NORIDIAN DIRECT DATA ENTRY (DDE) USER'S MANUAL FOR MEDICARE PART A

Introduction

The Fiscal Intermediary Shared System (FISS) is the processing system designated by the Centers for Medicare & Medicaid (CMS) to be used for Medicare Part A claims and Part B facility claims. DDE is a real-time FISS application giving providers interactive access for inquiries, claims entry and correction purposes. It also is a valuable tool for providers who use batch submissions to transmit electronic claims, to monitor claims and requested documentation as well as manage claim errors and check beneficiary information.

The purpose of this manual is to give DDE users an understanding of the information available in the DDE system, and instructions for entering and correcting claims.

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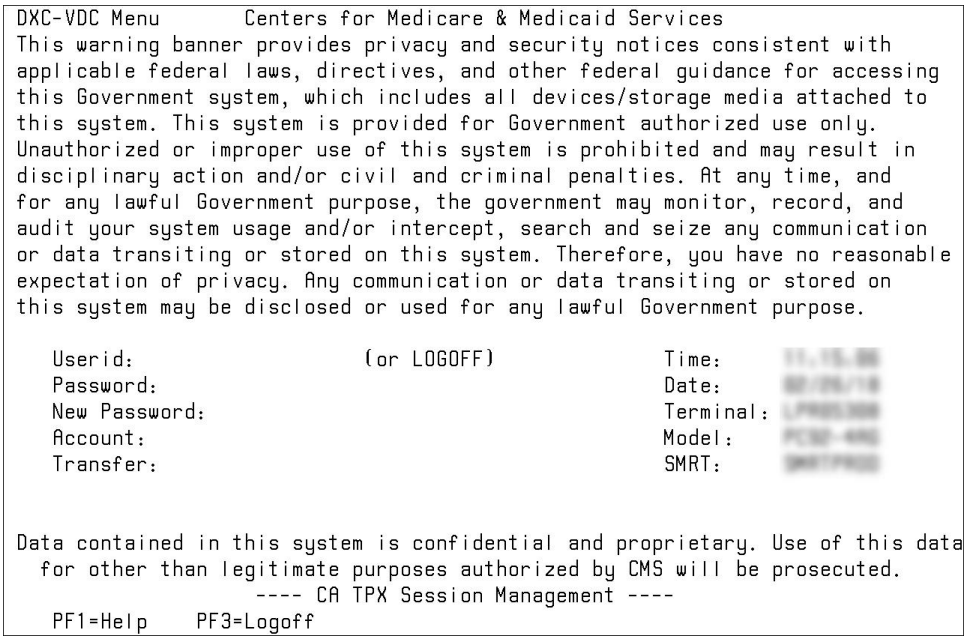
CHAPTER ONE – GETTING STARTED IN DDE

In this chapter, the user will be introduced to basic information about the Direct Data Entry (DDE) system and claim processing procedures.

Signing On

The process to access the DDE system may be site-specific according to the connectivity software used. Depending on the connectivity software, some or all of the following screens may appear. If the screens you see do not match these, watch for similar data entry fields.



Sign-on Screen 1

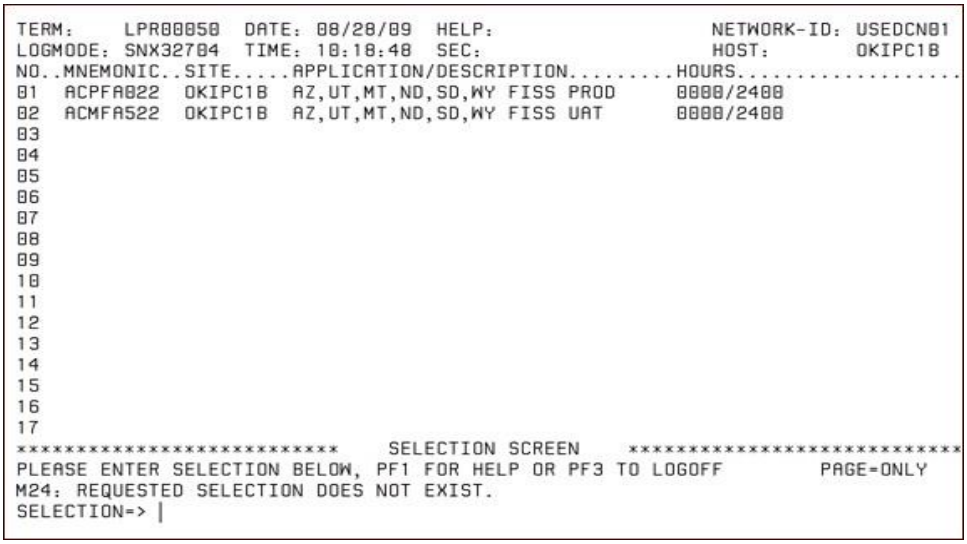
USERID: Type your DDE RACF User ID and press [TAB]. You have three tries to be successful before your login will be disabled.

The facility must request access from Noridian Healthcare Solutions (Noridian) for each user. Users should keep their RACF User ID private and not share it with anyone.

PASSWORD: Type your password, then press [TAB]. This is the password you select. If you are a new provider using DDE and have had an individual RACF ID assigned to you, the first time you log-on, you will use the temporary password emailed to you from User Provisioning. The system will then prompt you to change the temporary password.

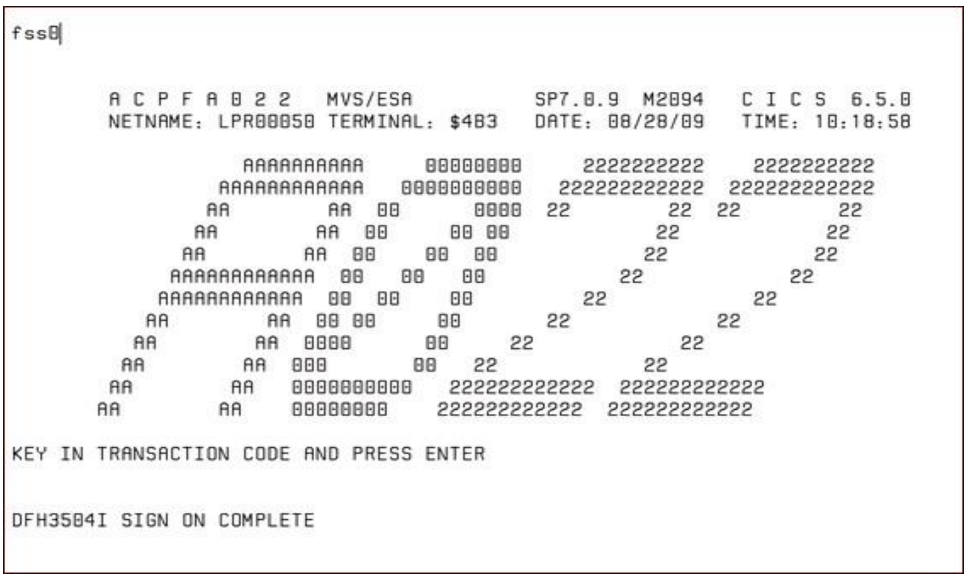
Your password will expire every 30 days for this screen. For security purposes, when your password is typed in, it will not appear on the screen.

Sign-on Screen 2



Select the FISS Production number for your state and enter it in the “Selection" field at the bottom of the screen.

Sign-on Screen 3



Type FSS0 (zero) at the top of the screen to go to the DDE menu screen.

Signing Off

Press [F3] to back out of each screen or from any screen on the system. Press [F4] and type “CSSF LOGOFF’ to exit the DDE system. This process also may be modified slightly by your facility systems.

How To Change Your Password

When you log on the system the very first time, you will use a password set by the Noridian System Administrator. You should change your password as soon as you log on the first time.

The following guidelines apply:

1. Your password will expire every 30 days. On the day after it expires, when you type your password, the system will send you the message “YOUR PASSWORD HAS EXPIRED. PLEASE ENTER YOUR NEW PASSWORD”. The screen will now contain two lines, both reading “New Password”.
2. RULES FOR PASSWORDS:
    a. Password length - 8 characters.
    b. At least one of each of the 4-character types are required:
        - Uppercase Letters = ABCDEFGHIJKLMNOPQRSTUVWXYZ
        - Lowercase Letters = abcdefghijklmnopqrstuvwxyz
        - Numbers = 0123456789
        - Special Characters = $@#.<+|&!*-%_>?:=
    c. No more than 3 consecutive characters of the user’s name or USERID may be used in the password.
    d. Consecutive repeating characters are not allowed – for example, the ‘ll’ in ‘allowed’ will cause an error. Characters can be repeated, for example ‘e’ in ‘Eve’ would be acceptable, but characters used more than once cannot be immediately next to each other in the password.
    e. Only 3 unchanged positions of the current password can be used in the new password. An unchanged position means the same character in the same position, 1 thru 8, in the new password.
    f. The following ‘words’ are restricted and may not be used in any position in the password:
        - IBM
        - RACF
        - PASSWORD
        - PHRASE
        - SECRET
        - IBMUSER
        - SYS1
    g. The following abbreviations may not be used as the 1st characters of passwords:
        - APPL
        - APR
        - AUG
        - ASDF

- BASIC
- CADAM
- DEC
- DEMO
- FEB
- FOCUS
- GAME
- JAN
- JUL
- JUN
- LOG
- MAR
- MAY
- NET
- NEW
- NOV
- OCT
- PASS
- ROS
- SEP
- SIGN
- SYS
- TEST
- TSO
- VALID
- VTAM
- XXX
- 1234

3. Your cursor will be located at the first "New Password" message. Type in the NEW PASSWORD you selected. Nothing shows on the screen, but the cursor moves right. Press [TAB].
4. Type your NEW PASSWORD again. Press [ENTER].
5. The system displays the message: “SIGN ON IS COMPLETE” OR you will have an error and must start over. The error may be the two password entries not matching, or they do not adhere to the rules for passwords.
6. Type FSSØ (zero), press [ENTER]. The main menu displays.

The user may be restricted in how many “attempts to login” will be granted before disabling the login (normally this would be 3 attempts).

Menu Selections

Asterisked (*) options may not be applicable.

Claim and information is accessed through the DDE Main Menu. The menu and submenu options allow the user to either view or enter claims information.

Main Menu

01 Inquiries

02 Claims/Attachments

03 Claims Correction

04 Online Reporting

Inquiry Menu

10 Beneficiary/CWF

11 DRG (Pricer/Grouper)

12 Claim Summary

13 Revenue Codes

14 HCPC Codes

15 DX/PROC Codes ICD-9

16 Adjustment Reason Codes

17 Reason Codes

88 Invoice No/DCN translator

19 ZIP Code File

1A OSC Repository Inquiry

56 Claim Count Summary*

67 Home Health Payment Totals*

68 ANSI Reason Codes*

FI Check History

1B DX/PROC Codes ICD-10

1C CMHC Payment Totals

1D Prov Practice Addr Quer

1E New HCPC Screen

1F OUD DEMO 99

Claims Entry Menu

Claims Entry:

20 Inpatient

22 Outpatient 24 SNF

26 Home Health*

28 Hospice*

49 NOE/NOA*

87 Roster Bill Entry

Attachment Entry:

41 Home Health*

54 DME History*

57 ESRD CMS-382 Form

Claims Corrections Menu

Claims Correction:

21 Inpatient

23 Outpatient

25 SNF

27 Home Health*

29 Hospice*

Claim Adjustment:

30 Inpatient

31 Outpatient

32 SNF

33 Home Health*

35 Hospice*

Claim Cancels:

50 Inpatient

51 Outpatient

52 SNF

53 Home Health*

55 Hospice*

Attachments:

45 Home Health*

Online Reports Menu

R1 Summary of Reports R2 View a Report

R3 Credit Balance Report – CMS 838

Navigation

Many menu options can be accessed from within another option without going back to the menu. To do this, type the menu option in the SC field in the upper left corner of the screen and press [ENTER]. When you are ready to return, press [F3] once. Keying information that shows the user how to move within the screen, suspend a claim or exit the application is displayed at the bottom of each screen.

The PF keys move within the screens as defined on the bottom of the page. While in the claims inquiry and entry screens, you can move between screens one at a time by using the PF keys or move between screens by typing the desired page number in the page number field at the top of the screen and pressing [ENTER].

PF Function Keys

PF Function keys are used to direct the action to be taken within DDE, such as moving to other screens and updating (suspending) the claim record. To move to another application without going back to the menu, type the menu option number in the SC field in the upper left corner of the screen. Note: Some users may have to use the [ALT] key plus the number key instead of the PF key. For example, instead of [F1], the user may have to press [ALT] and [1].

PF KEY	FUNCTION
[F1]	DDE reason codes - while in claims screens, pressing the [F1] key will take the user directly to the reason code narrative screen.
[F2]	Jump key – this key allows the user to move from the claim charge screen (MAP 1712) to the same revenue line on the line item detail screen (MAP 171A).
[F3]	Exit – this key is used to exit to a prior application or menu, i.e., to return to the claims entry screens from the reason code screen, or to move from an inquiry screen to the menu, you would press [F3]. It is not used to move to a prior screen within the same application.
[F4]	System exit – this key terminates the DDE session.
[F5]	Scroll backward – when a page contains more data than can be displayed in one screen image, you can move backward to the beginning of the page by using the [F5] key.
[F6]	Scroll forward – when a page contains more data than can be displayed in one screen image, you can move forward to the beginning of the page by using the [F6] key.
[F7]	Page back – this key moves back one page at a time within the same application.
[F8]	Page forward – this key moves forward one page at a time within the same application.
[F9]	Update – this key suspends the data just entered into the processing cycle.
[F10]	Scroll left - when a page contains more data than can be displayed in one screen image, you can move to the left side of the page by using the [F10] key.
[F11]	Scroll right - when a page contains more data than can be displayed in one screen image, you can move to the right side of the page by using the [F11] key.

Standards And Conventions

ITEMS	DESCRIPTION
ARROWS	Use the arrow keys to move one character at a time in any direction within a field.
TAB	Press [TAB] to move forward between fields. Some keyboards may be equipped with a “back tab” key. If yours doesn’t, hold down [SHIFT] key and press [TAB] to move backward between fields. Tabbing backwards is helpful if the cursor is at the top of the screen and you need to move to the bottom of the screen.
CTRL R (RESET)	If your screen “freezes up” or “locks up”, hold down the [CTRL] key and press “R” to reset the screen if your keyboard does not have a [RESET] key. Note: Do not use this key combination if the clock symbol “X :” or X SYSTEM displays at the bottom of the screen. This lets you know the system is processing your request.
CURSOR	The cursor is the flashing underline that shows you where you are on the screen.

ITEMS	DESCRIPTION
NUMBERS	In the examples in this manual, an “X” indicates a place holder for any number 0-9. For example, 42X represents 420 through 429.
X : or X SYSTEM	When this symbol displays at the bottom of the screen, the system is processing your request. Do not press keys until this goes away.
END KEY	The end key is used to exit or clear a field.
HOME	The home key is used to move the cursor to a DDE-defined home field on the screen.

Document Control Number (DCN)

The Document Control Number (DCN) is a unique identifier assigned to each claim submitted to Medicare. The DCV is a 23-position number assigned by the system. This number helps track and manage claims throughout the processing cycle. The DCN is used to facilitate the retrieval of individual claims and ensure accurate processing and payment.

Field Position	Field	Definition
1	Century Code:	Code used to indicate the century the Document Control Number (DCN) was established. **Valid values:** **1** - 1900-1999 **2** - 2000>
2-3	Year:	The last two digits of the year during which the claim was entered.
4-6	Julian Date:	Julian days corresponding to the calendar entry date of the claim.
7-10	Batch Sequence:	Primary sequencing field, beginning with 000 and ending with 9999.
11-12	Claim Sequence:	Secondary sequencing field, beginning with 00 and ending with 99.

Field Position	Field	Definition
13	Split/Demo Indicator:	**C** - Medicare Choices claim **E** - ESRD Managed Care **V** - Veterans Administration (VA) Demo **P** - Encounter Claims Systems Filled with **0** when not used at site.
14	Origin:	Code designating claim origin. **Valid values:** **0** - Unknown **1** - EMC Tape/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 Hard copy **9** - Other Hard copy
15-21	Reserved:	First position of “reserved” area is being used in the Home Health A/B shift automated adjustment. **Valid Values:** **H** - 1St position indicates a system generated Trailer 16 adjustment **P** - In 2nd position indicates a system generated Trailer 15 adjustment **Blank** - In position 15-21 indicates reserved for future use

Field Position	Field	Definition
22-23	Site Code:	When "Use Site Processing" on the Site Control record is set to **Y**, these positions of the DCN will coincide with the value indicated in the SITE field on the Operator Control File.

Claim Status/Location

When claims are received by the Medicare contractor, they pass through preliminary edits to validate the data submitted. If they do not pass these edits, they are returned to the provider for correction. If accepted, the claims continue through the processing cycle. At the end of each processing day, the incoming claims are transmitted to the Common Working File (CWF) host sites for validity, entitlement, remaining benefits, and deductible status. Most claims are accepted, and a response is sent back to the contractor the following day. The remainder will suspend for further action or reject. When the claim has completed processing, it is suspended until it has been in-house for the remainder of the waiting period. The waiting period, called the Payment Floor, is the period between the time the claim is received and accepted for processing and the time payment can be generated. Current CMS instructions define the payment floor as 14 days for electronic claims and 29 days for paper claims.

As the claim progresses through the processing system, its location is defined by the Status/Location codes. When a claim is submitted, it is "suspended', Status Code "S", for processing. It will remain in the suspense status as it moves through processing until it is completed or returned to the provider for correction. While a claim is in an "S" status, providers cannot make changes or additions to the claim record. The status/location codes contain 6 digits as follows:

Digit 1 – STATUS

CHARACTER	DEFINITION
A	Active
D	Deny
F	Force
I	Inactive
M	Manual Move
P	Paid
R	Reject

CHARACTER	DEFINITION
S	Suspense
T	Return to Provider
U	Return to QIO

Digit 2 – PROCESSING TYPE

CHARACTER	DEFINITION
B	Batch
M	Manual
O	Offline

Digits 3 and 4 – DRIVER LOCATION

CHARACTER	DEFINITION
01	Status/Location
02	Control
04	UB-04 Data
05	Consistency (I)
06	Consistency (II)
15	Administrative
25	Duplicate
30	Entitlement
35	Lab
40	ESRD
50	Medical Policy
55	Utilization
60	ADR
65	PPS/Pricer
70	Payment

CHARACTER	DEFINITION
75	Post Payment
80	MSP Primary
85	MSP Secondary
90	CWF
99	Session Term
AA-ZZ	Customer Defined

Digits 5 and 6 – LOCATION

CHARACTER	DEFINITION
00	00 – Batch Process
01	01 – CWF
02	02 – ADJ Orbit
10	10 – Inpatient
11	11 – Outpatient
12	12 – Special Claims
13	13 – Medical Review
14	14 – Program Integrity
16	16 – MSP
18	18 - Production QC
19	19 - System Research
21	21 – Waiver
65	65 – Non-DDE Pacemaker
66	66 – DDE Pacemaker
67	67 – DDE Home Health
96	96 – Payment Floor
97	97 – Final Online

CHARACTER	DEFINITION
98	98 – Final Offline
99	99 – Final Purged
22 through 64; 68 through 79; AA through ZZ	Customer Defined

Common Status/Location Codes

Driver Location and Description – 3rd thru 6th Digit (ex. SM2501)

Driver Location	Description
PB9996	Claims have completed processing and are being held in the payment floor.
PB9997	Claims have completed and have been released for payment.
PB9998	Claims have been finalized and no longer are online. These claims will have to be retrieved by Noridian before they can be worked.
SB6000/SB6001	Medical Review has sent out Additional Documentation Requests (ADRs) but the requested information has not yet been received.
SMSDEN/SMDENY; SM5XXX	Claims in these locations either are waiting to be reviewed by MR or have been reviewed and corrections need to be made by internal staff. MR staff will release claims for processing.
SB90FX-SB90M; SB9000 and SB9099	Claims are processing through CWF to verify patient information, days available, overlapping services, etc. as well as posting claim number (ICN) to file.
SMMADJ	Claims are hitting Medicare Secondary Payer (MSP) edits and have suspended for Noridian staff to work.
SMSPRX	Claims are processing through edits that have been automated.
SM0201	Claims in this location are adjustment or cancel claims to claims with medically denied lines. Adjudication staff verifies from the remarks why changes are being made or why the claim is being cancelled.
SM0401	Claims in this location are adjustment or cancel claims to claims with medically approved lines. Remarks are verified by adjudication staff. (Similar to SM0201)
SM0501	Claims in this location typically are no pay claims where remarks need to be verified to determine liability or remove denial information if claim is being adjusted to pay.
SM0601	SNF claims in this location are editing because the days billed need to be verified with days remaining or with the units billed with revenue code 0022. Non-SNF claims are suspended in this location because professional services are being billed incorrectly.

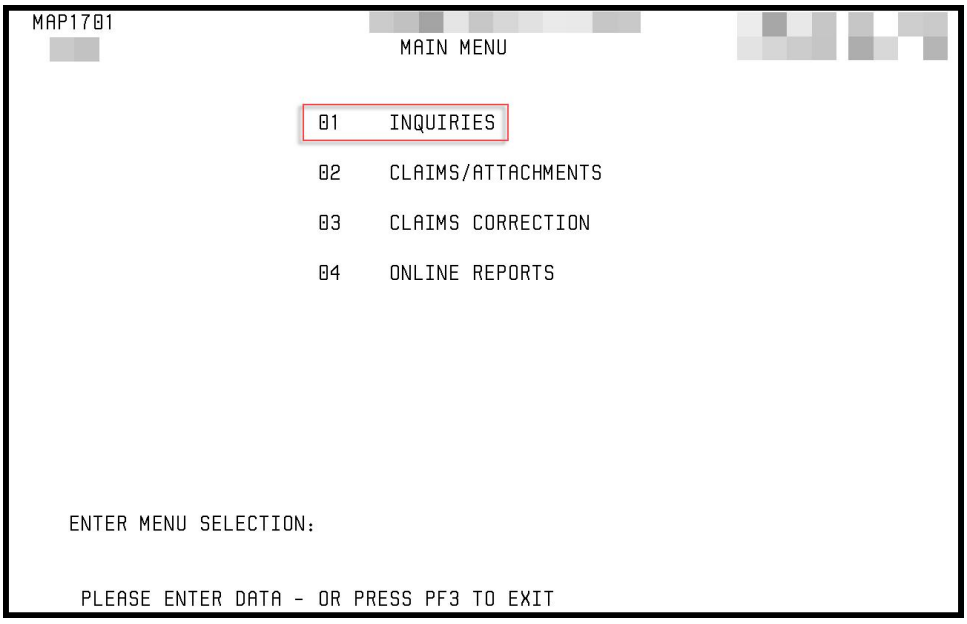
Driver Location	Description
SM1501	Claims in this location need name and dosage for unlisted drugs. Bilateral and non-covered procedures need appropriate remarks so claim can process correctly.
SM2501	Claims are duplicate or overlapping with the same date of service to other claims already in the system. Adjudication will verify if the services truly are duplicates or should be billed together on the same claim.
SM3001	Claims are past the appropriate guidelines for timely filing and need remarks as to why they are being submitted late. Claims meeting CMS guidelines will be approved and processed past these edits.
SM3501	Claims in this location need to be updated with the appropriate pricing by Noridian or will be returned to the provider to verify if the HCPC used is valid.
SM4001	ESRD claims typically editing out for too many runs billed within the appropriate month.
SM5501	INPT claims where adjudication needs to verify the days billed with the days actually remaining in CWF. Also LTR and co-insurance days need appropriate value codes and amounts.
SM6501	Claims in this location need to be edited for appropriate cost outlier billing.
SM7001	These are adjustment claims being reviewed by adjudication staff to verify the correct condition code was used for the adjustment claim.
SM9001	Claims in this location are editing for CWF related issues. Benefit days available, claims overlapping with other outpatient or inpatient claims, as well as HMO information are all reasons why claims may be in this location.
SM9501	Claims in this location have all non-covered lines. Adjudication staff verifies if the same reason code is on all the lines and rejects/denies the claim accordingly.
TB9996	Claims in this location have errors that need to be addressed by the provider and are being moved to the provider's RTP location. They will be available for correction the following day.
TB9997	Claims in this location need to be corrected by the provider. Be sure to check the remarks page for comments.

