1	Non Sterile Supply	NON-STER SUPPLY
2	Sterile Supply	STERILE SUPPLY
3	Take Home Supplies **(Not payable)**	TAKEHOME SUPPLY
4	Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5	Pace Maker	PACE MAKER
6	Intraocular Lens	INTRA OC LENS
7	Oxygen - Take Home **(Not payable)**	O2/TAKEHOME
8	Other Implants [(a)]	SUPPLY/IMPLANTS
9	Other Supplies/Devices (written description required)	SUPPLY/OTHER

(a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

Examples of other implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

Experimental devices that are implantable and have been granted an FDA Investigational Device Exemption (IDE) number should be billed with revenue code 0624.

028X Oncology

Charges for the treatment of tumors and related diseases.

	Subcategory	Standard Abbreviation
0	General Classification	ONCOLOGY
9	Other Oncology (written description required)	ONCOLOGY/OTHER

029X Durable Medical Equipment (Other Than Renal)

Charges for medical equipment that can withstand repeated use (excluding renal equipment).

	Subcategory	Standard Abbreviation
1	Rental	DME-RENTAL
2	Purchase of new DME	DME-NEW
3	Purchase of used DME	DME-USED
4	Supplies/Drugs for DME (**Not payable**)	DME-SUPPLIES/DRUGS
9	Other Equipment (written description required)	DME-OTHER

030X **Laboratory**

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

	Subcategory	Standard Abbreviation
0	General Classification	MED-SUR SUPPLIES
1	Chemistry	CHEMISTRY TESTS
2	Immunology	IMMUNOLOGY TESTS
3	Renal Patient (Home)	RENAL-HOME
4	Non-Routine Dialysis	NON-RTNE DIALYSIS
5	Hematology	HEMATOLOGY TESTS
6	Bacteriology & Microbiology	BACT & MICRO TESTS
7	Urology	UROLOGY TESTS
9	Other Laboratory (written description required)	OTHER LAB TESTS

031X **Laboratory Pathology**

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

	Subcategory	Standard Abbreviation
0	General Classification	PATHOLOGY LAB
1	Cytology	CYTOLOGY TESTS
2	Histology	HISTOLOGY TESTS
4	Biopsy	BIOPSY TESTS
9	Other Laboratory Pathology (written description required)	PATH LAB OTHER

032X **Radiology – Diagnostic**

Charges for diagnostic radiology services including interpretation of radiographs and fluorographs.

	Subcategory	Standard Abbreviation
0	General Classification	DX X-RAY
1	Angiocardiology	DX X-RAY/ANGIO
2	Arthrography	DX X-RAY/ARTHO
3	Arteriography	DX X-RAY/ARTER
4	Chest X-Ray	DX X-RAY/CHEST
9	Other Radiology –Diagnostic (written description required)	DX X-RAY/OTHER

033X **Radiology – Therapeutic and/or Chemotherapy Administration**

Charges for therapeutic radiology services and chemotherapy administration to care and treat patients. Therapies also include injection and/or ingestion of radioactive substances. Excludes charges for chemotherapy drugs; report these under the appropriate revenue code (025x). Usage note: When using 0331, 0332, or 0335 there must be use of Revenue Code 025x.

	Subcategory	Standard Abbreviation
0	General Classification (**Not payable**)	RADIOLOGY THERAPY
1	Chemotherapy Admin – Injected	RAD-CHEMO-INJECT
2	Chemotherapy Admin – Oral	RAD-CHEMO-ORAL
3	Radiation Therapy	RAD-RADIATION
5	Chemotherapy Admin – IV	RAD-CHEMO-IV
9	Other Radiology –Therapeutic (written description required)	RADIOLOGY OTHER

034X **Nuclear Medicine**

Charges for procedures, tests, and radiopharmaceuticals performed by a department handling radioactive materials as required for diagnosis and treatment of patients.

	Subcategory	Standard Abbreviation
0	General Classification	NUCLEAR MEDICINE
1	Diagnostic	NUC MED/DX
2	Therapeutic	NUC MED/RX
3	Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM
4	Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM
9	Other Nuclear Medicine (written description required)	NUC MED/OTHER

035X **CT Scan**

Charges for computed tomographic scans of the head and other parts of the body.