CHAPTER TWO – DIRECT DATA ENTRY (DDE)

After completing the logon procedures, the user will see the DDE Main Menu. Each of the four menu items accesses submenus which allow the user to select specific applications. Information accessed through Inquiries and Online Reports is available in a view-only format. The Claims/Attachments and Claims Correction applications allow the user to input data. Each of these will be discussed in detail in the following chapters.

Enter the desired function number in the ENTER MENU SELECTION field.

Main Menu – MAP1701



CHAPTER THREE – INQUIRY MENU

The submenus on the Inquiry Menu allow the user to:

- Verify beneficiary enrollment status and, home health, hospice, and Medicare Advantage enrollment and dates, review history of preventive services, and review Medicare Secondary Payer (MSP) information on file in the Common Working File (CWF)
- View DRG Pricer/Grouper Information
- Check the status of submitted claims and identify line item edits
- Locate claims in an ADR (Additional Development Request) status
- View a summary report of all claims currently being processed or in a “Return to Provider” location in the system
- Verify revenue codes, diagnosis codes, HCPCS codes, adjustment reason codes, reason codes, and ANSI (American National Standards Institute) codes
- View the amounts and payment dates of the last three checks to your facility.

Each of the options is identified by a number; this number can be entered on the Inquiry Menu or can be used within other applications to access the information without going back to the Inquiry Menu. To do this, enter the number in the SC field in the upper left corner of the screen. Information accessed through Inquiry Menu submenus is available in a view-only mode.

Inquiry Menu – MAP1702

```
MAP1702                    MEDICARE PART A - JE UAT          ACMFA546 09/06/23
KXB1907                       INQUIRY MENU                   A2023400 17:26:02


      BENEFICIARY/CWF          10    ZIP CODE FILE           19
      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY  1A
      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY     56
      REVENUE CODES            13    HOME HEALTH PYMT TOTALS 67
      DX/PROC CODES ICD-9      15    ANSI REASON CODES       68
      ADJUSTMENT REASON CODES  16    CHECK HISTORY           FI
      REASON CODES             17    DX/PROC CODES ICD-10    1B
      INVOICE NO/DCN TRANS     88    CMHC PAYMENT TOTALS     1C
                                     PROV PRACTICE ADDR QUER 1D
                                     NEW HCPC SCREEN         1E
                                     OUD DEMO 99             1F




   ENTER MENU SELECTION:

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

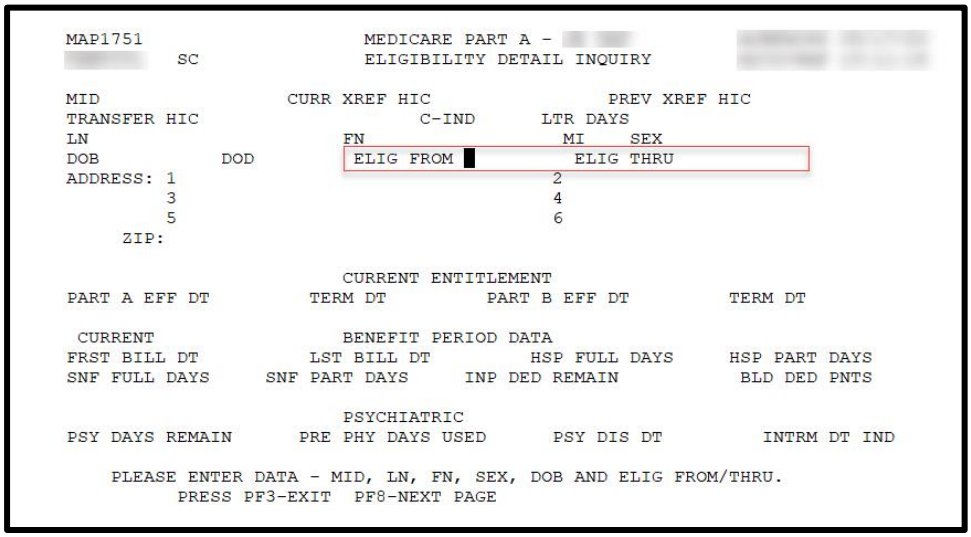
BENEFICIARY/CWF – OPTION 10

The eligibility detail inquiry screens display Medicare Part A and Part B entitlement information about a specific beneficiary. There are multiple pages of eligibility and enrollment information. However, CMS terminated the HIQA, HIQH, ELGA, and ELGH eligibility systems that fed CWF in 2021. This action reduced the accuracy of beneficiary eligibility information that can be queried in the screens below. For the most accurate beneficiary eligibility information, please use the Noridian Medicare Portal (NMP) and Interactive Voice Response (IVR) systems. The screens and functions listed below remain in the Manual for illustrative and navigational purposes only:

- Screens MAP 1751 and MAP 1752: Reflect information in the Fiscal Intermediary Standard System (FISS) at the contractor level
- Screens MAP 175J and MAP 175M: Contains information from the Common Working File (CWF)* regarding preventive services history
- Screen MAP 1755 Contains information from CWF related to Part A and Part B entitlement, current benefit period beginning date and last claim date, the number of benefit period hospital and skilled nursing facility days and lifetime reserve and psychiatric days remaining, as well as the amounts remaining under the Part B Therapy Cap, and the amount remaining of the Part deductible, blood deductible and psychiatric limit
- Screen MAP 1756: Contains information from CWF regarding Medicare Advantage enrollment, other entitlement, and End Stage Renal Disease (ESRD)
- Screen MAP 1757: Contains information from in CWF regarding pap, mammography and transplant history
- Screens MAP 1758 and 175C: Contains information from CWF regarding hospice enrollment
- Screen MAP 175K: Smoking Cessation Counseling Periods

- Screen MAP 175L: Home Health Certification
- Screen MAP 175N: Screening Services Data
- Screen MAP 175O: Beneficiary Eligibility, displaying Medicare Care Choices Model (MCCM) auxiliary file information
- Screen MAP 175P: Hospice Election Period screen, displaying auxiliary file information
- Screen MAP 175Q: Radiation Oncology (RO) Model screen displaying Prospective Bundled Payments for Radiation Oncology Model (PBRO) auxiliary file information
- Screen MAP 1759: Contains information from CWF regarding Medicare Secondary Payer (MSP) If there is no MSP information on CWF, Screen 10 will not appear. There may be up to 5 pages of MSP data.

Beneficiary/CWF Screen – MAP1751



FIELD	DESCRIPTION
MID	Type the beneficiary's Medicare id number as it appears on the Medicare ID card.
CURR XREF HIC	If the Medicare ID number has changed for the beneficiary, this field represents the most recent number (the Medicare ID number as returned by CWF).
PREV XREF HIC	This field is not used in DDE.
TRANSFER HIC	This field is not used in DDE.
C-IND	Century Indicator – This field represents a one-position code identifying if the beneficiary's date of birth is in the 18th or 19th century. Valid values are: 8 = 1800s 9 = 1900s

FIELD	DESCRIPTION
LTR DAYS	The number lifetime reserve days remaining for this beneficiary.
LN	The beneficiary's last name.
FN	The beneficiary's first name.
MI	The beneficiary's middle initial.
SEX	The beneficiary's sex.
DOB	The beneficiary's date of birth (MMDDYYYY).
DOD	The beneficiary's date of death.
ELIG FROM	The search starting date for eligibility
ELIG THRU	The search ending date for eligibility
ADDRESS	The beneficiary's street address, city, and state of residence.
ZIP	The zip code for state of residence.

CURRENT ENTITLEMENT

FIELD	DESCRIPTION
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

FIELD	DESCRIPTION
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 in the current benefit period.
HSP PART DAYS	The remaining hospital co-insurance days in the current benefit period.
SNF FULL DAYS	The full days remaining for a skilled nursing facility in the current benefit period.
SNF PART DAYS	The partial days remaining for a skilled nursing facility in the current benefit period.

FIELD	DESCRIPTION
INP DED REMAIN	The Part A inpatient deductible amount the beneficiary must pay.
BLD DED PNTS	The remaining blood deductible pints to be met.

PSYCHIATRIC

FIELD	DESCRIPTION
PSY DAYS REMAIN	The number of remaining lifetime 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 Interim Date Indicator. Valid values are: Y = Date is through date of interim bill / utilization day N = Discharge date / not a utilization day

Beneficiary/CWF Screen – MAP1752

```
MAP1752
      SC
RI      MAMMO DT
                        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
```

FIELD	DESCRIPTION
SC	Screen code – If you need to access other options within the Inquiries Menu, i.e., HCPCS, enter the option number here rather than going back to the Inquiries Menu.

FIELD	DESCRIPTION
RI	In DDE/CWF this Reason for Inquiry field is hard-coded with a “1.”
MAMMO DT	The date of the last mammogram.

PART B DATA

FIELD	DESCRIPTION
SRV YR	The calendar year for current Medicare Part B services 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 for the Part B blood deductible.
PSY EXP	The dollar amount associated with Part B psychiatric services.
SRV YR	The calendar year for current Medicare Part B services that are associated with the cash deductible amount entered in the Blood Deductible field.
BLD DED	This field is not used in DDE.
CSH DED	This field is not used in DDE.

PLAN DATA

FIELD	DESCRIPTION
ID CD	Plan Identification Code - This field identifies the Medicare Advantage (MA) 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	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 = MA Plan to process claims for directly provided service and for services from Providers with effective arrangements. Intermediary to process all other claims. Restricted— A = Intermediary to process all Part A and B provider claims. B = MA Plan to process claims only for directly provided services. C = MA Plan to process all claims.
EFF DT	The effective date for the MA Plan benefits.
CANC DT	The termination date for the MA Plan benefits.

HOSPICE DATA

FIELD	DESCRIPTION
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 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).
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 the identification number of the 2nd hospice provider.

FIELD	DESCRIPTION
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 that identifies the date of each earliest hospice bill (1-4).
LST BILL DT	A 6-digit numeric field 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).

If the beneficiary information cannot be located after polling all the CWF host sites, the following screen (MAP 1754) will appear. If this happens, check the information entered to make sure it matches the information on the Beneficiary's Medicare card.

CWF Error Screen – MAP1754

```
MAP1754
          SC

CLAIM               NAME           DOB         SEX    INTER

APP DT         REASON CD    DATE/TIME              REQ ID
DISP CD      TYPE



                         REQUIRED DATA NOT ENTERED




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

The next two screens, MAP175J and MAP175M, are used for Eligibility Dates data. They comprise several HCPCS categories and codes and the beneficiary's next eligible dates for these services.

Beneficiary/CWF Screen – MAP175J

```
 MAP175J          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT   ACMFA522 03/07/25
 TXM9331   SC                      ACCEPTED                  A20252CB 18:48:02
 MID                    NM          IT    DB                 SX
PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D
CARD/80061 010105 010105   DIAB/82951 010105 010105   AAA /       070107 070107
CARD/82465 010105 010105   PCBE/G0101 070101 070101   PTWR/G9143 080309 080309
CARD/83718 010105 010105   DIAB/83036 010124 010124   IPPE/G0402 SRV     SRV
CARD/84478 010105 010105   PROS/G0102 010100 010100   IPPE/G0403 SRV     SRV
COLO/G0104 010198 010198   PROS/G0103 010100 010100   IPPE/G0404 SRV     SRV
COLO/G0105 010198 010198   PAPT/Q0091 070105 070105   IPPE/G0405 SRV     SRV
COLO/G0106 010198 010198   GLAU/      010102 010102   PULM/G0424 0072    0072
COLO/G0120 010198 010198   MAMM/      010198 010198   CR   /      0000    0000
COLO/G0121 070101 070101   PAPT/      070101 070101   ICR  /      0000    0000
FOBT/G0107 010198 010198   HIBC/G0445 110811 110811   AWV /G0438 0000    010111
FOBT/G0328 010104 010104   HBV/       092816 092816   AWV /G0439 0000Δ   010111
FOBT/82270 010107 010107   SETS/93668 0072            BEHV/G0447 112911 112911
IPPE/G0344 SRV     SRV     CCBB/G0327 070121          APRP/G0465
IPPE/G0366 SRV     SRV     AUDG/      070123 070123
IPPE/G0367 SRV     0000    HIVP/      093024 093024
IPPE/G0368 0000    SRV     HIVS/      093024 093024
DIAB/82947 010105 010105   HPBV/      093024 093024
DIAB/82950 010105 010105
       PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF6-SCROLL FWD  PF7-PREV PAGE  PF8-NEXT PAGE
```

FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary.
DB	The date of birth of the beneficiary.
SX	The beneficiary's sex.
PRVN SERVC	This field identifies preventive screening service categories. These are displayed with a four-letter abbreviation and the accompanying HCPCS code for the particular service.

FIELD	DESCRIPTION
TECH D	This field identifies the date the beneficiary is eligible for coverage of the technical portion of preventive service charges. When there is not a date, one of the following messages display to explain why the beneficiary is not eligible: PTB = Beneficiary not entitled to Part B RCVD = Beneficiary already received service DOD =Beneficiary not eligible due to DOD GDR = Beneficiary not eligible due to sex AGE = Beneficiary not eligible due to age SRV = Beneficiary not eligible for the service VAC = Beneficiary already vaccinated 0000 = Service not applicable
PROF D	This field identifies the date the beneficiary is eligible for coverage of the professional portion of preventive service charges. When there is not a date, one of the following messages display to explain why the beneficiary is not eligible: PTB = Beneficiary not entitled to Part B RCVD = Beneficiary already received service DOD = Beneficiary not eligible due to DOD GDR = Beneficiary not eligible due to sex AGE = Beneficiary not eligible due to age SRV = Beneficiary not eligible for the service VAC = Beneficiary already vaccinated 0000 = Service not applicable

Beneficiary/CWF Screen – MAP175M

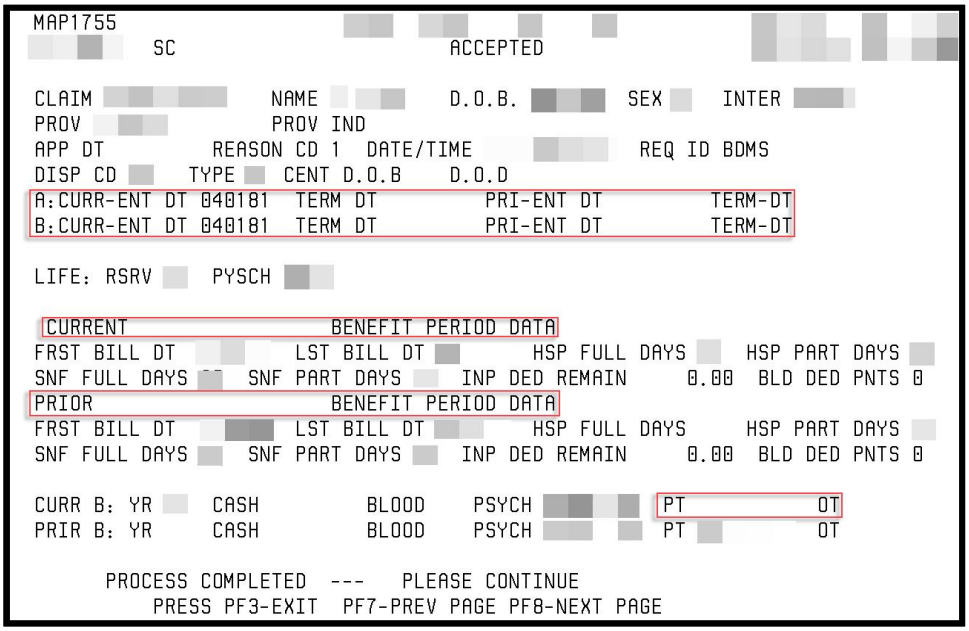
```
 MAP175M                    MEDICARE PART A - JE UAT          ACMFA546 06/09/22
 TXM9331   SC                        ACCEPTED                 A2022300 10:47:47
 MID                    NM          IT    DB                SX
PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D
TELH/99231 010111 010111   BONE/77085 070198 070198
TELH/99232 010111 010111   COCS/      AGE
TELH/99233 010111 010111   LDCT/G0297 AGE    AGE
TELH/99307 010111 010111   HPVS/G0476 AGE
TELH/99308 010111 010111   HIVS/      041315 SRV
TELH/99309 010111 010111   BONE/0508T 070198 070198
TELH/99310 010111 010111   BONE/0554T 070198 070198
BEHV/G0442        101411   BONE/0555T 070198 070198
BEHV/G0443        SVC      BONE/0556T 070198 070198
BEHV/G0444 101411 101411   BONE/0557T 070198 070198
BEHV/G0446 110811 110811   BONE/0558T 070198 070198
BONE/77078 070198 070198   ABPM/93784 070219 070219
BONE/77080 070198 070198   ACUP/      012120 012120
BONE/77081 070198 070198   LDCT/71271 AGE    AGE
BONE/76977 070198 070198
BONE/G0130 070198 070198
BEHV/G0473 010115 010115
HCAS/G0472 060214 060214
       PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF7-PREV PAGE  PF8-NEXT PAGE
```

FIELD	DESCRIPTION
MID	The Medicare ID number used to bill the claim.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary.
DB	The date of birth of the beneficiary.
SX	The beneficiary's sex.
PRVN SERVC	This field identifies preventive screening services. These are displayed with a four-letter abbreviation and the accompanying HCPCS code for the specific service.

FIELD	DESCRIPTION
TECH D	This field identifies the Technical Date, the date the beneficiary is eligible for preventive service coverage. This is a six-position alphanumeric field with 23 occurrences in MMDDYY format. An additional 31 occurrences are available for later use. Note: When there is not a date, one of the following messages display to explain why the beneficiary is not eligible. Value – Description: PTB - Beneficiary not entitled to Part B RCVD - Beneficiary already received service DOD - Beneficiary not eligible due to DOD GDR - Beneficiary not eligible due to sex AGE - Beneficiary not eligible due to age SRV - Beneficiary not eligible for the service VAC - Beneficiary already vaccinated 0000 - Service not applicable
PROF D	Professional Date – This field identifies the date the beneficiary is eligible for preventive service coverage. This is a six-position alphanumeric field with 23 occurrences in MMDDYY format. An additional 31 occurrences are available for later use. Note: When there is not a date, one of the following messages display to explain why the beneficiary is not eligible. Value – Description: PTB - Beneficiary not entitled to Part B RCVD - Beneficiary already received service DOD - Beneficiary not eligible due to DOD GDR - Beneficiary not eligible due to sex AGE - Beneficiary not eligible due to age SRV - Beneficiary not eligible for the service 0000 - Service not applicable

Beneficiary/CWF Screen – MAP1755

The benefit period information shown here is based on filed claims and does not reflect days used in stays not yet filed. It is very important that you ask the patient about hospital and SNF admissions within the previous 60 days so you will be aware of stays that haven't been reported yet.



FIELD	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.
SEX	Valid values are: F = Female M = Male
INTER	The Intermediary number for the Provider.
PROV	The CMS-assigned identification number of the institution that rendered services to the beneficiary. It is system generated for external operators that are directly associated with one Provider (as indicated on the operator control file).

FIELD	DESCRIPTION
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 inquiry. 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 the 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/beneficiary's date of birth. Valid values are: 8 = 18th Century 9 = 19th Century
D.O.D	Identifies the date of death of the beneficiary.

PART A

FIELD	DESCRIPTION
CURR-ENT DT	Current Part A benefits entitlement date.
TERM DT	Termination date for Part A benefits.
PRI-ENT DT	Prior entitlement date for Part A benefits.

FIELD	DESCRIPTION
TERM DT	Prior termination date for Part A benefits.

PART B

FIELD	DESCRIPTION
CURR-ENT	Current Part B benefits entitlement date.
TERM DT	Termination date for Part B benefits.
PRI-ENT DT	Prior entitlement date for Part B benefits.
TERM DT	Prior termination date for Part B benefits.
LIFE: RSRV	Number of lifetime reserve days remaining.
PSYCH	Number of lifetime psychiatric days available.

CURRENT BENEFIT PERIOD DATA

FIELD	DESCRIPTION
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 has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary for the benefit period.

PRIOR BENEFIT PERIOD DATA

FIELD	DESCRIPTION
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.

FIELD	DESCRIPTION
HSP FULL DAYS	The number of regular hospital full days the beneficiary has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary for the benefit period.

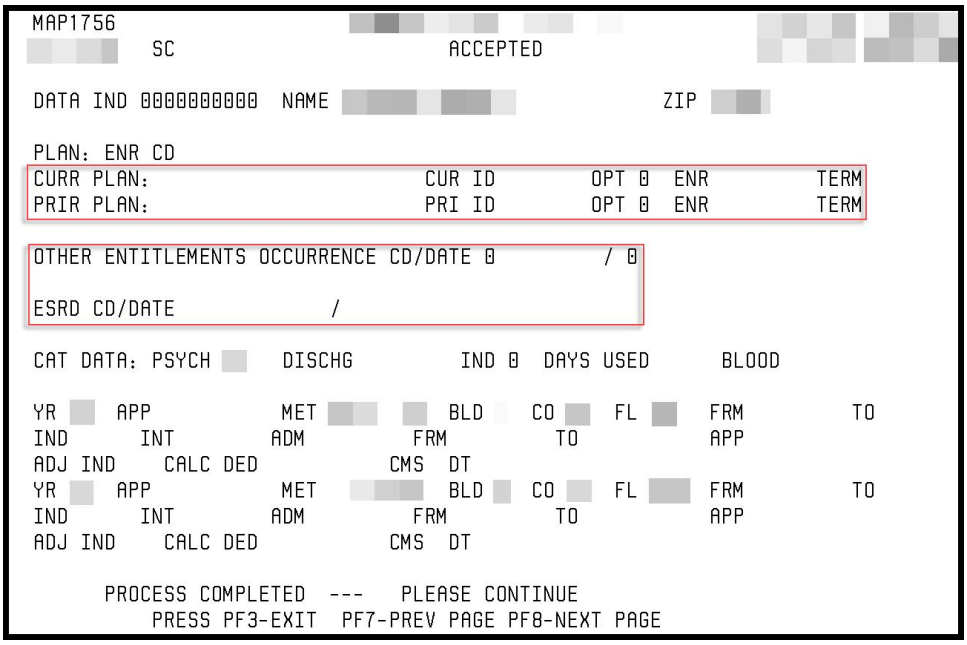
CURRENT B

FIELD	DESCRIPTION
YR	The most recent Medicare Part B year.
CASH	The remaining Part B cash deductible.
BLOOD	The remaining Part B blood deductible pints.
PSYCH	The remaining Part B psychiatric limit.
PT	The physical therapy/speech language pathology dollars applied year to date.
OT	The occupational therapy dollars applied year to date.