	Subcategory	Standard Abbreviation
0	General Classification	CT SCAN
1	CT Head Scan	CT SCAN/HEAD
2	CT Body Scan	CT SCAN/BODY
9	CT Other (written description required)	CT SCAN/OTHER

036X **Operating Room Services**

Charges for services provided to patients by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

	Subcategory	Standard Abbreviation
0	General Classification	OR SERVICES
1	Minor Surgery	OR/MINOR
2	Organ Transplant - Other Than Kidney	OR/ORGAN TRANS
7	Kidney Transplant	OR/KIDNEY TRANS
9	Other OR Services (written description required)	OR/OTHER

037X **Anesthesia**

Charges for anesthesia services.

	Subcategory	Standard Abbreviation
0	General Classification	ANESTHESIA
1	Anesthesia Incident to Radiology	ANESTH/INCIDENT RAD
2	Anesthesia Incident to Other Diagnostic Services	ANESTH/INCIDNT OTHR DX
4	Acupuncture **(Not Payable)**	ANESTHE/ACUPUNC
9	Other Anesthesia (written description required)	ANESTHE/OTHER

038X **Blood and Blood Components**

Charges for blood and blood components.

	Subcategory	Standard Abbreviation
0	General Classification	BLOOD & BLOOD COMP
1	Packed Red Cells	BLOOD/PKD RED
2	Whole Blood	BLOOD/WHOLE
3	Plasma	BLOOD/PLASMA
4	Platelets	BLOOD/PLATELETS
5	Leukocytes	BLOOD/LEUKOCYTES
6	Other Blood Components	BLOOD/COMPONENTS
7	Other Derivatives (Cryoprecipitate)	BLOOD/DERIVATIVES
9	Other Blood and Blood Components (written description required)	BLOOD/OTHER

039X **Administration, Processing, and Storage for Blood and Blood Components**

Charges for administration, processing and storage of whole blood, red blood cells, platelets, and other blood components.

	Subcategory	Standard Abbreviation
0	General Classification Administration (e.g., Transfusion)	BLOOD/ADMIN/STOR
1	Administration (e.g., Transfusion)	BLOOD/ADMIN
2	Processing and Storage	BLOOD/STORAGE
9	Other Blood Handling (written description required)	BLOOD/ADMIN/STOR/OTHER

040X **Other Imaging Services**

Charges for specialty imaging services for body structures.

	Subcategory	Standard Abbreviation
0	General Classification	IMAGING SERVICE
1	Diagnostic Mammography	DIAG MAMMOGRAPHY
2	Ultrasound	ULTRASOUND
3	Screening Mammography	SCRN MAMMOGRAPHY
4	Positron Emission Tomography	PET SCAN
9	Other Imaging Services (written description required)	OTHER IMAGE SVS

041X **Respiratory Services**

Charges for respiratory services including administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy.

	Subcategory	Standard Abbreviation
0	General Classification	RESPIRATORY SVC
2	Inhalation Services	INHALATION SVC
3	Hyperbaric Oxygen Therapy	HYPERBARIC 02
9	Other Respiratory Services (written description required)	OTHER RESPIR SVS

042X **Physical Therapy**

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

	Subcategory	Standard Abbreviation
0	General Classification	PHYSICAL THERAP
1	Visit	PHYS THERP/VISIT
2	Hourly	PHYS THERP/HOUR
3	Group	PHYS THERP/GROUP
4	Evaluation or Re-Evaluation	PHYS THERP/EVAL
9	Other Physical Therapy (written description required)	OTHER PHYS THER

043X **Occupational Therapy**

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

Services are provided by a qualified occupational therapist.

	Subcategory	Standard Abbreviation
0	General Classification	OCCUPATIONAL THER
1	Visit	OCCUP THERP/VISIT
2	Hourly	OCCUP THERP/HOUR
3	Group	OCCUP THER/GROUP
4	Evaluation or Re-Evaluation	OCCUP THER/EVAL
9	Other Occupational Therapy (written description required)	OCCUP THER/OTHER

044X **Speech Therapy - Language Pathology**

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

	Subcategory	Standard Abbreviation
0	General Classification	SPEECH THERAPY
1	Visit	SPEECH THERP/VISIT
2	Hourly	SPEECH THERP/HOUR
3	Group	SPEECH THERP/GROUP
4	Evaluation or Re-Evaluation	SPEECH THERP/EVAL
9	Other Speech Therapy (written description required)	SPEECH THERP/OTHER

045X **Emergency Room**

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

	Subcategory	Standard Abbreviation
0	General Classification	EMERG ROOM
1	EMTALA Emergency Medical Screening *(outpatient claims only)*	ER/EMTALA
2	ER Beyond EMTALA Screening *(outpatient claims only)*	ER/BEYOND EMTALA
6	Urgent Care *(outpatient claims only)*	ER/URGENT
9	Other Emergency Room *(outpatient claims only)* (written description required)	OTHER EMERGENCY ROOM

Usage Notes:
Report Patient's Reason for Visit Code (FL70) in conjunction with this revenue code.

The list below indicates the acceptable coding:
(a) General classification code 0450 should not be used in conjunction with any subcategory. The sum of 0451 and 0452 is the equivalent to 0450.
(b) Stand-alone usage of 0451 is acceptable when no services beyond an initial screening/assessment are rendered.
(c) Stand-alone usage of 0452 is not acceptable.

046X **Pulmonary Function**

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

	Subcategory	Standard Abbreviation
0	General Classification	PULMONARY FUNC
9	Other Pulmonary Function (written description required)	OTHER PULMONARY FUNC

047X **Audiology**

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

	Subcategory	Standard Abbreviation
0	General Classification	AUDIOLOGY
1	Diagnostic	AUDIOLOGY/DX
2	Treatment	AUDIOLOGY/RX
9	Other Audiology (written description required)	OTHER AUDIOL

048X **Cardiology**

Charges for cardiac procedures rendered by staff from the cardiology department of the hospital or under arrangement. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

	Subcategory	Standard Abbreviation
0	General Classification	CARDIOLOGY
1	Cardiac Cath Lab	CARDIAC CATH LAB
2	Stress Test	STRESS TEST
3	Echocardiology (**Not payable**)	ECHOCARDIOLOGY
9	Other Cardiology (written description required)	OTHER CARDIOL

049X **Ambulatory Surgical Care**

Charges for ambulatory surgery not covered by other categories.

	Subcategory	Standard Abbreviation
0	General Classification	AMBULTRY SURG
9	Other Ambulatory Surgical (written description required)	OTHER AMBUL SURG

050X **Outpatient Services (To be used on inpatient bill only)**

Charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. These charges are incorporated on the inpatient bill. (Note: Medicare no longer requires this revenue code).

	Subcategory	Standard Abbreviation
9	Other Outpatient (written description required)	OTHER – O/P SERVICES

051X **Clinic**

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

	Subcategory	Standard Abbreviation
0	General Classification	CLINIC
1	Chronic Pain Center	CHRONIC PAIN CLINIC
2	Dental Clinic **(Not Payable)**	DENTAL CLINIC
3	Psychiatric Clinic	PSYCHIATRIC CLINIC
4	OB-GYN Clinic	OB-GYN CLINIC
5	Pediatric Clinic	PEDIATRIC CLINC
6	Urgent Care Clinic* **(Not Payable)**	URGENT CARE CLINIC
7	Family Practice Clinic **(Not Payable)**	FAMILY CLINIC
9	Other Clinic (written description required)	OTHER CLINC

*Report the Patient's Reason for Visit diagnosis codes for all Urgent Care Clinic visits.

052X **Free-Standing Clinic - NOT COVERED**

053X **Osteopathic Services - Hospital Charges**

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumber spine by a doctor of osteopathy.

Rationale: Generally, these services are unique to osteopathic hospitals and cannot be accommodated in any of the existing codes. The use of this revenue code is restricted to a hospital charging for osteopathic services.

	Subcategory	Standard Abbreviation
0	General Classification	OSTEOPATH SVS
1	Osteopathic Therapy	OSTEOPATH RX
9	Other Osteopathic Services (written description required)	OTHER OSTEOPATH

054X **Ambulance**

Charges for ambulance services necessary for the transport of the ill or injured who require medical attention at a health care facility.