PRIOR B

FIELD	DESCRIPTION
YR	The prior Medicare Part B year.
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/speech language pathology dollars remaining in the prior year.
OT	Occupational therapy dollars remaining in the prior year.

Beneficiary/CWF Screen – MAP1756



FIELD	DESCRIPTION
DATA IND	Data Indicators – 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 = Does not apply 1 = Psychiatric pre-entitlement reduction applied 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
NAME	Displays last name, first name, and middle initial of the beneficiary.
ZIP	Zip Code of the residence of the beneficiary.
PLAN: ENR CD	Number of periods of MA 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

FIELD	DESCRIPTION
CUR ID	Current MA 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	MA Plan Option Code. Valid values are: Unrestricted 1 = Intermediary to process all Part A and Part B provider claims 2 = MA Plan to process claims for directly provided services from providers with effective arrangements, intermediary to process all other claims Restricted A = Intermediary to process all claims. B = MA Plan to process claims for directly provided services. C = MA Plan to process all claims.
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

FIELD	DESCRIPTION
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

FIELD	DESCRIPTION
OPT	MA Plan Option Code. Valid values are: Unrestricted 1 = Intermediary to process all Part A and Part B provider claims 2 = MA Plan to process claims for directly provided services from providers with effective arrangements, intermediary to process all other claims Restricted A = Intermediary to process all claims. B = MA Plan to process claims for directly provided services. C = MA Plan to process all claims.
ENR	The enrollment date of the MA Plan benefits for the prior year.
TERM	Termination date of the MA Plan benefits for the prior year.
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: 1 = Worker's Compensation Coverage 2 = Black Lung 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.

FIELD	DESCRIPTION
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

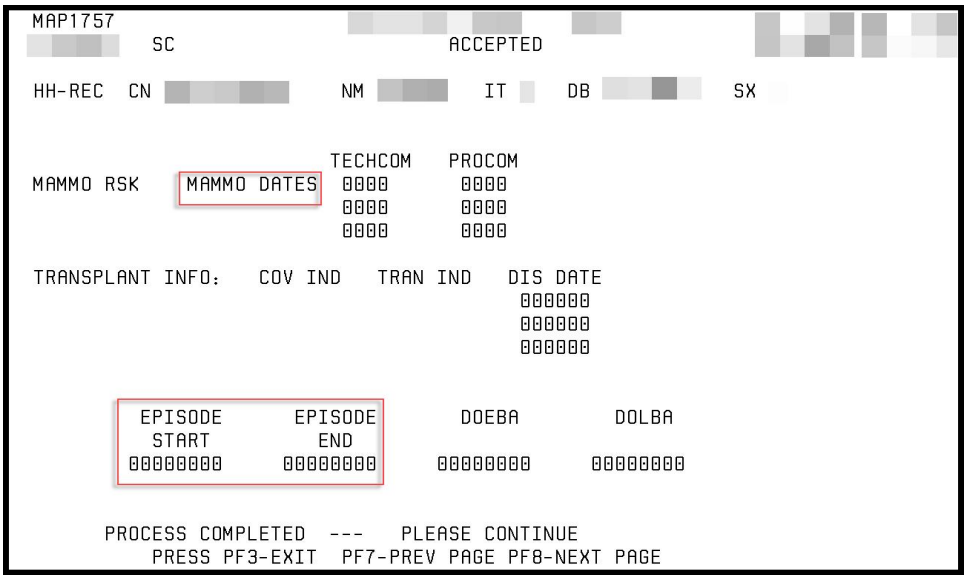
FIELD	DESCRIPTION
PSYCH	The remaining lifetime psychiatric days.
DISCHG	Last or through discharge date.
IND	Identifies whether the discharge date is an interim date. Valid values are: 0 = Initialized 1 = Interim
DAYS USED	The number of pre-entitlement psychiatric days used by the beneficiary.
BLOOD	The number of blood pints carried over from 1988 to 1989.

DAYS (2 OCCURRENCES)

FIELD	DESCRIPTION
YR	The catastrophic trailer year.
APP	Identifies whether an 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.

FIELD	DESCRIPTION
IND	The yearly data indicators: 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 Reserved 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.

Beneficiary/CWF Screen – MAP1757



FIELD	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, the DCN for the claim will appear. If this is a MSP claim the field will be blank.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	Sex of the beneficiary. 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.

FIELD	DESCRIPTION
MAMMO RSK	The mammography risk indicator. Valid values are: Y = Yes N = No

MAMMO DATES

FIELD	DESCRIPTION
TECHCOM	The date the technician interpreted the mammography screening.
PROCOM	The date the mammography screening was interpreted by a physician.
HCPC CD	The HCPC code.
DT 1	The date the HCPC code was returned from CWF.
TECH CD	The technical code.
DT 2	Date the TECH code was returned from CWF.
RISK CD	The breast cancer risk indicator for the beneficiary. Y = High Risk N = Not High Risk
DT 3	The date the RISK code was returned from CWF.

TRANSPLANT INFO

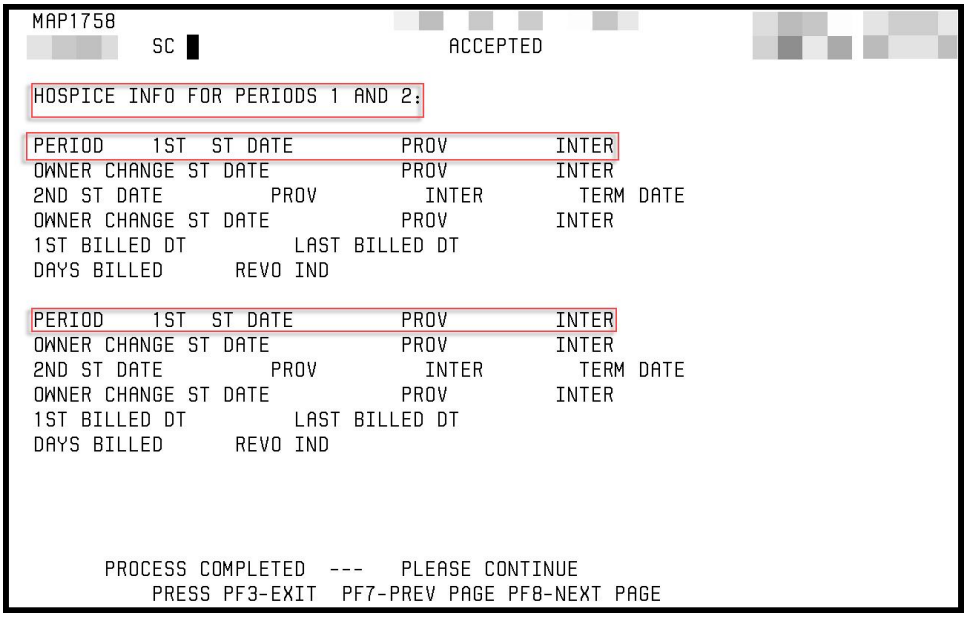
FIELD	DESCRIPTION
COV IND	The "Transplant Covered Indicator." Valid values are: Y = Covered Transplant N = Non-covered Transplant
TRAN IND	The type of transplant performed. Valid values are: 1 = Allogeneous Bone Marrow 2 = Autologous Bone Marrow H = Heart Transplant K = Kidney Transplant L = Liver Transplant

FIELD	DESCRIPTION
DIS DATE	The discharge date for the transplant patient. There may be up to three discharge dates displayed.

HOME HEALTH

FIELD	DESCRIPTION
EPISODE START	The start date of an episode of Home Health care.
EPISODE END	The end date of an episode of Home Health care.
DOEBA	The first service date of the Home Health PPS period.
DOLBA	The last service date of the Home Health PPS period.

Beneficiary/CWF Screen – MAP1758



FIELD	DESCRIPTION
HOSPICE INFO FOR PERIODS	There are four occurrences of Hospice Information on two screens to provide for the four most recent hospice periods.

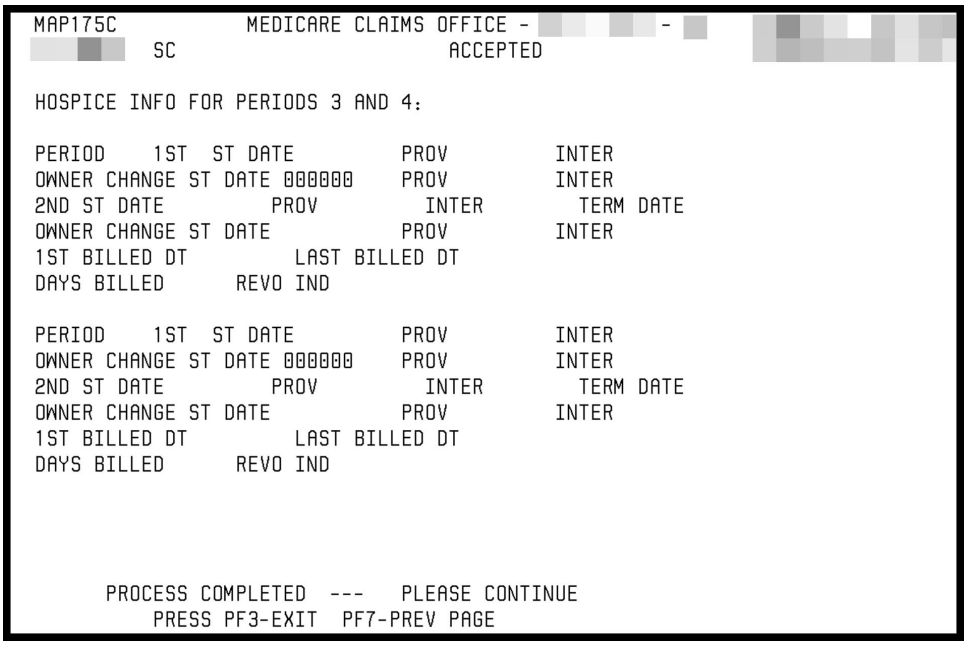
PERIOD 1

FIELD	DESCRIPTION
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.
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.
LAST BILLED DT	Each most recent hospice bill date.
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

PERIOD 2

FIELD	DESCRIPTION
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.
LAST BILLED DT	Each most recent hospice bill date.
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

Beneficiary/CWF Screen – MAP175C



FIELD	DESCRIPTION
HOSPICE INFO FOR PERIODS	There are four occurrences of Hospice Information on two screens to provide for the four most recent hospice periods.

PERIOD 3

FIELD	DESCRIPTION
PERIOD	The Hospice Benefit Period Number. Valid values are: 3 = Third time a beneficiary uses hospice benefits 4 = Fourth time a beneficiary uses hospice benefits
1ST START DATE	The beneficiary's effective period with the hospice provider.
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 provider within the election period.
PROV	The number of the Medicare hospice provider.
INTER	The Intermediary number.

FIELD	DESCRIPTION
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.
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.
LAST BILLED DT	Each most recent hospice bill date.
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

PERIOD 4

FIELD	DESCRIPTION
PERIOD	The Hospice Benefit Period Number. Valid values are: 3 = Third time a beneficiary uses hospice benefits 4 = Fourth time a beneficiary uses hospice benefits
1ST START DATE	The beneficiary's effective period with the hospice provider.
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 Provider within the election period.
PROV	The number of the Medicare hospice provider.

FIELD	DESCRIPTION
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.
LAST BILLED DT	Each most recent hospice bill date.
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

Beneficiary/CWF Screen – MAP175K

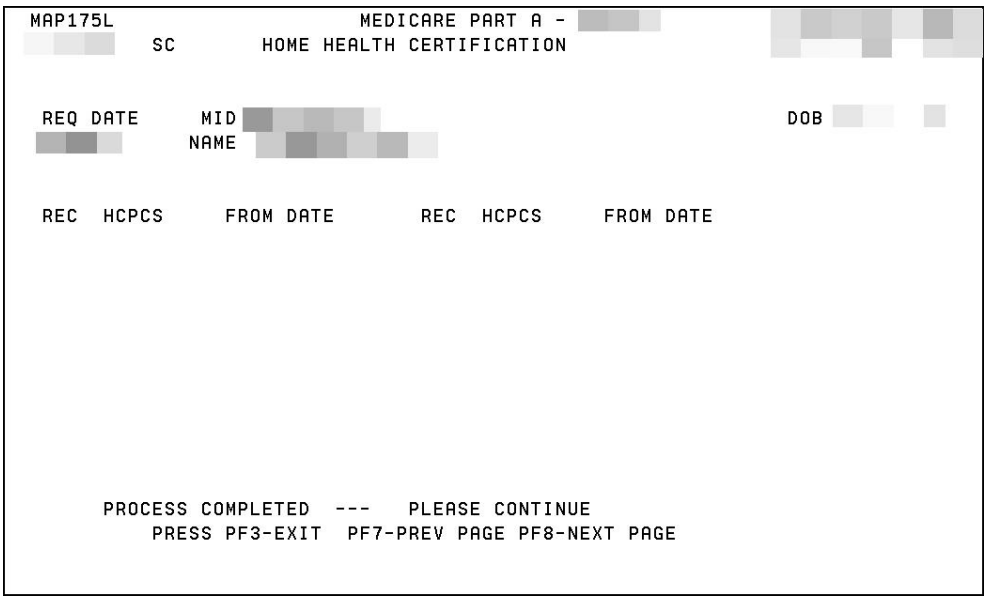
```
 MAP175K                    MEDICARE PART A -
       SC
          SMOKING AND TOBACCO USE CESSATION COUNSELING SERVICES

       MID                 LN      FI  DOB      SEX
COUNSELING PERIOD:
   TOTAL SESSIONS:   00  00  00  00  00
HCPCS   FROM     THRU   PER QT TP PRF  HCPCS   FROM     THRU   PER QT TP PRF









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

FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
LN	The beneficiary's last name.
FI	The beneficiary's first initial.
DOB	The beneficiary's date of birth.
SEX	The beneficiary's sex. The valid values are: F = Female M = Male
COUNSELING PERIOD	This field identifies up to five years of counseling data. 1 = One year 2 = Two years 3 = Three years 4 = Four years 5 = Five years
TOTAL SESSIONS	The number of sessions billed for each beneficiary. This is a one-position alphanumeric field. If a date range is billed on a detail, and a quantity that matches the range is not identified, CWF posts the session as 1 unit. (i.e., 10/25 - 10/27 Unit 1 will post as 1 session).
HCPCS	The HCPC code of 'G0375' or 'G0376'.
FROM	The from date of the claim.
THRU	The through date of the claim.
PER	This field identifies up to five years of counseling data. 1 = One year 2 = Two years 3 = Three years 4 = Four years 5 = Five years
QT	The number of services billed for each date.

FIELD	DESCRIPTION
TP	The claim type. Valid values are: 0 = Outpatient B = Part B

Beneficiary/CWF Screen – MAP175L

MAP175L is used for Home Health Certification Plan of Care data. It displays up to 20 occurrences of HCPC codes G0179 and G0180, with dates for certification up to nine months prior to the current date.

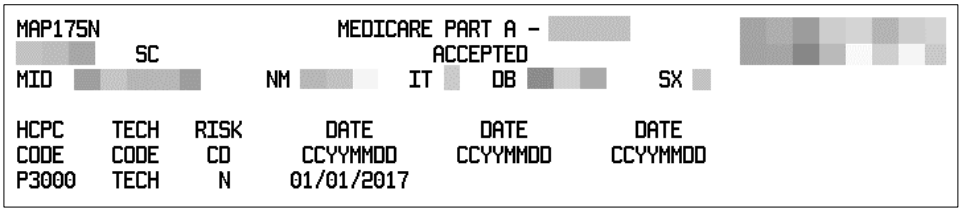


FIELD	DESCRIPTION
MID	The Medicare ID number used to bill the claim.
DOB	The beneficiary's date of birth.
REQ DATE	The date of the request.
NAME	The full name associated with the Medicare ID number.
REC (LEFT COLUMN)	This field displays the Home Health Certification records one through ten on the CWF Reply Record.
REC (CENTER COLUMN)	This field displays the Home Health Certification records 11 through 20 on the CWF Reply Record.

FIELD	DESCRIPTION
HCPCS (BOTH COLUMNS)	This field identifies the health insurance record number.
FROM DATE (LEFT)	This field identifies the Home Health From Date records one through ten.
FROM DATE (RIGHT)	This field identifies the Home Health From Date records 11 through 20.

Beneficiary/CWF Screen – MAP175N

MAP 175N is used for Screening Services data. It accommodates all the Screening HCPC codes.

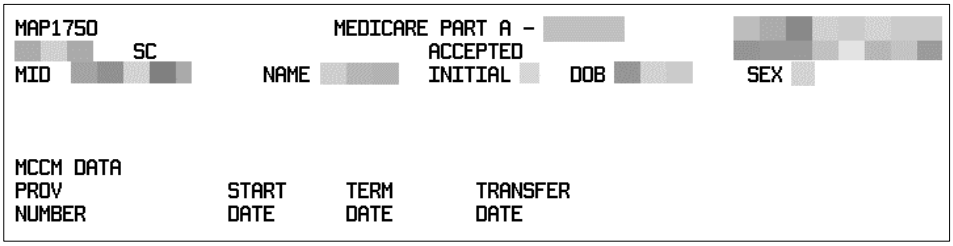


FIELD	DESCRIPTION
MID	The Medicare ID number used to bill the claim.
NM	The first six digits of the last name of the beneficiary.
IT	The first initial of the beneficiary.
DB	The beneficiary's date of birth.
SX	The sex of the beneficiary.
HCPC CODE	This field displays the Home Health Certification records one through ten on the CWF Reply Record.
TECH CODE	This field displays the Home Health Certification records eleven through twenty on the CWF Reply Record.
RISK CD	High Risk Indicator - This field identifies the breast cancer risk indicator for the beneficiary. This is a one-position alphanumeric field. Valid values are: Y = High Risk N = Not High Risk
DATE CCYYMMDD (CENTER)	The date the HCPC code was returned from CWF.
DATE CCYYMMDD (CENTER RIGHT)	The date the TECH code was returned from CWF.

FIELD	DESCRIPTION
DATE CCYYMMDD (RIGHT)	The date the RISK code was returned from CWF.

Beneficiary/CWF Screen – MAP175O

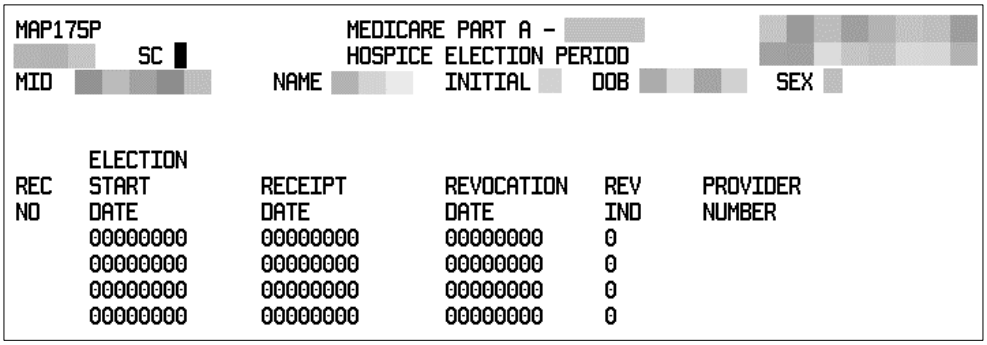
MAP175O is a Beneficiary Eligibility screen to show the MCCM auxiliary file information.



FIELD	DESCRIPTION
MID	The Medicare ID number used to bill the claim.
NAME	The first six digits of the last name of the beneficiary.
INITIAL	The first initial of the beneficiary.
DOB	The beneficiary's date of birth.
SEX	The sex of the beneficiary.
MCCM DATA PROV NUMBER	This field displays the identification number assigned by Medicare to the Hospice provider.
START DATE	This field identifies the beginning date of a beneficiary's election of the MCCM Hospice provider.
TERM DATE	This field identifies the ending date of a beneficiary's election of the MCCM Hospice provider.
TRANSFER DATE	This field identifies the date of the MCCM Hospice provider change of ownership.

Beneficiary/CWF Screen – MAP175P

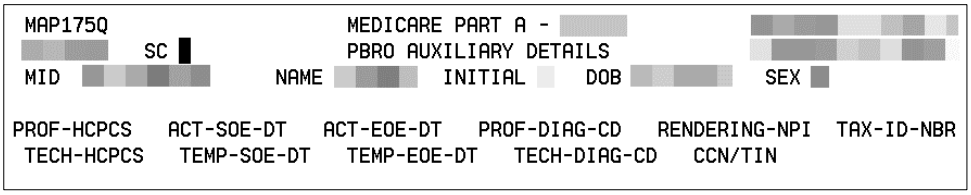
MAP175P is a Hospice Election Period screen displaying HOEP auxiliary file information. It displays the most recent four episodes.



FIELD	DESCRIPTION
MID	The Medicare ID number used to bill the claim.
NAME	The first six digits of the last name of the beneficiary.
INITIAL	The first initial of the beneficiary.
DOB	The beneficiary's date of birth.
SEX	The sex of the beneficiary.
HOEP DATA REC NO	This field displays the beneficiary's four most current hospice election periods listed in the CWF HOEP screen.
ELECTION START DATE	This field identifies the beginning date of a beneficiary's election of the MCCM Hospice provider listed in the CWF HOEP screen.
RECEIPT DATE	This field identifies the date the election for the beneficiary was received from the MCCM Hospice provider listed in the CWF HOEP screen.
REVOCATION DATE	This field identifies the date of the MCCM Hospice provider revoked the beneficiary's election.
REV IND	This field identifies the Revocation Indicator listed on the claim by MCCM Hospice provider a system-generated message.
PROVIDER NUMBER	This field displays the identification number assigned by Medicare to the Hospice provider.

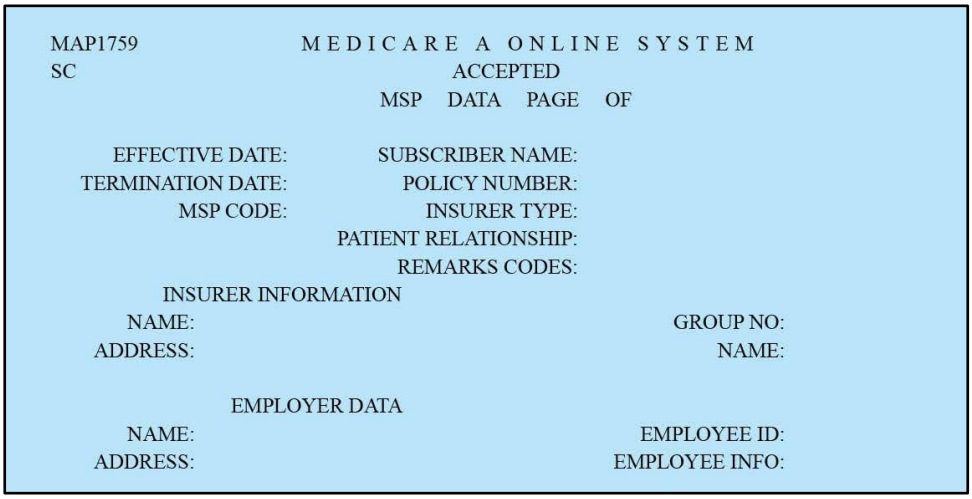
Beneficiary/CWF Screen – MAP175Q

MAP175Q is a Radiation Oncology (RO) Model screen showing the Prospective Bundled Payments for Radiation Oncology Model (PBRO) auxiliary file information.



FIELD	DESCRIPTION
MID	The Medicare ID number used to bill the claim.
NAME	The first six digits of the last name of the beneficiary.
INITIAL	The first initial of the beneficiary.
DOB	The beneficiary's date of birth.
SEX	The sex of the beneficiary.
PROF-HCPCS	The Professional RO Model HCPCS codes billed on the claim.
ACT-SOE-DT	The start date of the RO Model Episode.
ACT-EOE-DT	The end date of the RO Model Episode.
PROF-DIAG-CD	The RO Model Diagnosis Code billed on the claim.
RENDERING-NPI	The NPI of the Rendering Physician on the claim.
TAX-ID-NBR	The Professional Participant billed on the claim.
TECH-HCPCS	The Facility/Technical RO Model-specific HCPCS code billed on the claim.
TEMP-SOE-DT	The Temporary start of the episode.
TEMP-EOE-DT	The Temporary end of the episode.
TECH-DIAG-CD	The Technical First Diagnosis Code or Line Item Diagnosis Code billed on the claim.
CCN/TIN	The Facility/Technical participant billed on the claim.

Beneficiary/CWF Screen – MAP1759



MSP DATA

FIELD	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

FIELD	DESCRIPTION
INSURER TYPE	This field is not currently in use.
PATIENT RELATIONSHIP	Identifies the relationship of the beneficiary 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 is a two-character alphanumeric field. Each site determines the values.

INSURER INFORMATION

FIELD	DESCRIPTION
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

FIELD	DESCRIPTION
NAME	Name of employer that provides/may provide health coverage for the beneficiary.
EMPLOYEE ID	Identification number assigned by the employer to the beneficiary.
ADDRESS	The street, city, state and ZIP code of the employer.
EMPLOYEE INFO	This field is not currently in use.

DRG (PRICER/GROUPER) – OPTION 11

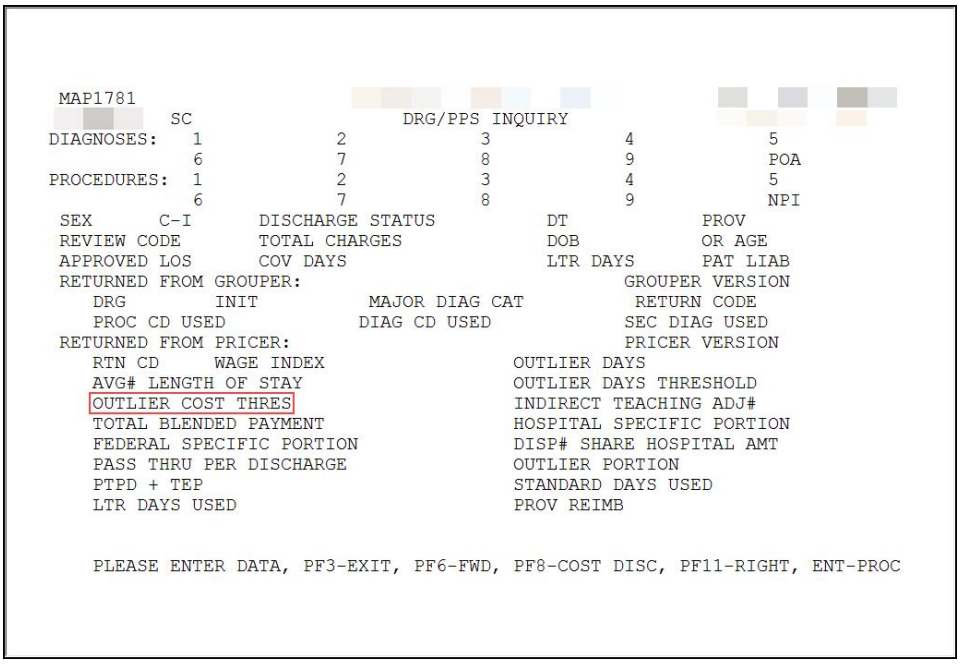
The DRG/PPS Inquiry screen displays detailed payment information calculated by the Pricer and Grouper software programs. Its purpose is to provide specific DRG assignment and PPS payment calculations for inpatient PPS stays. This page may have ICD-9 or ICD-10 entered, which must be consistent through the calculator. Please note that the payment portion of this calculator does not factor in certain carve outs and bonus payments.

To begin the inquiry, enter the following data:

- Principal and up to 8 additional diagnosis codes (do not include admitting diagnosis). Include the appropriate Present on Admission (POA) indicator (Y, N, U, W, or 1) following each diagnosis code.
- End of Present On Admission (POA) Indicator (Z or X)

- Principal and up to five additional procedures codes
- NPI
- Beneficiary's sex
- Discharge status code
- Discharge date (MMDDYY)
- Total Charges
- Beneficiary's date of birth or age (MMDDYYYY)
- Approved LOS – number of days approved by QIO, normally same as covered days
- Covered days

DRG/PPS Inquiry Screen – MAP1781



FIELD	DESCRIPTION
DIAGNOSIS	Diagnosis Codes - This field identifies up to nine ICD-9-CM codes for conditions coexisting on a particular claim. NOTE: The first page displays occurrences 01 through 09. Pressing PF6 displays occurrences 10 through 18. Pressing PF6 again displays occurrences 19 through 25. The last two occurrences on the last page are protected (no data may be entered.) Pressing PF5 allows the previous page to display. This is a seven-position alphanumeric field, with 25 occurrences. There are also two additional positions with one being blank, and the next position is the first character of the Present On Admission (POA) Indicator (for every principal and secondary diagnosis effective with discharges on or after 01/01/08). The POA Indicator identifies whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The valid values for the POA Indicator are: Y = Yes, Present at the time of inpatient admission. N = No, not present at the time of inpatient admission. U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission. W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not. 1 = Unreported/not used, exempt from POA reporting – This code is the equivalent code of a blank on the UB04, however, it is determined that blanks are undesirable when submitting the data via the 4010A1. ' ' = Not acute care, POAs do not apply.
POA	This field identifies the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. This is a one-position alphanumeric field. The valid values are: Z = The end of POA indicators for principal and, if applicable, other diagnoses. X = The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' = Not acute care, POA's do not apply.
PROCEDURES	Procedure Codes - The ICD-9-CM code(s) identifies the principal procedure (1st code) and up to 25 other procedures performed during the billing period covered by this claim. Required for inpatient claims. This is a seven-position alphanumeric field, with 25 occurrences. NOTE: The first page displays occurrences 01 through 09. Pressing PF6 displays occurrences 10 through 18. Pressing PF6 again displays occurrences 19 through 25. The last two occurrences on the last page are protected (no data may be entered.) Pressing PF5 allows the previous page to display.

FIELD	DESCRIPTION
NPI	NPI - This field identifies the National Provider Identifier number. This is a ten-position alphanumeric field.
SEX	The beneficiary's Sex.
C-I	Century Indicator – Enter if D.O.B. (date of birth) is used. Valid values are: 8 = 1800-1899 9 = 1900-1999
DISCHARGE STATUS	The beneficiary's Discharge Status Code. Refer to Noridian Quick Reference Billing Guide for code definitions.
DT	Discharge Date - This field identifies the date on which the patient was discharged from the type of care. This is a six- position alphanumeric field in MMDDYY format.
PROV	Provider Number - This field displays the identification number of the institution that rendered the services to the beneficiary/patient. This number is assigned by CMS. This is a 13- position alphanumeric field.

FIELD	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.
DOB	The beneficiary's date of birth.
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.

FIELD	DESCRIPTION
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.
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.

RETURNED FROM GROUPER

FIELD	DESCRIPTION
DRG	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.
INIT	Initial Diagnosis Related Group Code.

FIELD	DESCRIPTION
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

FIELD	DESCRIPTION
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.

RETURNED FROM PRICER

FIELD	DESCRIPTION
GROUPER VER	The program identification number for the Grouper program used.
RETURN CODE	Return Code - This field identifies the status of the claim when it has returned from the Grouper program. This is a one- position alphanumeric field.
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 hospitals 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 SPECIFIC PORTION	The hospital portion of the total blended payment.
FEDERAL SPECIFIC PORTION	The federal portion of the total blended payment.
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.

FIELD	DESCRIPTION
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.

CLAIMS – OPTION 12

The Claims inquiry screens contain information about claims in RTP, pending, and processed (paid, rejected or denied) status. This option commonly is used for:

- Beneficiary claim status and history for your facility
- Line item detail explaining how each line is processed or why it is being denied or rejected
- Additional Development Requests (ADR)
- Provider claims in a particular Status/Location

The screen formats shown on the claims screens under option 12 are just like the formats appearing in the Claims/Attachments and Claims Corrections applications. However, remember that information accessed under the Inquiries menu is available in a view-only mode. Any changes must be submitted through the Claims Correction menu.

The numbers and types of claims that are displayed depend on the selection criteria used; the broader the selection criteria, the more claims will be displayed. For example, if only the beneficiary Medicare ID number is entered, all claims submitted under your NPI in a RTP, pending or processed status would appear. If a date range is entered in the FROM DATE and TO DATE fields, only claims that fall between those two dates will appear. If only the FROM DATE is entered, all claims on or after that date will appear. Likewise, if the Type of Bill (TOB) field is completed, only the claims with that type of bill will appear.

If you are searching for all claims in a particular status location, enter your NPI and the Status Location (S/LOC). For example, you can see a list of all claims currently in the payment floor by selecting the status location codes PB9996. These claims have been finalized but have not been in-house long enough to be paid. This information can be used to estimate future payments. To look up a claim by DCN, only enter the NPI and DCN to display only that claim.

The OPERATOR ID field is completed automatically, based on the information used to sign into the DDE system. If your Operator ID has been authorized for access to more than one NPI/provider number, the system will pull claims according to the NPI entered. Crosswalk is used to determine which PTAN is assigned to the NPI entered and pulls claims based on that information.

Type in your NPI and any desired selection criteria; press [ENTER]. The Claim Summary Inquiry screen will appear with a listing of claims matching the search criteria.

To see the claim detail, place an “S” in the SEL field in front of the desired claim and press [ENTER]. Each claim includes 6 screens closely following the layout of a UB-04 claim form. It may be necessary to scroll down the screen [F6] to access more information; for example, if a claim includes more charge line items than are available on one screen view, scrolling down will allow you to view the additional charge line items. If an Additional Development Request is pending, that information will appear beginning on Claim Page 7.

The line item detail can be reached from Claim Page 2 by pressing the [F2] key.

Each of the claim screens and the field descriptions can be found in Chapter 3 “Claim/Attachments”.

Claim Summary Inquiry – MAP1741

```
MAP1741                    MEDICARE PART A -
      SC                 CLAIM SUMMARY INQUIRY
                            NPI
      MID                PROVIDER              S/LOC          TOB
  OPERATOR ID          FROM DATE        TO DATE          DDE SORT
  MEDICAL REVIEW SELECT              DCN
       MID            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
```

FIELD	DESCRIPTION
NPI	The National Provider Identifier number.
MID	The Medicare ID number for a particular beneficiary’s claims data.
PROVIDER	If there is a one-to-one relationship between your NPI and provider number, the provider number will appear.
S/LOC	Status and location codes. See Chapter One ”Getting Started” for more information regarding status and location codes.

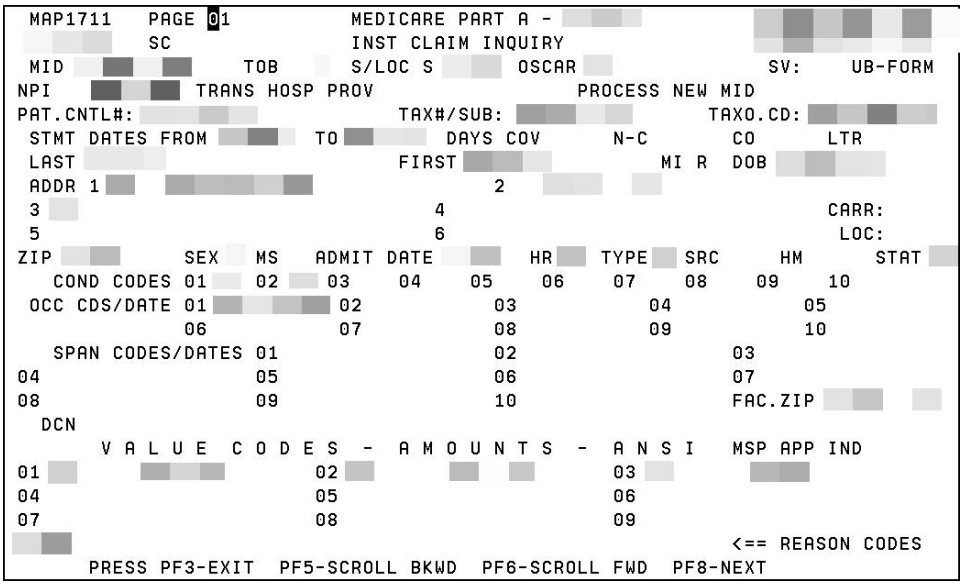
FIELD	DESCRIPTION
TOB	The claim Type of Bill. The first two positions are required for a search under a particular type of bill.
OPERATOR ID	Operator ID is automatically displayed and indicates the individual who accessed the screen.
FROM DATE	The “From Date” of service.
TO DATE	The “To Date” of service.
DDE SORT	Available only in Claims Correction mode.
MEDICAL REVIEW SELECT	Available only in Claims Correction mode.
DCN	Document Control Number assigned by DDE.
SEL	This field is used to select a claim to view or update. Tab down to the claim and enter an “S” to view the claim detail.
MID	Beneficiary’s Medicare ID 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.
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.

FIELD	DESCRIPTION
REAS	Reason code assigned by the FISS (refer to the online reason code file).

	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)
NPC	13 = Office of Personnel Management (OPM) Data Match (Contractor 11113)

FIELD	DESCRIPTION
	14 = Workers' Compensation (WC) Data Match (Contractor 11114)
#DAYS	Not available in inquiry mode.

Claim Screen 1 – MAP1711



FIELD	DESCRIPTION
SV	Suppress View - This field allows a claim to be suppressed. Use this field ONLY for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03).
MID	The beneficiary's Medicare ID number.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied P = Paid R = Rejected S = Suspended T = Returned to Provider I = Inactive

FIELD	DESCRIPTION
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
OSCAR	The provider number of the facility that is billing for the services provided. If your access identification number is assigned to multiple provider numbers, check this field to be sure the correct number appears.
UB-FORM	UB Form - This field identifies the type of claim form used. A = UB-04 9 = UB-92
NPI	The National Provider Identifier number.
TRANS HOSP PROV	The identification number of the institution which rendered services to the beneficiary /patient. It is system generated for external operators that are directly associated with one provider.
PROCESS NEW MID	Process New Health Insurance Claim Number. Use this field ONLY in for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03).

PATIENT STAY INFORMATION

FIELD	DESCRIPTION
PAT.CNTL#	Patient Control Number - the patient's number assigned by the provider.
FED TAX NO/SUB	Federal Tax Number - the number assigned to the provider by the Federal Government for tax reporting purposes. Also known as a tax identification number (TIN) or an employer identification number (EIN).
TAXO.CD	The Health Care Provider Taxonomy Code - 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 FROM	Statement Dates From - the beginning service date of the period included on this claim.
TO	Statement Dates To – the ending service date of the period included on this claim.
DAYS COV	Days Covered - the number of days covered by Medicare.
N-C	Non-Covered Days - the number of days not covered by Medicare.
CO	Coinsurance Days – the covered inpatient Medicare days occurring after exhaustion of the paid in full days.(Days 61- 90 hospital and 21-100 SNF)

FIELD	DESCRIPTION
LTR	Lifetime Reserve Days - Under the Medicare program, each beneficiary has a lifetime reserve of 60 LRD additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.

PATIENT INFORMATION

FIELD	DESCRIPTION
LAST	Last Name - the patient's last name at the time services were rendered. Enter the patient name as it appears on the Medicare care.
FIRST	First Name - the patient's first name. Enter the patient name as it appears on the Medicare care.
MI	Middle Initial - the patient's middle initial. Not Required.
ADDR	Address - This field identifies the patient's street address including the house number, post office box number, and/or apartment number, the patient's city address, and the patient's state address abbreviation.
CARR	Carrier – the identification number of the Medicare carrier as designated by the CMS. The carrier and locality information is associated with the nine-digit service facility zip code on the claim.
LOC	Locality – the specific locality of a provider in a state under the carrier's jurisdiction.
ZIP	ZIP Code - the patient's ZIP code address.
DOB	Date of Birth - the patient's date of birth.
SEX	Sex - This field identifies the patient's sex as recorded at the time services were rendered. The valid values are: M = Male F = Female U = Unknown

FIELD	DESCRIPTION
MS	Marital Status - the patient's marital status at the time services were rendered. Not Required. The valid values are: S = Single M = Married X = Legally separated D = Divorced W = Widowed U = Unknown

ADMISSION DATA

FIELD	DESCRIPTION
ADMIT DATE	Admission Date - the date of the patient's admission to this provider.
HR	Admission Hour.
TYPE	Admission Type - the priority of admission. The valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center

FIELD	DESCRIPTION
SRC	Source of Admission - the way a patient was referred to the hospital for admission. The valid values are: 1 = physician referral 2 = Clinical referral 4 = Transfer from a hospital 5 = Transfer from a SNF (Skilled Nursing Facility) 6 = Transfer from another health care facility 7 = Emergency room 8 = Court/law enforcement 9 = Information not available B = Transfer from another Home Health Agency C = Readmission to the same Home Health Agency D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer E = Transfer from Ambulatory Surgical Facility F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
D HM	Discharge Hour and Minutes.
STAT	Patient Status - the code indicating the patient's status at the ending service date in the period.
COND CODES	Condition Codes - the codes used to identify conditions relating to the claim that may affect payer processing.
OCC CDS /DATE	Occurrence Codes and Dates - identifies a significant event relating to payment of this claim.
SPAN CODES /DATES	Occurrence Span Codes and Dates (From/Through) - identify events that relate to the payment of the claim. The date identifies the commencement and ending of an event that relates to the payment of the claim.
FAC.ZIP	Facility Zip Code – This field identifies the provider or subpart zip code.
DCN	Adjusting Document Control Number - This field displays the identification number of the claim which the claim being processed is adjusting.
VALUE CODES/-AMOUNTS	Value codes and Amounts - code that identifies data, usually of a monetary nature, that is necessary for processing the claim. The value amount entered in a monetary format with whole numbers to the left of the delimiter.

FIELD	DESCRIPTION
ANSI	ANSI codes associated with the value code amount. The ANSI codes and amounts are forwarded to the financial system for remittance processing.
MSP APP IND	MSP Apportion Indicator - This field identifies to the MSP PAY module whether the system apportions the primary payer's amount and the OTAF amounts (if present). The valid values are: ' ' = Apportion N = Do not apportion.

Claim Screen 2 – MAP1712

If additional revenue lines are needed, press [F6] to go to additional entry screens.

```
MAP1712   PAGE 02          MEDICARE PART A - JE UAT          ACMFA546 09/06/23
KXB1907   SC               INST CLAIM INQUIRY                A2023400 17:05:17
                                                  REV CD PAGE 01
MID [redacted]    TOB 771  S/LOC P B9997  PROVIDER [redacted]
UTN                PROG       REP PAYEE    RRB EXCL IND    PROV VAL TYPE
CL  REV  HCPC MODIFS   RATE      TOT UNITS  COV UNITS   TOT CHARGE  SERV DATE
                                                        NCOV CHARG  RED IND
 1 0521 G0467                   0000000001 0000000001       200.00 112022

 2 0521 99213                   0000000001 0000000001       300.00 112022

 3 0001                                                     500.00

37192                                                    <== REASON CODES
     PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.

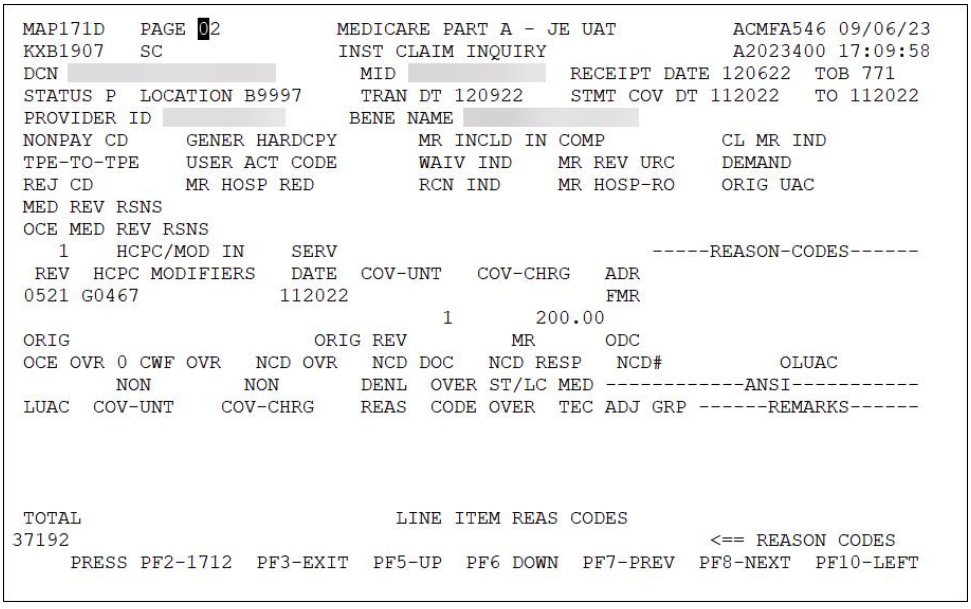
FIELD	DESCRIPTION
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied P = Paid R = Rejected S = Suspended T = Returned to Provider I = Inactive
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
CL	Claim Line Number - This field identifies the line number of the revenue code.
REV	Revenue Code - This field identifies the code for a specific accommodation or service that was billed on the claim. NOTE: When correcting a claim under the Claims Correction or Adjustment Menus, to delete a Revenue Code line, place a 'D' in the first position of the affected line, position the cursor on the page number field, press [ENTER]. To add a Revenue Code line, pass the 0001 line, add the Revenue Code, position the cursor on the page number field, press [ENTER].
HCPC	Health Care Common Procedure Coding - identifies certain medical procedures or equipment for special pricing. The field also is used to report HIPPS codes for Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) claims.
MODIFS	Common Procedure Coding System Modifier - This field identifies the HCPCS modifier codes. If more than two modifiers are needed, additional modifiers can be entered on the line item detail screen.
RATE	Rate - a per unit cost for a particular revenue code line item.
TOT UNT	Total Units - Units of service is a quantitative measure of service rendered by revenue category.
COV UNT	Covered Units - Units of service is a quantitative measure of service rendered by revenue category.
TOT CHARGES	Total Charges - identifies the total amount of charges for a particular revenue line identifying a specific service for the current period.