	Subcategory	Standard Abbreviation
0	General Classification **(Not Payable)**	AMBULANCE
1	Supplies **(Not Payable)**	AMBUL/SUPPLY
2	Medical Transport	AMBUL/MED TRANS
3	Heart Mobile **(Not Payable)**	AMBUL/HEART MOB
4	Oxygen **(Not Payable)**	AMBUL/OXYGEN
5	Air Ambulance **(Not Payable)**	AIR AMBULANCE
6	Neonatal Ambulance Services **(Not Payable)**	AMBUL/NEONAT
7	Pharmacy **(Not Payable)**	AMBUL/PHARMAS
8	EKG Transmission	AMBUL/EKG TRANS
9	Other Ambulance (written description required)	OTHER AMBULANCE

055X **Skilled Nursing - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

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

056X **Home Health (HH) - Medical Social Services - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

Home Health (HH) charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

057X **Home Health (HH) Aide - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

Home Health (HH) charges for personnel (aides) that are primarily responsible for the personal care of the patient.

058X **Home Health (HH) - Other Visits - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

Home Health (HH) agency charges for visits other than physical therapy, occupational therapy or speech therapy, requiring specific identification.

059X **Home Health (HH) - Units of Service - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

Home Health (HH) charges for services billed according to the units of service provided.

060X **Home Health (HH) - Oxygen - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

061X **Magnetic Resonance Technology (MRT)**

Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA).

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	MRT
1	MRI - Brain/Brainstem	MRI/BRAIN
2	MRI - Spinal Cord/Spine	MRI/SPINE
4	MRI-OTHER **(Not payable)**	MRI/OTHER
5	MRA – Head and Neck **(Not payable)**	MRA/HEAD & NECK
6	MRA – Lower Extremities **(Not payable)**	MRA/LOWER EXTRM
8	MRA – OTHER **(Not payable)**	MRA/OTHER
9	Other MRT (written description required)	MRT/OTHER

062X **Medical/Surgical Supplies - Extension of 27X**

Charges for supply items required for patient care. The category is an extension of 027X for reporting additional breakdown where needed. Subcategory code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcategory code 2 is for providers that cannot bill supplies used for other diagnostic procedures.

	Subcategory	Standard Abbreviation
1	Supplies Incident to Radiology	MED-SUR SUPL - INCDT RAD
2	Supplies Incident to Other DX Services	MED-SUR SUPL - INCDT ODX

063X **Drugs Requiring Specific Identification**

	Subcategory	Standard Abbreviation
7	Self-Administrable Drugs (a)	DRUG/SELF ADMIN

(a) Charges for self-administrable drugs not requiring detailed coding. Use Value Codes A4, A5, and A6 to indicate the dollar amount included in covered charges for self-administrable drugs. Amounts for non-covered self-administrable drugs should be charged using Revenue Code 0637 in the non-covered column. **(**Must report NDC Code on outpatient claims for dates of service 1/1/2008 forward**).**

064X **Home IV Therapy Services - NOT PAYABLE**

065X **Hospice Service – NOT PAYABLE UNDER HOSPITAL PROGRAM**

066X **Respite Care - NOT PAYABLE UNDER HOSPITAL PROGRAM**

067X **Outpatient Special Residence Charges – NOT PAYABLE**

Residence arrangements for patients requiring continuous outpatient care.

068X **Trauma Response NOT PAYABLE**

Charges representing the activation of the trauma team.

069X **Reserved/Not Assigned**

070X **Cast Room**

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

	Subcategory	Standard Abbreviation
0	General Classification	CAST ROOM
1-9	RESERVED	

071X **Recovery Room**

Room charge for patient recovery after surgery.

	Subcategory	Standard Abbreviation
0	General Classification	RECOVERY ROOM
1-9	RESERVED	

072X **Labor Room/Delivery**

	Subcategory	Standard Abbreviation
0	General Classification	DELIVERY ROOM/LABOR
1	Labor	LABOR
2	Delivery Room	DELIVERY ROOM
3	Circumcision	CIRCUMCISION
4	Birthing Center	BIRTHING CNTR
9	Other Labor Room/Delivery (written description required)	OTHER/DELIV-LABOR

073X **EKG/ECG (Electrocardiogram)**

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

	Subcategory	Standard Abbreviation
0	General Classification	EKG/ECG
1	Holter Monitor	HOLTER MONT
2	Telemetry (includes fetal monitoring)	TELEMETRY
9	Other EKG/ECG (written description required)	OTHER EKG/ECG

074X **EEG (Electroencephalogram)**

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

	Subcategory	Standard Abbreviation
0	General Classification	EEG
1-9	RESERVED	

075X **Gastro Intestinal Services (GI) Services**

Charges for GI procedures not performed in the operating room.

	Subcategory	Standard Abbreviation
0	General Classification	GASTR-INST SVS
1-9	RESERVED	

076X **Specialty Room - Treatment/Observation Room**

Charges for the use of specialty rooms such as treatment or observation rooms.

	Subcategory	Standard Abbreviation
0	General Classification	SPECIALTY ROOM
1	Treatment Room	TREATMENT RM
2	Observation Room [(a)]	OBSERVATION RM
9	Other Specialty Rooms (written description required)	OTHER SPECIALTY RMS

(a) FL 76 – Patient's Reason for Visit should be reported in conjunction with 0762.

077X **Preventive Care Services – NOT PAYABLE**

Revenue Code used to capture preventive care services established by payers (e.g., vaccination).

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	PREVENT CARE SVCS
1	Vaccine Administration **(Not payable)**	VACCINE ADMIN

078X **Telemedicine – NOT PAYABLE**

Facility charges related to the use of telemedicine services.

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	TELEMEDICINE

079X **Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)**

Charges related to Extra-Corporeal Shock Wave Therapy (ESWT).

	Subcategory	Standard Abbreviation
0	General Classification	ESWT
1-9	RESERVED	

080X **Inpatient Renal Dialysis**

Charges for the use of equipment that is designed to remove waste when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

	Subcategory	Standard Abbreviation
1	Inpatient Hemodialysis	DIALY/INPATIENT
2	Inpatient Peritoneal (Non-CAPD)	DIALY/IP/PER
3	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/IP/CAPD
4	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/IP/CCPD
9	Other Inpatient Dialysis (written description required)	DIALY/IP/OTHER

081X **Acquisition of Body Components**

The acquisition and storage costs of body, tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

	Subcategory	Standard Abbreviation
0	General Classification	ORGAN ACQUISIT
1	Living Donor	LIVING DONOR
2	Cadaver Donor	CADAVER DONOR
3	Unknown Donor	UNKNOWN DONOR
4	Unsuccessful Organ Search – Donor Bank Charges	UNSUCCESSFUL SEARCH
9	Other Donor (written description required)	OTHER DONOR

Notes:
Unknown is used whenever the status of the individual source cannot be determined. Use the other category whenever the organ is non-human.

Revenue Code 0814 is used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.

082X **Hemodialysis - Outpatient or Home – PAYABLE TO FREESTANDING DIALYSIS FACILITIES ONLY**

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

	Subcategory	Standard Abbreviation
0	General Classification	HEMO/OP OR HOME
1	Hemodialysis Composite or Other Rate	HEMO/COMPOSITE
2	Home Supplies **(Not payable)**	HEMO/HOME/SUPPL
3	Home Equipment **(Not payable)**	HEMO/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	HEMO/HOME/100%
5	Support Services	HEMO/HOME/SUPSERV
9	Other OP Hemodialyis	HEMO-OTHER OP

083X **Peritoneal Dialysis - Outpatient or Home - PAYABLE TO FREESTANDING DIALYSIS FACILITIES ONLY**

	Subcategory	Standard Abbreviation
0	General Classification	PERTNL/OP OR HOME
1	Peritoneal Composite or Other Rate	PERTNL/COMPOSITE
2	Home Supplies **(Not payable)**	PERTNL/HOME/SUPPL
3	Home Equipment **(Not payable)**	PERTNL/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	PERTNL/HOME/100%
5	Support Services **(Not payable)**	PERTNL/HOME/SUPSERV
9	Other OP Peritoneal **(Not payable)**	PERTNL/HOME/OTHER

084X **Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home - PAYABLE TO FREESTANDING DIALYSIS FACILITIES ONLY**

	Subcategory	Standard Abbreviation
0	General Classification	CAPD/OP OR HOME
1	CAPD/Composite or Other Rate	CAPD/COMPOSITE
2	Home Supplies **(Not payable)**	CAPD/HOME/SUPPL
3	Home Equipment **(Not payable)**	CAPD/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	CAPD/HOME/100%
5	Support Services **(Not payable)**	CAPD/HOME/SUPSERV
9	Other OP CAPD	CAPD/HOME/OTHER

085X **Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home - PAYABLE TO FREESTANDING DIALYSIS FACILITIES ONLY**

	Subcategory	Standard Abbreviation
0	General Classification	CCPD/OP OR HOME
1	CCPD/Composite or Other Rate	CCPD/COMPOSITE
2	Home Supplies **(Not payable)**	CCPD/HOME/SUPPL
3	Home Equipment **(Not payable)**	CCPD/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	CCPD/HOME/100%
5	Support Services **(Not payable)**	CCPD/HOME/SUPSERV
9	Other OP CCPD	CCPD/HOME/OTHER

086X **Reserved**

087X **Reserved**

088X **Miscellaneous Dialysis**

Charges for dialysis services not identified elsewhere.