FIELD	DESCRIPTION
NCOV CHARGES	Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line.
SERV DT	Line Item Date of Service.
RED IND	Reduction Indicator - This field identifies if the payment for the line was paid using the therapy reduced rate. F=100% Reimbursement for multiple surgical or endoscopic procedures M=Partial Reimbursement for multiple surgical or endoscopic procedures P=Partial, all of the units except one were reduced R=All units were reduced ' '= Default

Claim Screen 2A – Line-Item Detail – MAP171D

This screen contains information explaining how each line item was processed. If space is needed for additional HCPCS code modifiers, they can be entered on this page. Access this screen from the charge screen, claims entry screen 2, by pressing [F2].

Line-Item Detail – MAP171D



FIELD	DESCRIPTION
UNTITLED	The revenue line number from the claim charge screen.
DCN	Document Control Number assigned by DDE.
MID	The beneficiary's Medicare ID number.
RECEIPT DATE	The date the claim was received.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied P = Paid R = Rejected S = Suspended T = Returned to Provider I = Inactive
LOCATION	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
TRAN DT	Transaction date – system assigned.
STMT COV DT	Statement Covers From date.
TO	Statement Covers To date.
PROVIDER ID	The identification number of the Provider submitting the claim.
BENE NAME	The name of the Beneficiary.
NONPAY CODE	The reason for Medicare's decision not to make payment.
GENER HARDCOPY	This field instructs the system to generate a specific type of hard copy document.
MR INCLD IN COMP	Composite Medical Review Included In The Composite Rate - For ESRD bills, this field identifies if the claim has been denied because the service should have been included in the Comp Rate. The valid value is: Y = The claim has been denied

FIELD	DESCRIPTION
CL MR IND	Complex Manual Medical Review Indicator – This field identifies if all services on the claim 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 medical review.
TPE-TO-TPE	Tape-to-Tape Flag - This field identifies the tape-to-tape flag (if applicable).
WAIV IND	Waiver Indicator - This field identifies whether the provider has their presumptive waiver status. The valid values are: Y = The provider does have their waiver status. N = The provider does not have their waiver status
MR REV URC	Medical Review Utilization Review Committee Reversal - This field indicates whether an SNF URC Claim has been reversed. The valid values are: P = Partial reversal F = Full reversal, the system reverses all charges and days
DEMAND	Medical Review Demand Reversal - This field identifies if a SNF demand claim has been reversed. The 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	Reject Code - The reason code for which the claim is being denied.
MR HOSP RED	Medical Review Hospice Reduced - This field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. The valid values are: ' ' = Not reduced Y = Reduced
RCN IND	Reconsideration Indicator - This field used only for home health claims. The valid values are: A = Finalized count affirmed B = Finalized no adjustment count (pay per waiver) R = Finalized count reversal (adjustment) U = Reconsideration

FIELD	DESCRIPTION
MR HOSP-RO	Medical Review Regional Office Referred - This field identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. The valid values are: ' ' = Not referred Y = Referred
ORIG UAC	Original User Action Code - the original user action code.
MED REV RSNS	Medical Review Reasons - a specific error condition relative to medical review.
FIELD	DESCRIPTION
OCE MED REV RSNS	This field identifies the edit returned from the OPPS version of OCE. The valid values are: 11 = Non-covered service submitted for review (condition code 20). 12 = Questionable covered service. 30 = Insufficient services on day of partial hospitalization. 31 = Partial hospitalization on same day as electroconvulsive therapy or type T procedure. 32 = Partial hospitalization claim spans three or less days with insufficient services, or electroconvulsive therapy or significant procedure on at least one of the days. 33 = Partial hospitalization claim spans more than three days with insufficient number of days having mental health services.
REV	Revenue Code - the code for a specific accommodation or service.
HCPC	HCPCS/CPT code describing service provided.
MODIFIERS	The HCPCS modifier codes.
SERV DATE	The line item date of service.
COV-UNT	The covered units billed by revenue code.
COV-CHRG	The total amount of covered charges for the revenue line.
ADR REASON CODES	Additional Development Reason - the ADR reason codes uses to create the appropriate reason code narrative on ADR letters.
FMR REASON CODES	Focused Medical Review Suspense Codes - This field identifies when a claim is edited in the system, based on a Medical Policy parameter.
ODC REASON CODES	Original Denial Reason Codes.
ORIG	Original HCPC and Modifiers Billed.

FIELD	DESCRIPTION
ORIG REV CD	Original Revenue Code.
MR	Complex Manual Medical Review Indicator – This field identifies if all services on the claim 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 medical review.
OCE OVR	OCE Override - This field overrides the way the OCE module controls the line item.
CWF OVR	CWF Home Health Override.
NCD OVR	National Coverage Determinations Override Indicator - This field identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. The valid values are: ' ' = The NCD edits are not bypassed, (default value) 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	National Coverage Determination Documentation Indicator – identifies whether the documentation was received for the medically necessary service. The valid values are: Y = The documentation supporting the medical necessity was received. N = The documentation supporting the medical necessity was not received, (default value.)

FIELD	DESCRIPTION
NCD RESP	National Coverage Determination Response Code –The valid values are: ' ' = Set to space for all lines on resubmitted RTP'D claims 0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria. 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.
OLUAC	Original Line User Action Code.
LUAC	Line User Action Code.
NON COV-UNT	Non-Covered Units - Units of service is a quantitative measure of service rendered by revenue category.
NON COV-CHRG	Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line.
DENIAL REAS	Denial Reason - the cause of denial for the revenue code line.
OVER CODE	ANSI Override Code - the override code that allows the operator to manually override the system generated ANSI codes.
ST/LC OVER	Status Location Override - the override of the reason code file status when a line item has been suspended.

FIELD	DESCRIPTION
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. The valid values are: M = Medial 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
ANSI ADJ	ANSI Adjustment Reason Code.
ANSI GRP	ANSI Group Code.
ANSI REMARKS	ANSI Remarks Code.
TOTAL	The total of all revenue code non-covered units and charges present on MAP171D.
LINE ITEM REASON CODES	Line-Item Reason Code - This field identifies the reason code that is assigned out of the system for suspending the line item.

Claim Screen 2B – Line-Item Detail – MAP171A

This screen is a continuation of the line-item detail information beginning on claims entry screen 2A. To move between the two screens, use the [F10] and [F11] keys. To return to the charge screen, use the [F3] key.

```
MAP171A   PAGE 02 MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT   ACMFA522 03/10/25
TXM9331   SC               INST CLAIM INQUIRY                A2025200 15:06:33
DCN                          MID                RECEIPT DATE 051424  TOB 771
STATUS P  LOCATION B9997     TRAN DT 070524    STMT COV DT 051424   TO 051424
  1    REP PAYEE       SERV      SERV    UTN                 PGM       CAH
 REV  HCPC MODIFIERS   DATE      RATE         TOT-UNT    COV-UNT   TOT-CHRG
0521 G0467            051424                      1          1       200.00
                                                        COV-CHRG       200.00
 ANES CF       ANES BV                   FQHCADD              PC/TC IND
HCPC TYPE       DEDUCTIBLES        COINSURANCE          ESRD-RED/
            BLOOD        CASH    WAGE-ADJ     REDUCED  PSYCH/HBCF
PAT->                             37.55
MSP->                                    ANSI ->              PAY/HCPC
MSP ->                                OUTLIER ->              APC CD 00000
            PAYER-1     PAYER-2      OTAF  DENIAL      OCE FLAGS
MSP ->                                     IND  1  2  3  4  5  6  7  8  9  10
 ID ->                                          A 10  1  0  0  0  5  0 01   0
        REIMB        RESP        PAID
PAT ->                    37.55                     LABOR      NON-LABOR
PROV ->      147.21
MED ->       147.21               PRICER        PAY                    ASC
         ADJUSTMENT  ANSI        AMT    RTC    METHOD    IDE/NDC/UPC   GRP %
CONTR-       12.24  CO 45        187.76  01      10
37192                                                    <== REASON CODES
PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF10-LEFT PF11-RIGHT
```

Line-Item Detail – MAP171A

FIELD	DESCRIPTION
DCN	Document Control Number assigned by DDE.
MID	The beneficiary's Medicare ID number.
RECEIPT DATE	The date the claim was received.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOCATION	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
TRAN DT	Transaction date – system assigned.
STMT COV DT	Statement Covers From date.
TO	Statement Covers To date.
UNTITLED	The revenue line number from the claim charge screen.
REV	Revenue Code - the code for a specific accommodation or service.
HCPC	HCPCS/CPT code describing service provided.
MODIFIERS	The HCPCS modifier codes.
SERV DATE	The line-item date of service.
SERV RATE	The per-unit cost for a particular line item.
TOT-UNT	The total units billed by revenue code.
COV-UNT	The covered units billed by revenue code.

FIELD	DESCRIPTION
TOT-CHRG	The total amount of charges for the revenue line.
COV-CHRG	The total amount of covered charges for the revenue line.
ANES CF	Anesthesia Conversion Factor – the anesthesia conversion factor.
ANES BV	Anesthesia Base Unit Value - the anesthesia base unit value
FQHCADD	This field identifies the line level FQHC (Federally Qualified Health Center) additional payment amount for a new patient or initial Medicare visit.
PC/TC IND	Professional Component/Technical Component - the PC/TC indicator PC/TC HPSA Payment Policy Pay the Health Professional Shortage Area (HPSA) bonus. 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. Bill the service as a separate professional and technical component procedure code. The HPSA modifier should only be used with the professional component code; the incentive payment should not be paid unless the professional component can be separately identified. Professional component only, pay the HPSA bonus. Technical component only, do not pay the HPSA bonus. Global test only, the professional component of this Service qualifies for the HPSA bonus payment. Bill the service as a separate professional and technical component procedure code. The HPSA modifier should only be used with the professional component code; the incentive payment should not be paid unless the professional component can be separately identified. Incident codes, do not pay the HPSA bonus. Laboratory physician interpretation codes, pay the HPSA bonus. Physical therapy service, do not pay the HPSA bonus. Physician interpretation codes, pay the HPSA bonus. Concept of PC/TC does not apply, do not pay the HPSA bonus

FIELD	DESCRIPTION
CAH INCEN IN	CAH Incentive Indicator, identifies whether a claim line is eligible for a specific type of bonus. 1=HPSA 2=PSA 3=HPSA AND PSA 4=HSIP 5=HPSA and HSIP 6=PCIP 7=HPSA and PCIP ' '=Not applicable
HCPC TYPE	HCPC Type –identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. The value values are: M = Originated from MPFS database files ' ' = Did not originate from the MPFS database files
COINSURANCE	Identifies the Variable Coinsurance Percentage used for Drug HCPCs.
BLOOD DEDUCTIBLES	Identifies the amount of the patient's Medicare blood deductible applied to the line item. The blood deductible is applied at the line level on revenue codes 380, 381, and 382.
CASH DEDUCTIBLES	The amount of the patient's Medicare cash deductible applied to the line item.
WAGE-ADJ COINSURANCE	The amount of coinsurance applicable to the line, based on the particular service rendered. The service is defined by the revenue and HCPCS code submitted. For services subject to outpatient PPS (OPPS) in hospitals (TOBs '12X', '13X', and '14X') and in community mental health centers (TOB '76X'), the applicable coinsurance is wage adjusted. This field will have either a zero (for services which no coinsurance is applicable), 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.
REDUCED COINSURANCE	The amount of the reduced coinsurance applicable to the line for a particular service (HCPCS) rendered on which the provider has elected to reduce the coinsurance amount for all services subject to OPPS.

FIELD	DESCRIPTION
ESRD-RED/ PSYCH/HBCF	ESRD Reduction Amount / Psychiatric Reduction Amount / Hemophilia Blood Clotting Factor Amount ESRD Reduction Amount - This value refers to the ESRD Network Reduction amount. Psychiatric Reduction Amount - 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 Amount - An additional payment to the DRG payment for hemophilia. The payment is based on the applicable HCPC and add-on applies to inpatient claims.
MSP BLOOD DEDUCTIBLES	The blood deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
MSP CASH DEDUCTIBLES	The cash deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
MSP COINSURANCE	The coinsurance amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module.
ANSI ESRD-RED/PSYCH/HBCF	The 2 position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice.
MSP PAYER 1	The amount entered by the user or apportioned by FISS as payment from the primary payer.
MSP PAYER 2	Identifies the amount entered by the user (if available) or apportioned by FISS as payment from the secondary payer.
OTAF	Obligated To Accept Payment In Full - This field identifies the line item apportioned amount entered by the user (if available) or apportioned amount calculated by FISS, of the obligated to accept as payment in full, when value code 44 is present.
DENIAL IND	Denial Indicator - This field identifies the MSPPAY module that an insurer primary to Medicare has denied this line item. The valid values are: '' = Not denied D = Denied

FIELD	DESCRIPTION
OCE FLAGS	OCE Flags- This field identifies 10 flags, two alphanumeric positions each. Flag 1 – Status Indicator Flag 2 – Payment Indicator Flag 3 – Discounting Formula Number Flag 4 – Line Item Denial or Rejection Flag 5 – Packaging Flag 6 – Payment Adjustment Flag 7 – Payment Method Flag 8 – Line Item Action Flag 9 – Composite Adjustment Flag 10 – Payment Adjustment Refer to the Noridian Quick Reference Billing Guide for code definitions.
PAY/HCPC APC CD	Payment Ambulatory Patient Classification Code or HCPC Ambulatory Patient Classification Code - This field displays the number that identifies the APC group.
PAYER 1	MSP Payer 1 ID - This field displays the one-position alphanumeric code identifying the specific payer. If Medicare is primary, this field is blank.
PAYER 2	MSP Payer 2 ID - This field displays the one-position alphanumeric code identifying the specific payer. If Medicare is primary, this field is blank.
PAT REIMB	Patient Reimbursement - This field identifies the system generated calculated line amount to be paid to the patient on the basis of the amount entered by the provider on claim page 4, in the Due From PAT field.
PAT RESP	Patient Responsible - This field identifies the amount for which the individual receiving services is responsible. If Payer 1 indicator is 'C' or 'Z', then the amount equals: cash deductible + coinsurance + blood deductible. If Payer 1 indicator is not 'C' or 'Z', then the amount equals: MSP blood + MSP cash deductible + MSP coinsurance.
PAT PAID	Patient Paid - This field identifies the line item 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 4).
REIMB	Provider Reimbursement - This field identifies the system calculated line item amount to be paid to the provider.
LABOR	Labor - This field identifies the labor amount of the payment as calculated by the pricer.

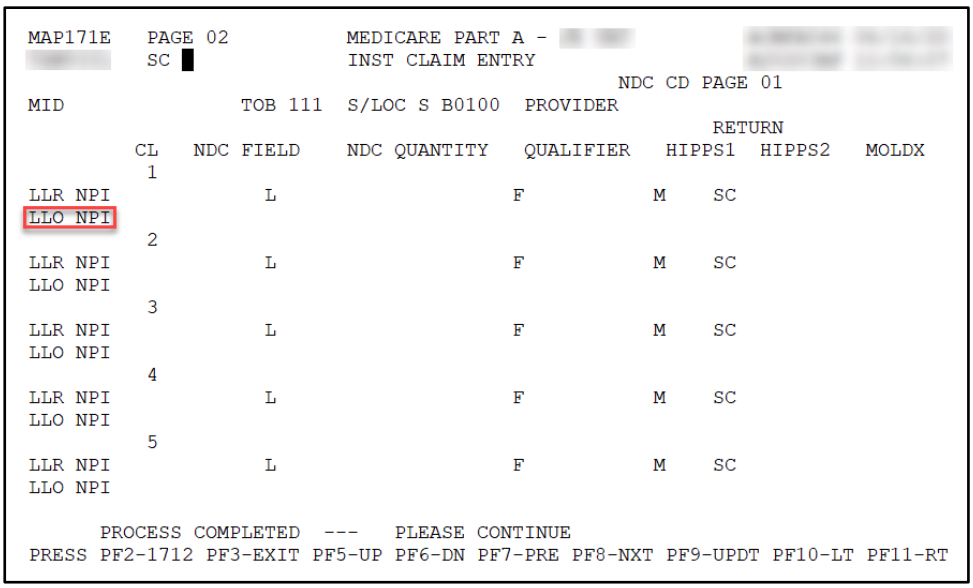
FIELD	DESCRIPTION
NON-LABOR	Non-Labor - This field identifies the non-labor amount of the payment as calculated by the pricer.
MED REIMB	Medicare Reimbursement - This field identifies the total Medicare reimbursement for the line item, which is the sum of the patient reimbursement and the provider reimbursement.
CONTR ADJUSTMENT	Contractor Adjustment - The field identifies the total contractual adjustment. The calculation is: submitted charge - deductible - wage adjusted coinsurance - blood deductible - value code 71 - psychiatric reduction - value code 05/other - reimbursement amount. NOTE: 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	ANSI - This field identifies the two-position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice.
OUTLIER	Outlier Amount - This field identifies the apportioned line level outlier amount returned from MSPPAYOL
PRICER AMT	Pricer Amount - This field identifies the total reimbursement received from a pricer.
PRICER RTC	Pricer Return Code - This field identifies the return code from Outpatient Prospective Payment System (OPPS)
PAY METHOD	Payment Method - This field identifies the payment method returned from OCE. 1=Paid standard OPPS amount (status indicators K, S, T, V, X or P) 2=Services not paid under OPPS (status indicator A) 3=Not paid (status indicators W, Y, or E) or not paid under OPPS (status indicators B, C, or Z) 4=Acquisition cost paid (status indicator L or F) 5=Additional payment for drug or biological (status indicator G) 6-Additional payment for device (status indicator H) 7=Additional payment for new drug or new biological (status indicator J) 8=Paid partial hospitalization per diem (status indicator P) 9= No additional payment, payment included in line items with APCs (status indicator 'N', or no HCPCS code and certain revenue codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy), or G0177 (partial hospitalization program services)
IDE/NDC/UPC	IDE/NDC/UPC - This field contains IDE, NDC, or UPC.

FIELD	DESCRIPTION
IDE	Investigational Device Exemption authorization number assigned by the FDA. It is only used for revenue code 0624.
NDC	Reserved for future use.
UPC	Reserved for future use.
ASC GRP	ASC Group - This field identifies the ASC Group code for the indicated revenue code
%	ACS Percentage - This field identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code.

Claim Screen 2C – National Drug Code (NDC) Information – MAP 171E

Hospitals subject to OPPS must include NDC information for drugs coded with HCPCS code C9399, and all hospital outpatient departments who serve patients who are dually eligible for Medicare and Medicare need to include the NDC, corresponding amounts and qualifiers on crossover claims. This information is added on MAP 171E in the corresponding line item of the drug code, which can be access from the charge screen, claims entry screen 2, by pressing [F11], or from MAP171A by pressing [F10]. To return to the charge screen, press [F10].

National Drug Code Information – MAP171E

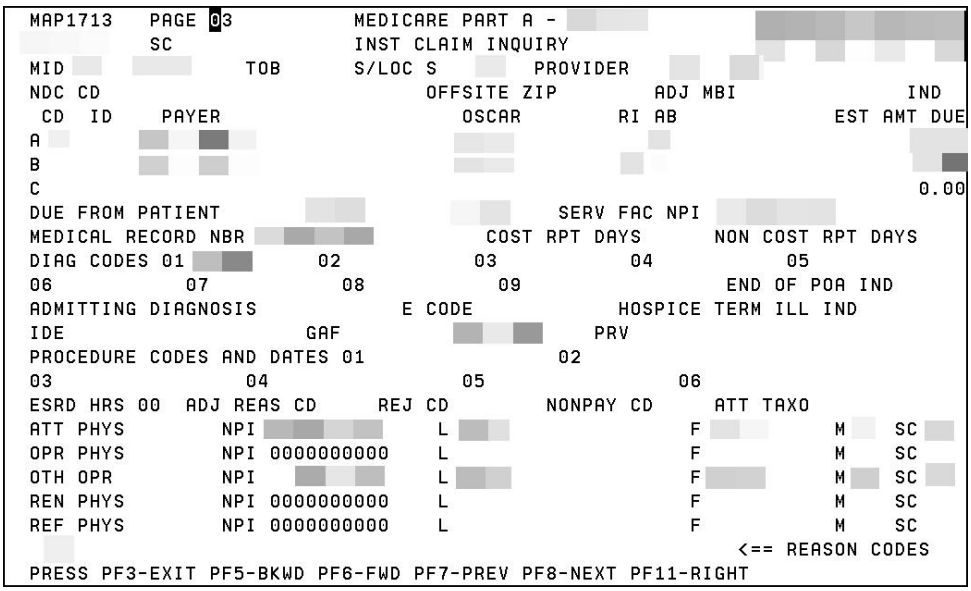


FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.

FIELD	DESCRIPTION
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied P = Paid R = Rejected S = Suspended T = Returned to Provider I = Inactive
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
CL	Code line number.
NDC FIELD	National Drug Code - 11-digit number. Only one NDC will cross to the secondary payer; providers will need to supply any additional NDCs directly to the secondary payer.
NDC QUANTITY	The quantity amount of the drug represented by the NDC code, based on HCPCS description and the amount distributed to the patient. Enter the decimal point if necessary. If there is not a dollar amount, enter a zero before the decimal.
QUALIFIER	NDC Qualifier – The valid values are: F2 = International Unit FR = Gram ML = Milliliter UN = Units
LLR NPI	This field identifies the line level rendering physician's NPI (National Provider Identifier) number.
LLO NPI	This field identifies the line level ordering physician's NPI (National Provider Identifier) number.
L	Last Name - This field identifies the last name of the physician.
F	First Name - This field identifies the first name of the physician.
M	Middle Name - This field identifies the middle initial of the physician.
SC	Specialty Code - This field identifies the specialty code.

FIELD	DESCRIPTION
MOLDX	Molecular Diagnostic Services – Enter the DEX Z-Code™ identifier

Claim Screen 3 – MAP1713



FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.