	Subcategory	Standard Abbreviation
1	Ultrafiltration	DIALY/ULTRAFILT
2	Home Dialysis Aid Visit **(Not payable)**	HOME DIALYSIS AID VISIT
9	Other Miscellaneous Dialysis (written description required)	DIALY/MISC/OTHER

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

089X **Reserved**

090X **Behavioral Health Treatment/Services (also see 091x, an extension of 090x)**

Charges for prevention, intervention, and treatment services in the areas of: mental health, substance abuse, developmental disabilities, and sexuality. Behavioral Health Care services are individualized, holistic, and culturally competent and may include on-going care and support and non-traditional services.

	Subcategory	Standard Abbreviation
0	General Classification	BH/TREATMENTS
1	Electroshock Treatment	BH/ELECTRO SHOCK
2	Milieu Therapy	BH/MILIEU THERAPY
3	Play Therapy	BH/PLAY THERAPY
4	Activity Therapy	BH/ACTIVITY THERAPY
5	Intensive Outpatient Services – Psychiatric	BH/INTENS OP/PSYCH

	Subcategory	Standard Abbreviation
6	Intensive Outpatient Services – Chemical Dependency	BH/INTENS OP/CHEM DEP
7	Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY

091X **Behavioral Health Treatment/Services (an extension of 090x)**

	Subcategory	Standard Abbreviation
0	RESERVED (use 090 for General Classification) **(Not payable)**	
1	Rehabilitation	BH/REHAB
2	Partial Hospitalization – Less Intensive	BH/PARTIAL HOSP
3	Partial Hospitalization – Intensive	BH/PARTIAL INTENSV
4	Individual Therapy	BH/INDIV RX
5	Group Therapy	BH/GROUP RX
6	Family Therapy	BH/FAMILY RX
7	Bio Feedback	BH/BIOFEED
8	Testing	BH/TESTING
9	Other Behavioral Health Treatments (written description required)	BH/OTHER

092X **Other Diagnostic Services**

Charges for various diagnostic services specific to: common screenings for disease, illness, or medical condition.

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	OTHER DX SVCS
1	Peripheral Vascular Lab	PERI VASCUL LAB
2	Electromyelgram	EMG
3	Pap Smear	PAP SMEAR
4	Allergy Test	ALLERGY TEST
5	Pregnancy Test	PREG TEST
9	Other Behavioral Health Treatments (written description required)	BH/OTHER

093X **Medical Rehabilitation Day Program - NOT COVERED**

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

	Subcategory	Standard Abbreviation
1	Half Day (**Not covered**)	HALF DAY
2	Full Day (**Not covered)**	FULL DAY

094X **Other Therapeutic Services (also see 095x, an extension of 094x)**

Charges for other therapeutic services not otherwise categorized.

	Subcategory	Standard Abbreviation
1	Recreational Therapy **(Not payable)**	RECREATION RX
2	Education/Training	EDUC/TRAINING
3	Cardiac Rehabilitation	CARDIAC REHAB
4	Drug Rehabilitation	DRUG REHAB
5	Alcohol Rehabilitation	ALCOHOL REHAB
6	Complex Medical Equipment – Routine **(Not payable)**	CMPLX MED EQUIP – ROUT
7	Complex Medical Equipment – Ancillary **(Not payable)**	CMPLX MED EQUIP – ANC
9	Other Therapeutic Services (written description required)	ADDITIONAL RX SVS

095X **Other Therapeutic Services (an extension of 094x) - NOT COVERED**

	Subcategory	Standard Abbreviation
1	Athletic Training (**Not covered**)	ATHLETIC TRAINING
2	Kinesiotherapy (**Not covered**)	KINESIOTHERAPY
3-9	RESERVED	

096X **Professional Fees (also see 097x and 098x)**

Charges for medical professionals that the institutional health care provider, along with the third-party payer, require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals (CAH) who bill both the technical and professional service components on the UB.

	Subcategory	Standard Abbreviation
1	Psychiatric	PRO FEE/PSYCH
2	Ophthalmology	PRO FEE/EYE
3	Anesthesiologist (MD)	PROF FEE/ANEST MD
4	Anesthetist (CRNA) **(Not payable)**	PROF FEE/ANEST CRNA
9	Other Professional Fees (written description required)	PRO FEE/OTHER

097X **Professional Fees (Extension of 096x)**

	Subcategory	Standard Abbreviation
1	Laboratory	PRO FEE/LAB
2	Radiology – Diagnostic	PRO FEE/RAD/DX
3	Radiology – Therapeutic	PRO FEE/RAD/RX
4	Radiology – Nuclear	PRO FEE/NUC MED
5	Operating Room	PRO FEE/OR

	Subcategory	Standard Abbreviation
6	Respiratory Therapy	PRO FEE/RESPIR
7	Physical Therapy (**Not payable)**	PRO FEE/PHYSI
8	Occupational Therapy **(Not payable)**	PRO FEE/OCCUPA
9	Speech Therapy **(Not payable)**	PRO FEE/SPEECH

098X **Professional Fees (Extension of 096x and 097x)**

Charges for medical professionals that the institutional health care provider, along with the third-party payer, require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals (CAH) who bill both the technical and professional service components on the UB.

	Subcategory	Standard Abbreviation
1	Emergency Room Services	PRO FEE/ER
2	Outpatient Services	PRO FEE/OUTPT
3	Clinic	PRO FEE/CLINIC
4	Medical Social Services **(Not payable)**	PRO FEE/SOC SVC
5	EKG	PRO FEE/EKG
6	EEG	PRO FEE/EEG
7	Hospital Visit **(Not payable)**	PRO FEE/HOS VIS
8	Consultation **(Not payable)**	PRO FEE/CONSULT
9	Private Duty Nurse **(Not payable)**	PRO FEE/PVT NURSE

099X **Patient Convenience Items – NOT PAYABLE**

100X **Behavioral Health Accommodations - NOT COVERED**

Charges for routine accommodations at specified behavioral health facilities.

	Subcategory	Standard Abbreviation
0	General Classification **(Not covered)**	BH R&B
1	Residential Treatment – Psychiatric **(Not covered)**	BH R&B RES/PSYCH
2	Residential Treatment – Chemical Dependency **(Not covered)**	BH R&B RES/CHEM
3	Supervised Living **(Not covered)**	BH R&B SUP LIVING
4	Halfway House **(Not covered)**	BH R&B HALWAY HOUSE
5	Group Home **(Not covered)**	BH R&B GROUP HOME

101X to 209X **RESERVED**

210X **Alternative Therapy Services - NOT COVERED**

Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042X, 043X, 044X, 091X, 094, 095X) or services such as anesthesia or clinic (0374, 0511).

	Subcategory	Standard Abbreviation
0	General Classification **(Not covered)**	ALTTHERAPY
1	Acupuncture **(Not covered)**	ACUPUNCTURE
2	Acupressure **(Not covered)**	ACUPRESSURE
3	Massage **(Not covered)**	MASSAGE
4	Reflexology **(Not covered)**	REFLEXOLOGY
5	Biofeedback **(Not covered)**	BIOFEEDBACK
6	Hypnosis **(Not covered)**	HYPNOSIS
9	Other Alternative Therapy Service (written description required) **(Not covered)**	OTHER ALTTHERAPY

Notes:
Alternative therapy is intended to enhance and improve standard medical treatment. These revenue codes would be used to report services in a separately designated alternative inpatient/outpatient unit.

211X to 309X **RESERVED**

310X **Adult Care - NOT COVERED**

Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADL).

	Subcategory	Standard Abbreviation
1	Adult Day Care, Medical and Social Hourly **(Not covered)**	ADULT MED/SOC HR
2	Adult Day Care, Social – Hourly **(Not covered)**	ADULT SOC HR
3	Adult Day Care, Medical and Social – Daily **(Not covered)**	ADULT MED/SOC DAY
4	Adult Day Care, Social – Daily **(Not covered)**	ADULT SOC DAY
5	Adult Foster Care Daily **(Not covered)**	ADULT FOSTER DAY
9	Other Adult Day Care (written description required) **(Not covered)**	OTHER ADULT

311X to 999X **RESERVED**