FIELD	DESCRIPTION
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
OFFSITE ZIPCD	Identifies offsite Clinic/Outpatient department zip codes. It determines the claim line HPSA/PSA bonus eligibility.
CD	Payer Code – Valid values are: 1 = Medicaid secondary 2 = Blue Cross secondary 3 = Other secondary 4 = None A = Working Aged (value code 12) B = ESRD beneficiary in 18-month coordination period with (value code 13) C = Conditional Payment D = Auto no-fault (value code 14) E = Workers Compensation (value code 15) F = Public Health of Federal Agency (value code 16) G = Disabled (value code 43) H = Black Lung (value code 41) I = Veterans Administration (value code 42) L = Liability (value code 47) Z = Medicare
ID	Payer ID - not used at this time.
PAYER	Payer name identifying each payer organization from which the provider might expect some payment.
OSCAR	The provider number of the facility that is billing for the services provided.
RI	Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are: R = Restricted or modified release N = No release

FIELD	DESCRIPTION
AB	Assignment of Benefits – identifies whether or not the provider has a signed form authorizing the third-party payer to pay the provider. The valid values are: Y = Yes benefits assigned N = No benefits assigned
EST AMT DUE	Estimated Amount Due - This field identifies the amount estimated by the provider to be still due from the indicated payer (estimated responsibility less prior payments).
DUE FROM PATIENT	Due from Patient - Entry only in Prior Payments portion of this field.
MEDICAL RECORD NBR	Identifies the number assigned to the patient's medical/health record by the provider.
COST RPT DAYS	Cost Report Days - This field identifies the number of days claimable as Medicare patient days for inpatient and SNF types of bills. The system calculates this field and generates the applicable data.
NON COST RPT DAYS	Non-Cost Report Days - This field identifies the number of days not claimable as Medicare patient days.
DIAGNOSIS CODES	The ICD-9-CM code(s) describing the principal diagnosis (first code) and additional conditions (codes two through nine) that co-exist at the time of admission or develop subsequently. Each diagnosis code is a six-position alphanumeric field, with two additional positions with the 7th being blank, and the 8th position is the first character of the Present On Admission (POA) Indicator for every principal and secondary diagnosis effective with discharges. The POA Indicator identifies whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The valid values for the POA Indicator are: Y = Yes, Present at the time of inpatient admission. N = No, not present at the time of inpatient admission. U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission. W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not. 1 = Unreported/not used, exempt from POA reporting – This code is the equivalent code of a blank on the UB04, however, it is determined that blanks are undesirable when submitting the data via the 4010A1. ' ' = Not acute care, POA's do not apply

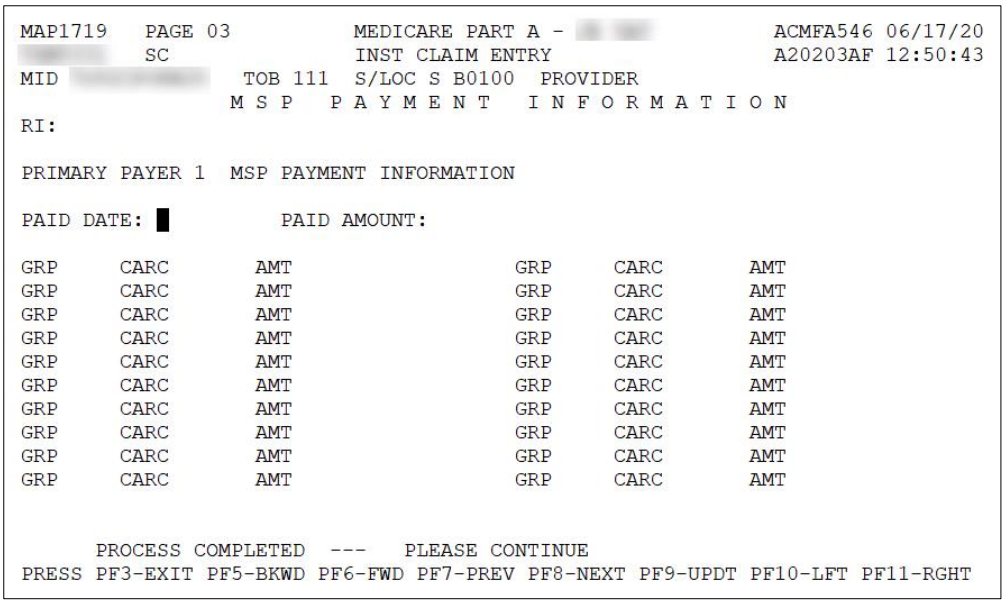
FIELD	DESCRIPTION
END OF POA INDICATOR	End of POA Indicator – the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. The valid values are: Z = The end of POA indicators for principal and, if applicable, other diagnoses. X = The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' = Not acute care, POA's do not apply
ADMITTING DIAGNOSIS	The ICD-9-CM code describing the inpatient condition at the time of the admission.
E-CODE	The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
HOSPICE TERM ILL IND	Identifies whether a hospice patient has a terminal illness. It is only used for hospice claims.
IDE	Investigational Device Exemption Number (IDE) – the IDE authorization number assigned by the FDA.
PROCEDURE CODES AND DATES	Identifies the principal procedure (first code) and other procedures (codes two through six) performed, and dates on which they occurred. This field is required for inpatient claims where a surgical procedure is performed.
ESRD HOURS	End Stage Renal Disease Hours - the number of hours of certain dialysis treatments such as peritoneal.
ADJUSTMENT REASON CODE	Identifier for the type of adjustment being performed. Enter “16” in the SC field in the upper left corner of the screen to access a listing of codes.
REJECT CODE	The reason code for which the claim is being non-medically denied.
NON PAY CODE	The reason for Medicare's decision not to make payment.
ATT PHYS	Attending Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Attending physician’s NPI number.
LN	Attending physician’s last name.
FN	Attending physician’s first name.
MI	Attending physician’s middle initial.
SC	Specialty Code - This field identifies the specialty code.

FIELD	DESCRIPTION
OPER PHYS	Operating Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Operating physician's NPI number.
LN	Operating physician's last name.
FN	Operating physician's first name.
MI	Operating physician's middle initial.
SC	Specialty Code - This field identifies the specialty code.
OTH PHYS	Other Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Other physician's NPI number.
LN	Other physician's last name.
FN	Other physician's first name.
MI	Other physician's middle initial.
SC	Specialty Code - This field identifies the specialty code.
REN PHYS	Rendering Physician/UPIN Code - This field identifies the physician identification number or the UPIN number of the rendering licensed physician.
NPI	Rendering Physician NPI Number– This field identifies the National Provider Identifier number.
L	Last Name - This field identifies the last name of the rendering physician
F	First Name - This field identifies the first name of the rendering physician
M	Middle Initial - This field identifies the middle initial of the rendering physician.
SC	Specialty Code - This field identifies the specialty code.
REF PHYS	Referring Physician/UPIN Code - This field identifies the physician identification number or the UPIN number of the referring licensed physician.
NPI	Referring Physician NPI Number– This field identifies the National Provider Identifier number.
L	Last Name - This field identifies the last name of the referring physician
F	First Name - This field identifies the first name of the referring physician
M	Middle Initial - This field identifies the middle initial of the referring physician.

FIELD	DESCRIPTION
SC	Specialty Code - This field identifies the specialty code.

Claim Screen 3 – MAP1719

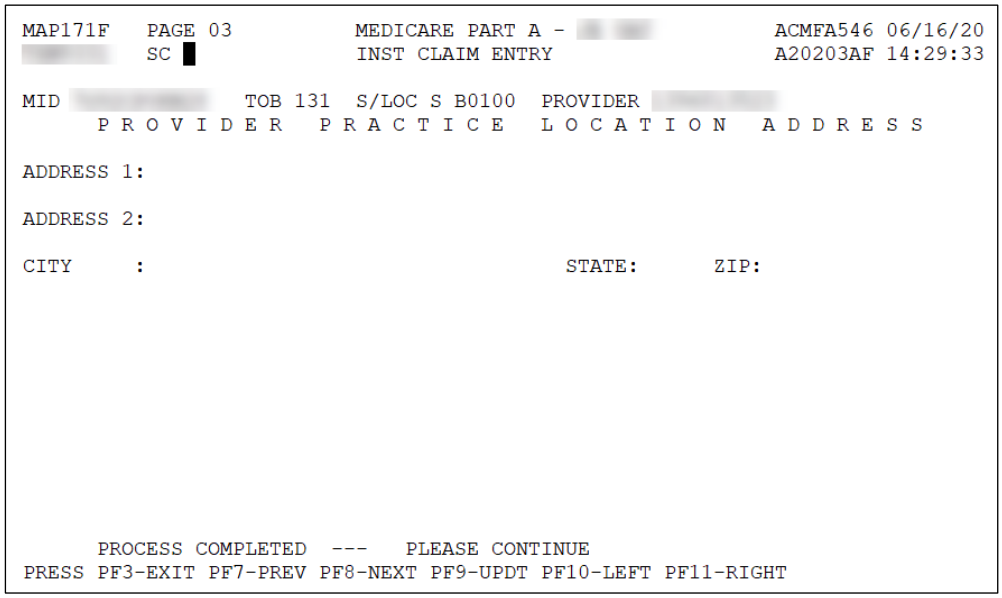
The DDE screen MAP1719 – MSP Payment Information – is used for claim level adjustments and the Coordination of Benefits (COB) payer paid amounts. To access MAP1719, press F11 from page 3 (MAP1713). MAP1719 can display up to two MSP Payment information records. Press F6 from this page to access the second record (if applicable).



FIELD	DESCRIPTION
RI	Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are: R = Restricted or modified release N = No release
PAID DATE	The date that the provider received payment from Primary Payer 1. This is a six-position alphanumeric field in MMDDYY format. PF6 and PF7 to scroll forward and backward between the screen for Primary Payer 1 and Primary Payer 2.
PAID AMOUNT	The payment the provider received from Primary Payer 1. This is an eleven-position numeric field in 999999999.99 format.
GRP	ANSI group codes. This is a two-position alphanumeric field, with 20 occurrences.

FIELD	DESCRIPTION
CARC	ANSI CARC codes. This is a four-position alphanumeric field, with 20 occurrences.
AMT	The dollar amount associated with the group/CARC combination. This field is an eleven-position numeric field in 999999999.99 format, with 20 occurrences.

Claim Screen 3 – MAP171F

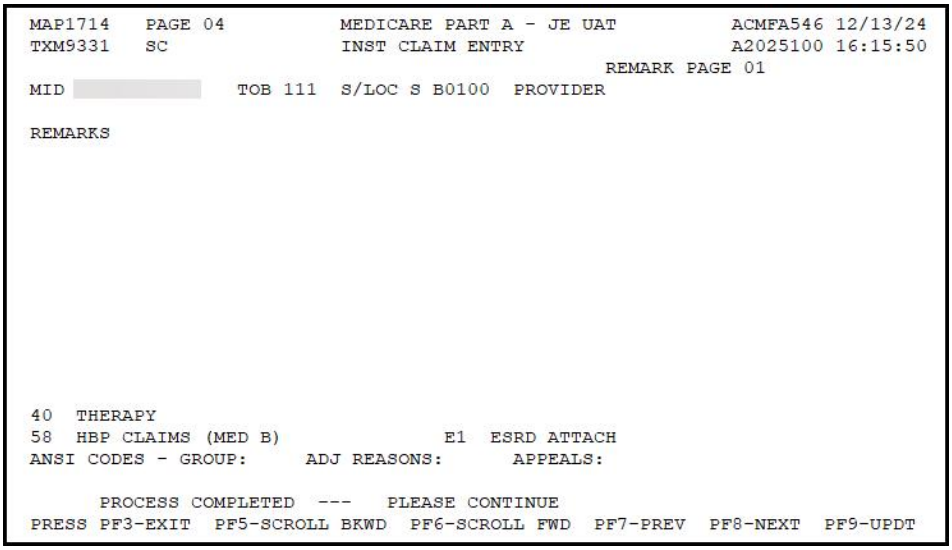


FIELD	DESCRIPTION
MID	The Health Insurance Claim (HIC) Number or Medicare Beneficiary Identifier (MBI) assigned to the beneficiary by CMS. This is a twelve-position alphanumeric field.
TOB	The type of bill. This is the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field.
S	The status of the claim (e.g., good, suspended, inactive). The location field is subsequent. This is a one-position alphanumeric field.
LOC	the location of where the claim resides in the system. This is a five-position alphanumeric field.
ADDRESS 1	The Service Facility address 1. This is a 55-position alphanumeric field.
ADDRESS 2	The Service Facility Address 2. This is a 55-position alphanumeric field.
CITY	The Service Facility City. This is a 30-position alphanumeric field.
STATE	The Service Facility State. This is a two-position alphanumeric field.

FIELD	DESCRIPTION
ZIP	The Service Facility Zip. This is a 15-position alphanumeric field.

Claim Screen 4 – MAP1714 – Remarks

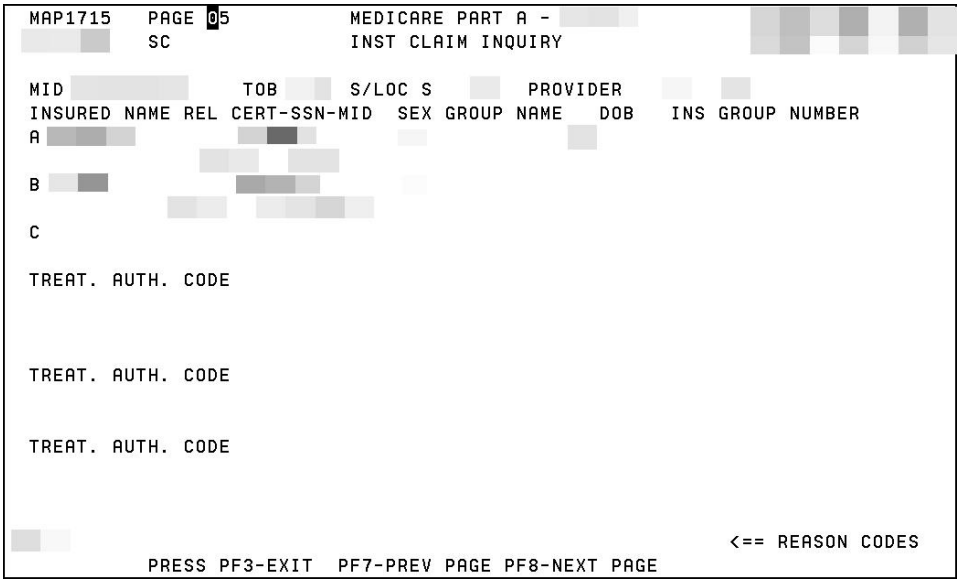
Remarks can be entered by provider staff and by Noridian staff and are used to add clarifying information. They become part of the permanent claim record. It is not necessary to use complete sentences, but the information should be easily understandable, and any abbreviations should be commonly used. Add your initials and the date the remarks are added to each entry.



FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider

FIELD	DESCRIPTION
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
REMARKS	Information submitted by providers or contractor staff to provide permanent comments regarding special considerations that affect adjudicating the claim. Common abbreviations are acceptable. End each entry with your initials and the date. Addition space is available by pressing [F6].
ZIP	Identifies the zip code.
40 THERAPY	Therapy Attachment – not used.
41 HOME HEALTH	Home Health Attachment – not used.
58 HBP CLAIMS	Hospital-based Physician Attachment – not used.
ANSI CODES-GROUP	General category of payment adjustment. Used for claims submitted in an ANSI automated format only.
ADJ REASONS	Claim adjustment standard reason code identifying the detailed reason the adjustment was made. This is a three-position alphanumeric field. See Claims Entry Screen 3 for explanation.
APPEALS	ANSI Appeals Codes - This field identifies codes for inpatient or outpatient.

Claim Screen 5 – MAP1715



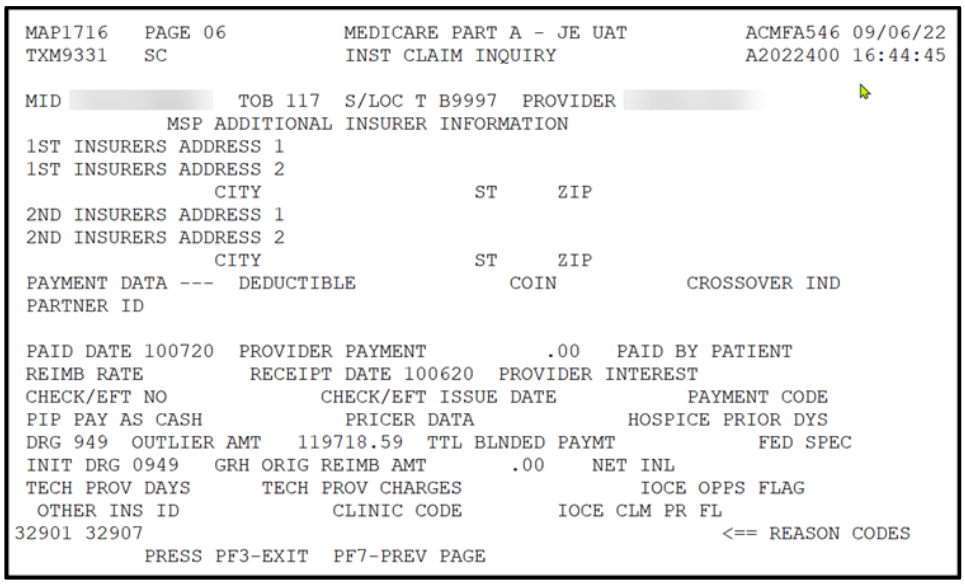
FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
INSURED NAME	The individual whose name the insurance is carried, as qualified by the payer organization. Enter last name, first name, and middle initial. Name must be the same as on the patient's health insurance card or other Medicare notice.
REL	Patient Relationship to Insurer – Enter the HIPAA relationship codes (these cross-reference to CWF codes); Valid Values are listed in the next table
CERT-SSN-MID	Identifies the insurer assigned beneficiary number or Medicare ID number.
SEX	The sex of the beneficiary.
GROUP NAME	Name of the group or plan through which the insurance is provided to the insured.
DOB	The insured's date of birth.
INS GROUP NUM.	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.
TREAT AUTH CODE	HHPPS Treatment Authorization Code – used for home health claims.

Valid Patient Relationship to Insurer Values

HIPAA CODE	CWF CODE	RELATIONSHIP
1	4	Spouse
4	19	Grandparent
5	13	Grandchild
7	14	Nephew/Niece
10	6	Foster Child
15	7	Ward of the Court
17	5	Stepchild
18	1	Self
19	3	Child
20	8	Employee
21	9	Unknown
22	10	Handicapped/Dependent
23	16	Sponsored Dependent
24	17	Dependent of Minor
29	None	Significant Other
32	None	Mother
33	None	Father
36	None	Emancipated Donor
39	11	Organ Donor
40	12	Cadaver Donor
41	15	Injured Plaintiff
43	4	Child where insured has no financial responsibility
53	None	Life Partner
G8	None	Other Relationship

Claim Screen 6 – MAP1716

MAP1716 contains the Medicare Secondary Payer (MSP) address information, payment data and PC Pricer data information.



FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider

FIELD	DESCRIPTION
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.

MSP ADDITIONAL INSURANCE INFORMATION

FIELD	DESCRIPTION
1ST INSURERS ADDRESS 1	The street address of the beneficiary's insurer.
1ST INSURERS ADDRESS 2	The second street address line of the beneficiary's insurer and is used to indicate the post office box, apartment number, etc.
CITY	The insurer's city address.
ST	The insurer's state address abbreviation.
ZIP	The insurer’s nine-digit ZIP code.
2ND INSURERS ADDRESS 1	The street address of the beneficiary's second insurer.
2ND INSURERS	The second street address line of the beneficiary's second insurer and is used to indicate the post office box,
ADDRESS 2	apartment number, etc.
CITY	The second insurer's city address.
ST	The second insurer's state address abbreviation.
ZIP	The second insurer’s nine-digit ZIP code.

PAYMENT DATA

FIELD	DESCRIPTION
DEDUCTIBLE	The amount of deductible for which the beneficiary/patient is liable.
COIN	The amount of coinsurance for which the beneficiary/patient is responsible.

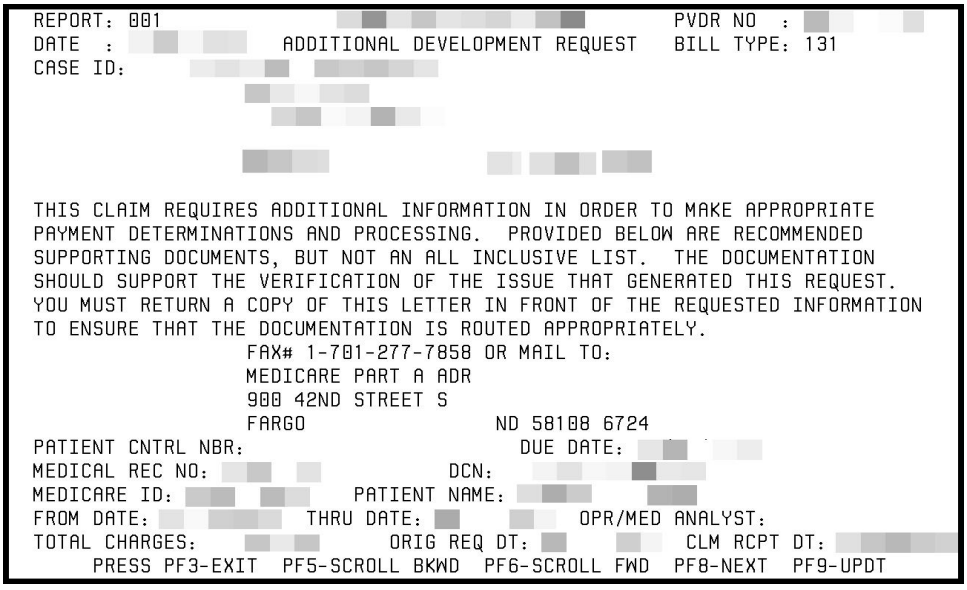
FIELD	DESCRIPTION
CROSSOVER IND	This field identifies the Medicare payer on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. The valid values are: 1 = Primary 2 = Secondary 3 = Tertiary
PARTNER ID	The trading partner identification number.
NO TITLE	The production COBA Trading Partner(s) that did not receive the claim due to claim errors. The valid values are: ' ' = Crossed Over N = Not crossed over due to claim data errors
PAID DATE	The scheduled payment date of the claim or the date the provider is actually reimbursed.
PROVIDER PAYMENT	The provider payment amount.
PAID BY PATIENT	This field is not used by FISS.
REIMB RATE	The per diem amount to be paid for providers reimbursed on per diem reimbursement or percentage of reimbursement if the provider's type of reimbursement is based on a percentage of charges.
RECEIPT DATE	The date the claim was received by the Medicare Intermediary.
PROVIDER INTEREST	The amount of interest paid to the provider for late payment on clean claims.
CHECK/EFT NO	The identification number of the check or electronic funds transfer.
CHECK/EFT ISSUE DATE	The date the check was issued or the date the electronic funds transfer occurred.
PAYMENT CODE	The payment method of the check or electronic funds transfer. The valid values are: ACH = Automated Clearing House or Electronic Funds Transfer CH = Check NON = Non-payment Data
DRG	Diagnosis Related Group Code – the Diagnosis Related Group Code assigned by the CMS grouper program using length of stay, covered days, sex, age, diagnosis and procedure codes, discharge date, and total charges.

FIELD	DESCRIPTION
INIT DRG	Initial Diagnosis Related Group Code.
OUTLIER AMT	Capital Outlier Payment - This field identifies the outlier portion of the PPS payment for capital and the PPS dollar threshold for a cost outlier
TTL BLENDED PAYMENT	This field is not used by FISS.
FED SPEC	This field is not used by FISS.
GRAMM RUDMAN ORIG REIMBURSEMENT AMT	Gramm Rudman Original Reimbursement Amount - the amount reduced from the provider's reimbursement as mandated by Gramm/Rudman/Hollings legislation.
NET INL	Internal use.
TECH PROV DAYS	The days present on the benefit savings record or the days reflected in the occurrence span '77' if the benefit savings record is not present.
TECH PROV CHARGES	The charges present on the benefit savings record.
IOCE OPPS FLAG	Identifies OPPS claims.
OTHER INS ID	This field not used by FISS.
CLINIC CODE	This field not used by FISS.
IOCE CLM PR FL	IOCE Claim Processed Flag 0 - Claim is processed. 1 - Claim could not be processed (edits 23, 24, 46*, TOB 83x or other invalid bill type). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted. 9 - Fatal error; OCE cannot run - the environment cannot be set up as needed.

Additional Development Requests (ADRs)

DDE providers can access a listing of claims that have been selected for medical review by entering the status location codes S B6001 in the S/LOC fields of the Claims Summary Inquiry screen (MAP 1741). To see the type of information being requested and the instructions for submitting that

information, place an “S” in the SEL field in front of the claim. The ADR information will be found beginning on claim page 7.



FIELD	DESCRIPTION
REPORT	The report number for additional development requests.
PVDR NO	The provider number assigned by Medicare to the provider (PTAN).
DATE	The system date on which the ADR is being viewed.
BILL TYPE	The type of bill.
PATIENT CNTRL NBR	The patient account number assigned by the provider.
MEDICAL REC NO	The medical review number assigned by the provider.
DCN	The claim identification number.
DUE DATE	The due date for the requested documentation.
MID	The beneficiary Medicare ID number.
PATIENT NAME	The patient’s full name.
FROM DATE	The beginning date of service on the claim.
THRU DATE	The ending date of service on the claim.
OPR/MED ANALYST	The ID code assigned to the medical analyst requesting the documentation.

FIELD	DESCRIPTION
TOTAL CHARGE	The total charges on the claim.
ORIG REQ DT	The date the first ADR request was generated for this claim.
CLM RCPT DT	The date the claim was received by the intermediary/A/B MAC.

Press [F8] to see a list of the documentation being requested.

FIELD	DESCRIPTION
REASONS	Displays a list of up to 10 ADR reason codes that identify the specific information being requested.
REASON CODE NARRATIVES FOR MID/DCN	The definitions for each ADR reason code for the specific Medicare ID/DCN combination listed.

REVENUE CODES – OPTION 13

The Revenue Code inquiry screens displays information that can be used to verify if a revenue code can be used with a particular type of bill. It also contains information indicating if a HCPCS code, rate, or unit is required.

Enter the revenue code in the REV CD field and press [ENTER] to access this information. The Types of Bill (TOB) are listed in numerical order; press [F6] to continue to the next page.

Revenue Code Table Inquiry – MAP1761

```
MAP1761                                                    
      SC              REVENUE CODE TABLE INQUIRY           

              REV CD                                       
EFF DT           IND                    TERM DT          

NARR                                                       

        ALLOW:             HCPC:              UNITS:            RATE:
 TOB      EFF-DT TRM-DT      EFF-DT TRM-DT      EFF-DT TRM-DT     EFF-DT TRM-DT
 ---    ---------------    ---------------    ---------------   ---------------

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

FIELD	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	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
UNITS	Identifies if the revenue code requires units to be present for a specific Type of Bill. Valid values are: Y = Yes N = No

FIELD	DESCRIPTION
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

HCPC CODES – OPTION 14

The HCPC Codes inquiry screens under the previous Option 14 have been reassigned due to changes in the Common Working File. This functionality in DDE has been reassigned to the NEW HCPC CODES Option 1E and its screens 1E01 and 1E02, located further down in this guide.

DX/PROC CODES – OPTION 15

The DX/PROC Codes inquiry screens display the ICD-9-CM diagnosis and procedure codes, along with the effective and termination dates.

Enter the diagnosis code, or, if you are looking for an ICD-9-CM procedure code, enter a "P" followed by the procedure code. Press [ENTER].

Please remember that even though a code is listed, DDE may not accept it. Only the most definitive code in a category is acceptable for claims processing.

ICD-9-CM Code Inquiry – MAP1731

```
MAP1731                    MEDICARE PART A -
      SC                    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
```

FIELD	DESCRIPTION
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 CODES – OPTION 16

The Adjustment Reason Codes inquiry screen displays a listing of the adjustment reason codes and the code definitions. Adjustment reason codes are required for submitting a claim adjustment through DDE.

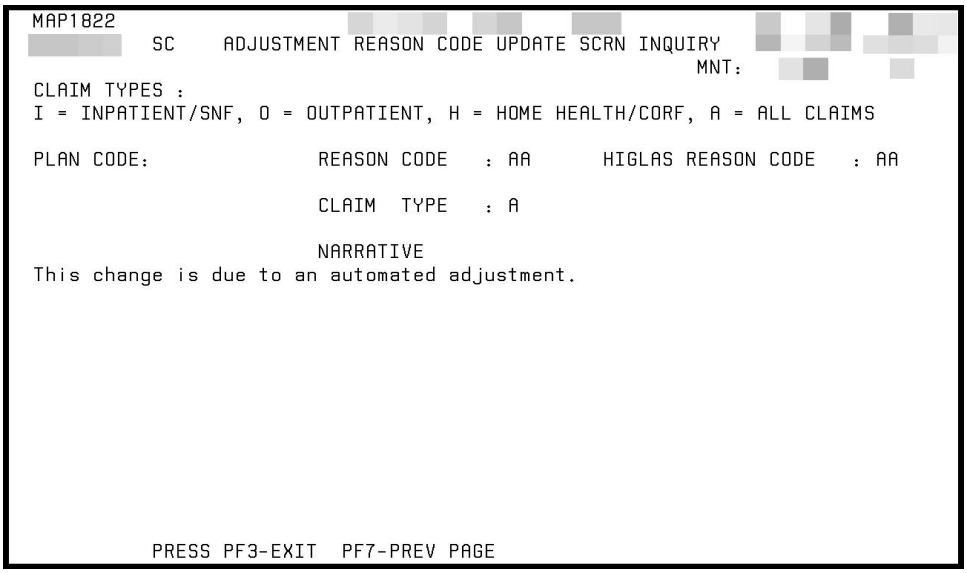
To begin the inquiry, enter an adjustment reason code or just press the [ENTER] key. If you press the [ENTER] key without entering an adjustment reason code, the following screen will appear with an alphabetical listing of adjustment reason codes. Use [F6] to scroll through the entire list.

Adjustment Reason Codes Inquiry Selection Screen – MAP1821

```
 MAP1821
 [redacted]    SC          ADJUSTMENT REASON CODES INQUIRY
                                 SELECTION SCREEN         MNT: [redacted]
 CLAIM TYPES:
 I = INPATIENT/SNF, O = OUTPATIENT, H = HOME HEALTH/CORF, A = ALL CLAIMS
 PLAN CODE: 1        REASON CODE:
S PC RC HC TYPE                  NARRATIVE
  1  AA AA A This change is due to an automated adjustment.
  1  AC OT A ADMIT DATE CORRECTION
  1  AD AD I This overpayment is a result of a Quality Improvement Organizati
  1  AG OT A ICD-9 DIAGNOSIS CODING CHANGE
  1  AM AM I This overpayment is a result of a Quality Improvement Organizati
  1  AR AR I This claim adjustment is due to a review that reversed the
  1  AS OT O AMBULATORY SURGICAL CENTER
  1  AT TB A ORIGINALLY PROCESSED AS AUTO LIABILITY, NOW MAKE MEDICARE PRIME.
  1  AU AU A This overpayment is a result of a claim being processed with
  1  AW AW I An admission denial adjustment has been processed, however, the
  1  BB BB A This overpayment is a result of a same day transfer.
  1  BC BC A This overpayment is a result of the beneficiary file being
  1  BD OT A PROCESS AS DEMAND BILL, CC 20.
  1  BE SG A CANCEL/VOID, CHARGES BILLED IN ERROR
  1  BF BF H HHPPS FINAL NOT RECEIVED
       PROCESS COMPLETED  ---   PLEASE CONTINUE
   PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

If a specific adjustment reason code is entered, the following screen will appear:

Adjustment Reason Code Update Screen inquiry – MAP1822



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	Two-digit adjustment reason code.
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.
HC	Identifies the HIGLAS adjustment reason code.

FIELD	DESCRIPTION
TYPE	Displays the type of claim associated with this reason code. Valid values are: A = All Claims H = Home Health/CORF I = Inpatient/SNF O = Outpatient
NARRATIVE	The narrative provides a short description for the adjustment reason code.

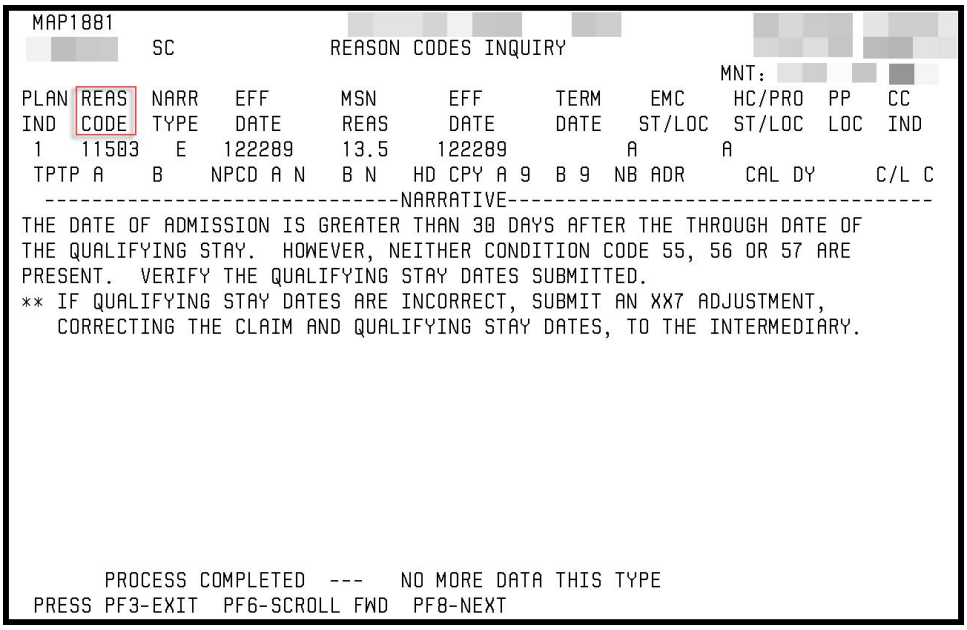
REASON CODES – OPTION 17

The Reason Code inquiry screens list the reason codes assigned to a claim to define something about the claim. Sometimes the reason code simply gives information about the claim, such as it is a finalized claim. In other situations, the reason code defines why a claim and/or line item was denied, rejected, or cannot be processed as submitted. It is important to understand the relationship among the UB04 data fields; the reason code is applied to the first data element that identifies a logic failure among related fields, however that data element may not be the only one in error. Providers should check all related fields and correct the appropriate data.

Like the other inquiry options, the reason codes can be accessed through the Inquiry Menu, or by entering the option number (17) in the SC field in the upper left corner of the screen when in other applications. The reason codes also can be accessed within a claim screen by pressing the [F1] key and entering the specific reason code number. When [F1] is selected, the narrative will appear. To see the narrative for another reason code, simply type in the new code and press [ENTER].

The corresponding ANSI reason code can be displayed by pressing [F8].

Reason Codes Inquiry – MAP1881



FIELD	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.

FIELD	DESCRIPTION
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.

To go to the next page, press [F8]. This screen will give the appeal rights information.

ANSI Related Reason Code Inquiry – MAP1882

```
MAP1882                    MEDICARE PART A - JE UAT          ACMFA546 06/09/21
TXM9331   SC       ANSI RELATED REASON CODES INQUIRY         A2021300 14:09:37
                                                          MNT: SHC8915  030314

REASON CODE: 56900
PIMR ACTIVITY CODE:          DENIAL CODE: 100007          MR INDICATOR:
CWF NCD IND:                 PCA INDICATOR: N             LMRP/NCD ID :
ANSI CODES
  ADJ REASONS: 50

  GROUPS     : CO

  REMARKS    : N102

  APPEALS (A): MA02  M27


  APPEALS (B): MA01  M27


  CATEGORY   :  EMC F2                HC F2

  STATUS     :  EMC 0585              HC 0585

          PRESS PF3-EXIT  PF7-PREV PAGE
```

FIELD	DESCRIPTION
REASON CODE	FISS reason code related to the following ANSI codes relate.
PIMR ACTIVITY CODE	Program Integrity Management Reporting (PIMR) Activity Code – identifies the PIMR activity code. The valid values are: AI = Automated CCI Edit AL = Automated Locally Developed Edit AN = Automated National Edit CP = Prepay Complex Probe Review DB = TPL or Demand Bill Claim Review MR = Manual Routine Review PS = Prepay Complex Provider Specific Review RO = Reopening SS = Prepay Complex Service Specific Review

FIELD	DESCRIPTION
DENIAL CODE	Program Integrity Management Reporting (PIMR) Denial Reason Code –the PIMR Denial reason. The valid values are: NOPIMR = Default 100001 = Documentation Does Not Support Service 100002 = Investigation/Experimental 100003 = Item/Services Excluded From Medicare Coverage 100004 = Requested Information Not Received 100005 = Services Not Billed Under The Appropriate Revenue Or Procedure Code (Includes Denials Due To Unbundling In This Category 100006 = Services Not Documented In Record 100007 = Services Not Medically Reasonable And Necessary 100008 = Skilled Nursing Facility Demand Bills 100009 = Daily Nursing Visits Are Not Intermittent/ Part Time
DENIAL CODE CONT'D	100010 = Specific Visits Did Not Include Personal Care Service 100011 = Home Health Demand Bills 100012 = Ability To Leave Home Unrestricted 100013 = Physician's Order Not Timely 100014 = Service Not Ordered/Not Included In Treatment Plan 100015 = Services Not Included In Plan Of Care 100016 = No Physician Certification (E.G. Home Health) 100017 = Incomplete Physician Order 100018 = No Individual Treatment Plan 100019 = Other
M/R IND	Complex Manual Medical Review – This field identifies whether or not 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 medical review.

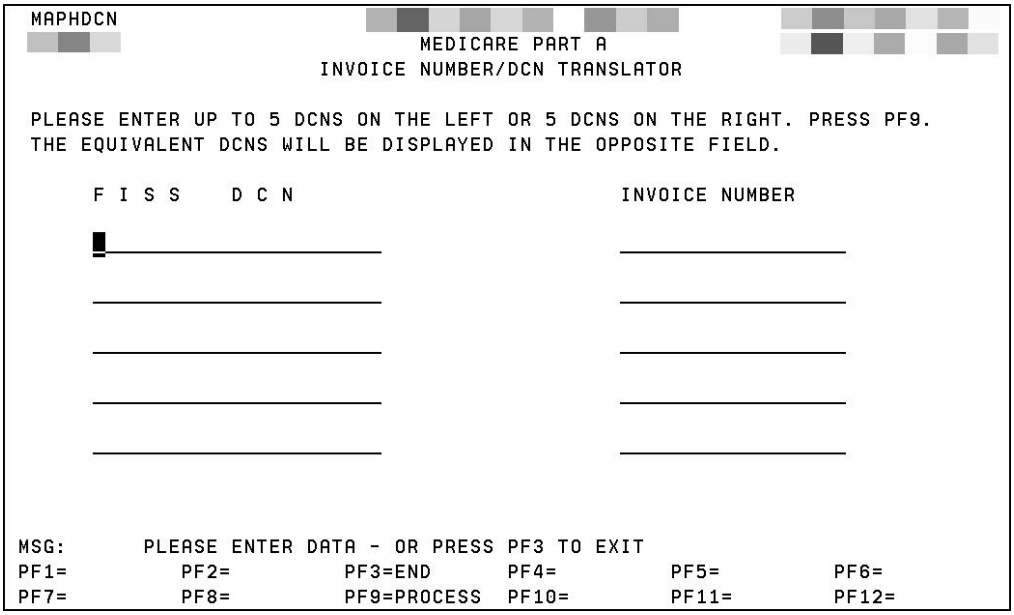
FIELD	DESCRIPTION
CWF NCD IND	Common Working File National Coverage Determination Indicator. The values displayed are: Y = Yes N = No This value will indicate whether an NCD-related reason code (59CXX) affects the claim.
PCA INDICATOR	Progressive Correction Action –the progressive correction action indicator. The valid values are: ' ' = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files. Y = The Medical Policy Parameter is PCA-related and is included in the PCA transfer files. N = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID	Local Medical Review Policy (LMRP) and/or National Coverage Determination (NCD) identification number –the LMRP/NCD identification numbers assigned to the FMR reason code for reporting on the beneficiaries Medicare Summary Notice.
ADJ REASONS	Adjustment Reason Codes - the ANSI reason code related to the FISS reason code.
GROUPS	The ANSI Group Codes.
REMARKS	ANSI Remarks - identifies the reason for non-payment.
APPEALS (A)	ANSI Appeal-A Codes - used for inpatient only.
APPEALS (B)	ANSI Appeal-B Codes - used for outpatient only.
EMC CATEGORY	Electronic Media Claim Category Code – the EMC category of the claim that is returned on a 277 claim response.
HC CATEGORY	Hard Copy Claim Category Code – the Hard Copy category of the claim that is returned on a 277 claim response.
EMC STATUS	Electronic Media Claim Status Code – the EMC status of the claim that is returned on a 277 claim response.
HC STATUS	Hard Copy Claim Status – the Hard Copy status of the claim that is returned on a 277 claim response.

INVOICE NO/DCN TRANS – OPTION 88

This Invoice Number and DCN translator inquiry accepts entry of either the claim's DCN or the invoice number. Upon entry of either field, the corresponding element will be returned as a cross

reference. Providers can now use the invoice number to look up the DCN, which can be entered in option 12, claims inquiry, to return the claim information, including the MID and dates of service.

Invoice No/DCN Trans – MAPHDCN

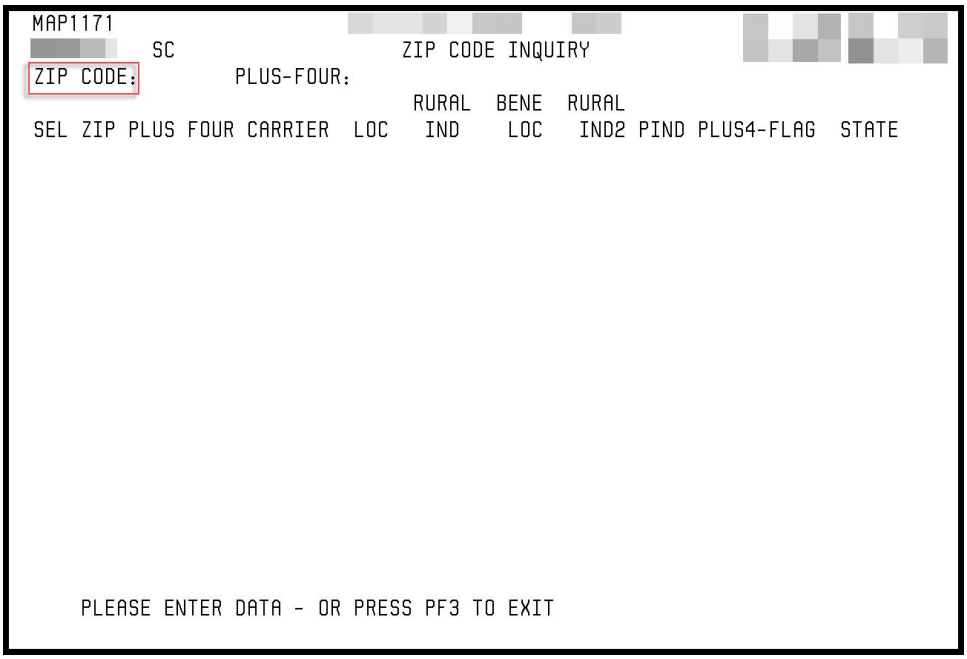


ZIP CODE FILE – OPTION 19

The ZIP Code inquiry shows the zip code and urban, rural, and rural bonus location information used for pricing services.

Enter the nine-digit ZIP code of the facility in question. If the facility is provider-based and is located off-campus from the main provider, be sure to enter the ZIP code for the off-site facility.

ZIP Code Inquiry – MAP1171



FIELD	DESCRIPTION
SEL	Identifies a selection option, which is used to access MAP1172 (ZIP9 Information). Enter an S.
ZIP	Identifies the zip code on the zip code file.
PLUS FOUR	The four-digit zip code extension.
CARRIER	Identifies the carrier number assigned.
LOC	Locality Code – The locality identification number for the area (or county) where the provider is located.
RURAL IND	Rural Indicator – This field identifies the rural indicator. The valid values are: U = Urban R = Rural B = Rural Bonus

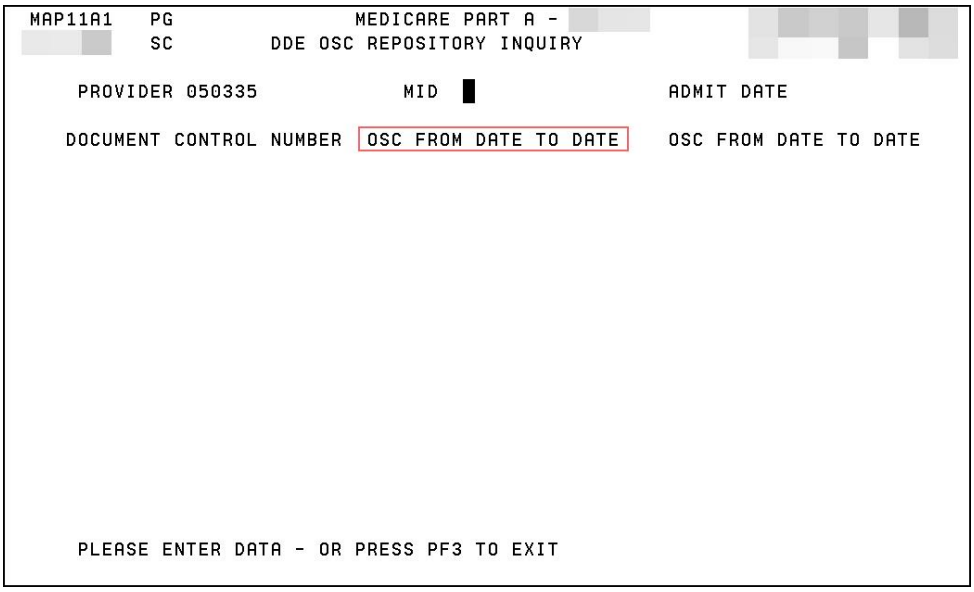
FIELD	DESCRIPTION
BENE LOC	Beneficiary Lab CB Locality – This field is used in the Laboratory Competitive Bidding Demonstration. The valid values are: Z1 = CBA 1 Z2 = CBA 2 Z9 = Not a demo locality
RURAL IND2	Rural Indicator 2–The rural indicator 2. The valid values are: U = Urban R = Rural B = Rural Bonus
PLUS4-FLAG	Plus4-Flag – The plus 4 flag indicator. The valid values are: 0 = No +4 Extension 1 = +4 Extension
STATE	State associated with the zip code.

OSC REPOSITORY INQUIRY – OPTION 1A

The purpose of the OCE (Occurrence Span Code) Repository Inquiry screen is to display the occurrence span code repository record. Up to three occurrences can display on a page. Specific occurrences can be displayed by typing a page number in the PG field at the upper left-hand corner of the screen. Additionally, PF5 will page backward through the data and PF6 will page forward.

NOTE: The occurrence span code repository can contain up to 100 sets of data. Each set consists of a document control number, along with ten occurrence span codes and the 'from' and 'to dates'. This screen MAP13B1 displays up to three sets per page.

OSC Repository Screen – MAP11A1/MAP11B1



FIELD	DESCRIPTION
PG	Page - This field navigates to the possible pages of data. Valid values range from 01 to 34, depending on the number of occurrences that exist on the record. Typing a number greater than the possible entries results in a display of the last page of data.
SC	Scroll - This field allows displaying other menu options, without having to return to the main menu. When a menu option related to processing a claim is entered, the key of the record transfers over to the requested screen, allowing the requested data to automatically display.
PROVIDER	Provider Number - This field displays the identification number of the institution who rendered services to a particular beneficiary/patient.
MID	Medicare ID Number - This field identifies the Medicare ID Number used to display existing therapy attachments.
ADMIT DATE	Admit Date - This field identifies the patient's admission date
DCN	Document Control Number - This field displays the identification number for a claim. If an adjustment or an RTP is being processed, enter the DCN for that claim.
OSC	OSC - This field identifies the occurrence span code that identifies events that relate to the payment of the claim.
FROM DATE	From Date - This field identifies the commencement of an event that relates to the payment of a claim
TO DATE	To Date - This field identifies the ending of an event that relates to the payment of a claim

FIELD	DESCRIPTION
OSC	OSC - This field identifies the occurrence span code that identifies events that relate to the payment of the claim.
FROM DATE	From Date - This field identifies the commencement of an event that relates to the payment of a claim
TO DATE	To Date - This field identifies the ending of an event that relates to the payment of a claim

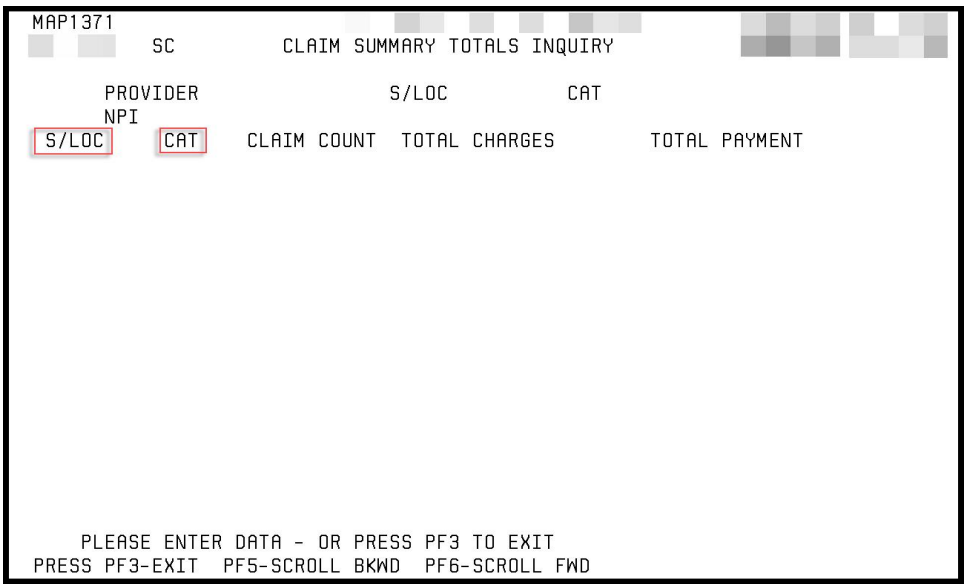
CLAIM COUNT SUMMARY – OPTION 56

The Claim Count Summary screens display a summary listing of all the claims in an RTP and pending status. This information is updated at the end of each day. Within each status location code, the claim totals are sorted by types of bill. Only those claims that are in the payment floor will show a payment amount (S/LOC PB9996).

Key in the NPI. Press [ENTER] to display the summary information. It is suggested that the first S/LOC and CAT fields be left blank when selecting the summary information so all claims will be included.

The Claim Count Summary screens are a good resource for identifying claims that are out of the ordinary and that may not be identified otherwise. For example, if a hospital erroneously submits a claim with a SNF type of bill, that claim will RTP, but it will not appear in the provider's RTP information unless the user specifically uses the SNF type of bill in the RTP selection criteria. By reviewing the claims in the Claims Summary Count, the user will be able to see that there is a claim under the SNF type of bill and make the appropriate corrections.

Claim Summary Totals Inquiry – MAP1371



FIELD	DESCRIPTION
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
S/LOC	Leave blank.
CAT	Leave blank.
S/LOC	The status/location identifies the condition of the claim and/or location of the claims. (A list of the S/LOC definitions is available in Chapter One "Getting Started").
NPI	Enter the National Provider Identifier number.
CAT	The Bill Category identifies the type of claims in specific locations by Type of Bill. In addition, a value that identifies the total claims number for each status/location. Valid values include: GT = Grand Total – All categories in all status/locations. TC = Total Count – The total within each status/location excluding claims with a category of AD, MN, or MP. XX= First two digits of any TOB entered by provider; e.g., 11, 13, 32, 72, etc. MP = Medical Policy –identifies RTP'd claims where the first digit of the primary reason code is a 5. NM = Non-Medical Policy –identifies RTP'd claims where the first digit of the primary reason code is not a 5. AD = Adjustments – Within each status/location. Claims in this category are also counted under the standard bill category.
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.

HOME HEALTH PAYMENT – OPTION 67

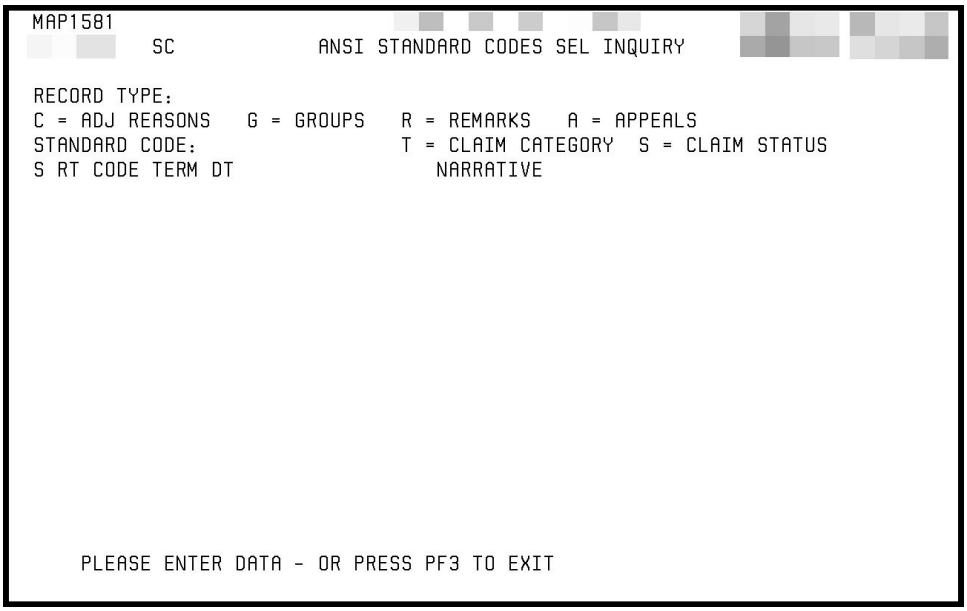
Noridian currently does not process home health claims. To access home health claim information, sign into the DDE applications available through the Medicare contractor who processes those claims.

ANSI REASON CODES – OPTION 68

The ANSI Reason Codes Inquiry screens show the code and definitions specified by the American National Standards Institute to be used by all payers. The ANSI codes appear on the paper and electronic remittances.

To access the information, you may enter a specific code or just press the [ENTER] key and a list of ANSI reason codes will be displayed. To view the full narrative, tab to the specific code, enter “S” and press [ENTER].

ANSI Related Reason Codes Inquiry – MAP1581

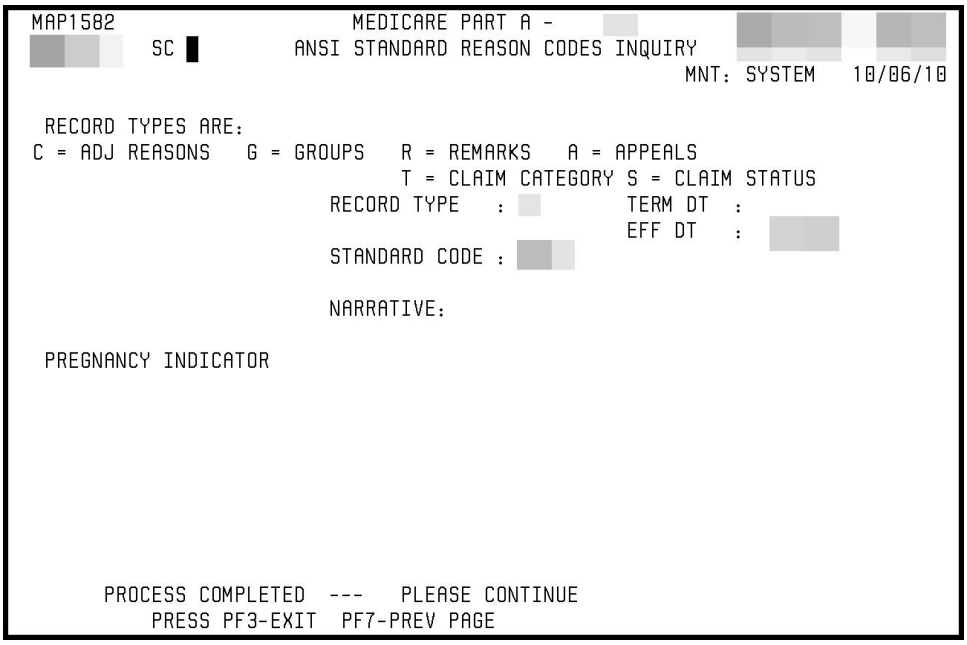


FIELD	DESCRIPTION
RECORD TYPE	Identifies the record type for the standard code: A = Appeals C = Adjustment reasons G = Groups R = Reference remarks S = Claim status T = Claim category
STANDARD CODE	The standard code within the above record type that is being inquired upon or updated. If record code is present and no standard code is shown, all standard codes for the record type displays. If both record type and standard codes are present, the specific standard code displays. If neither the record type nor the standard code is shown, all ANSI codes are displayed in record type/standard code sequence.
S	Used to select a specific code when a list is displayed.

FIELD	DESCRIPTION
RT	Identifies the record type selected.
CODE	Identifies the standard code you selected.
TERM DT	Term Date - This field identifies the date the ANSI Standard Code is deactivated. This is a six-digit field in MMDDYY format.
NARRATIVE	Description of the standard code.

When the Standard Code (see above) is entered the narrative screen will display.

ANSI Reason Code Narrative – MAP1582



FIELD	DESCRIPTION
RECORD TYPE	Identifies the record type for the standard code: A = Appeals C = Adjustment reasons G = Groups R = Reference remarks S = Claim status T = Claim category
TERM DT	Identifies the date the ANSI Standard Code is deactivated; ANSI codes that do not have a termination date has a default value of 'blank'.

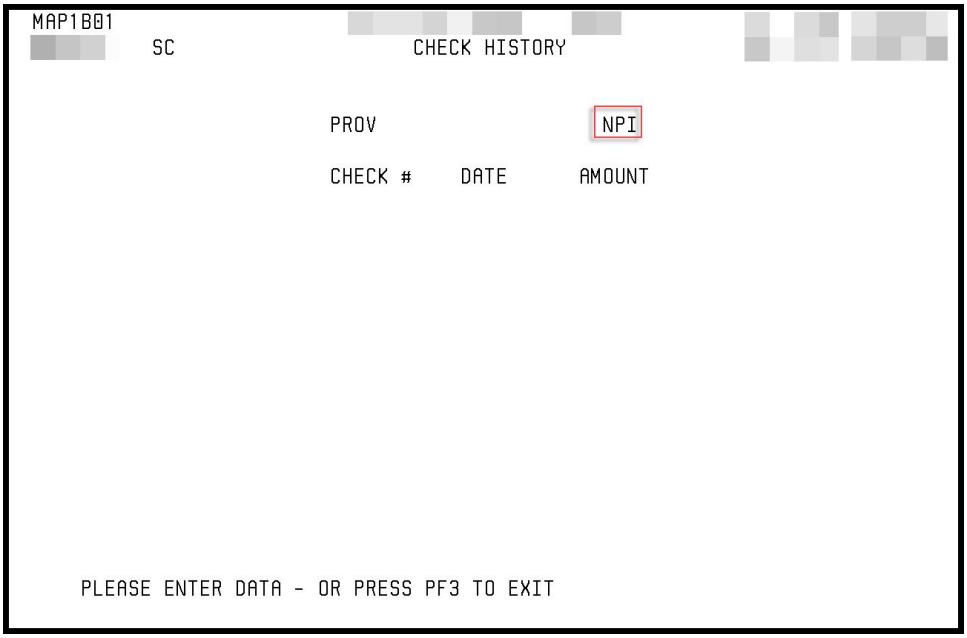
FIELD	DESCRIPTION
STANDARD CODE	The standard code within the above record type that is being inquired upon or updated. If record code is present and no standard code is shown, all standard codes for the record type displays. If both record type and standard codes are present, the specific standard code displays. If neither the record type nor the standard code is shown, all ANSI codes are displayed in record type/standard code sequence.
NARRATIVE	Description of the standard code.

CHECK HISTORY – OPTION FI

The Check History inquiry screen shows the three most recent checks issued to the provider number. If the payment is issued through Electronic Funds Transfer, the check number will be preceded by EFT.

Type in the NPI and the provider number (PTAN) and press [ENTER].

Check History – MAP1B01



FIELD	DESCRIPTION
PROV	The Medicare assigned provider number.
NPI	The National Provider Indicator number.
CHECK #	The last three payments issued to the provider by Medicare. Leading zeros indicate a check. 'EFT' indicates electronic fund transfer.

FIELD	DESCRIPTION
DATE	The date when the payments were issued (YYYYMMDD).
AMOUNT	The dollar amount of the last three payments issued to the provider.

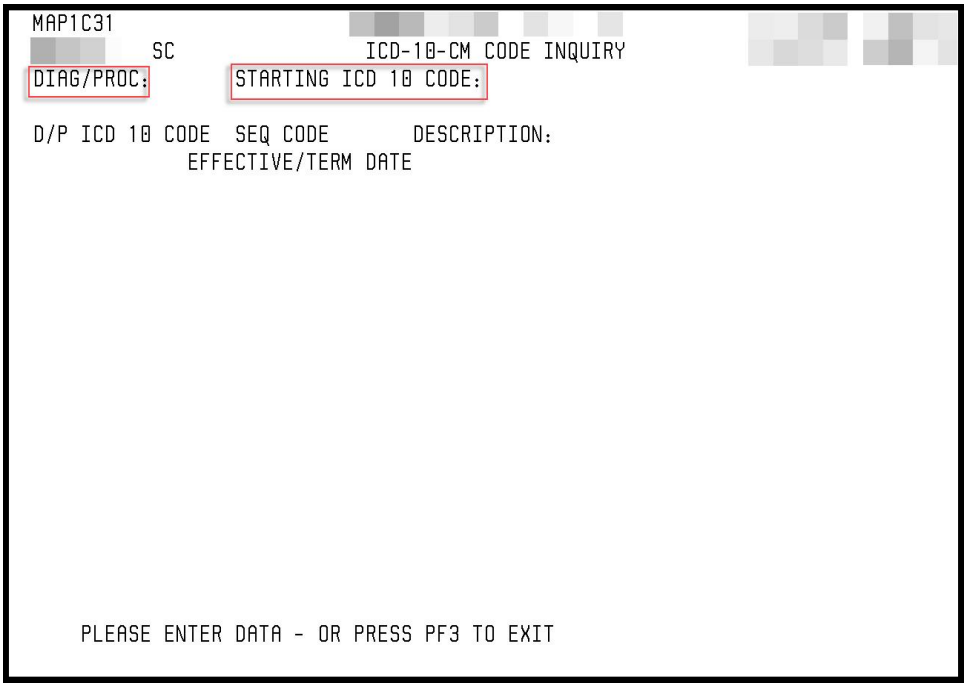
DX/PROC CODES ICD-10 – OPTION 1B

The DX/PROC Codes inquiry screens display the ICD-10-CM diagnosis and procedure codes, along with the effective and termination dates.

Enter “D” followed by the diagnosis code, or, if you are looking for an ICD-10-CM procedure code, enter a “P” followed by the procedure code. Press [ENTER].

Please remember that even though a code is listed, DDE may not accept it. Only the most definitive code in a category is acceptable for claims processing

ICD-10 Code Inquiry Screen – MAP1C31



FIELD	DESCRIPTION
DIAG/PROC	Diag\Proc - This field identifies whether this is an ICD-10 diagnosis or procedure: D=Diagnosis code P=Procedure code

FIELD	DESCRIPTION
STARTING ICD 10 CODE	Starting ICD-10 Code - The ICD-10 code is used to identify a specific diagnosis(s) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim.
D/P	Diag\Proc - This field identifies whether this is an ICD-10 diagnosis or procedure: D=Diagnosis code P=Procedure code
ICD 10 CODE	ICD-10 Code - The ICD-10 code is used to identify a specific diagnosis(s) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim.
DESCRIPTION	ICD-10 Description - This field displays the description for the ICD-10 code.
EFF DT	Medicare Code Editor Effective Date - This field identifies the effective date of the program. This is a six-digit field in MMDDYY format, with three occurrences.
TERM DT	Medicare Code Editor Termination Date - This field identifies the date in which this program was no longer in effect. This is a six-digit field in MMDDYY format, with three occurrences.

PROVIDER PRACTICE ADDRESS QUERY SUMMARY – OPTION 1D

The Provider Practice Address inquiry screens display the additional practice addresses for a facility.

To access the information, enter the NPI and/or OSCAR, press the [ENTER] key and a list of addresses will be displayed.

Provider Practice Address Query Summary Screen – MAP1AB1

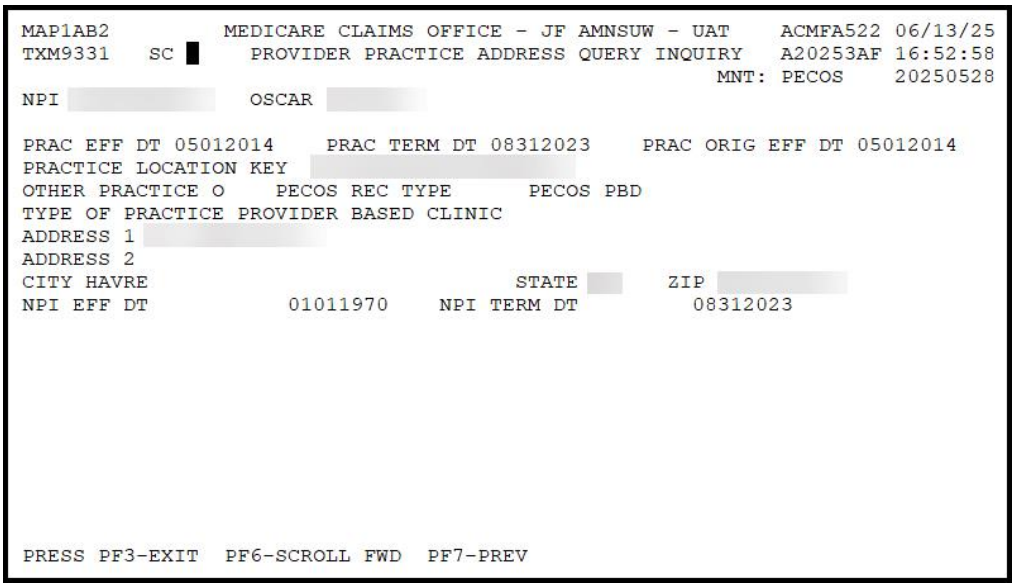
```
MAP1AB1          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT  ACMFA522 09/06/22
TXM9331   SC     PROVIDER PRACTICE ADDRESS QUERY SUMMARY   A2022400 16:02:47

NPI              OSCAR

                                 PRAC      PRAC
SEL  NPI         OSCAR           EFF DT    TERM DT   ADDRESS          ZIP
S                                08102009  12319999
```

FIELD	DESCRIPTION
NPI	The National Provider Indicator number
OSCAR	The Provider Transaction Access Number (PTAN)
PRAC EFF DT	Practice Effective Date

FIELD	DESCRIPTION
PRAC TERM DT	Practice Termination Date
ADDRESS	Street address of the practice location
ZIP	Nine digit ZIP code of the practice location

To view the full practice address information, tab to the specific listing, enter "S" below the SEL field and press [ENTER].

Provider Practice Address Query Inquiry Screen – MAP1AB2



FIELD	DESCRIPTION
NPI	The National Provider Indicator number
OSCAR	The Provider Transaction Access Number (PTAN)
MNT: PECOS	The date the file was created in PECOS. Anything prior to 2017 will display December 19, 2016
PRAC EFF DT	Practice Effective Date
PRAC TERM DT	Practice Termination Date
PRAC ORIG EFF DT	Practice Original Effective Date
PRACTICE LOCATION KEY	The ID of the application approval. The first 8 digits are in the YYYYMMDD format

FIELD	DESCRIPTION
PECOS REC TYPE	Record Type
PECOS PBD	Provider-Based Department type
TYPE OF PRACTICE	The practice type
ADDRESS 1 AND 2	Street address of the practice location
ZIP	Nine-digit ZIP code of the practice location

NEW HCPC CODES – OPTION 1E

The New HCPC Codes inquiry screens are a replacement for the previous Option 14 function. It displays the same information as its predecessor in the same fields and format: coding/pricing information used to validate codes for outpatient services subject to fee schedule reimbursement. If the code is limited to certain revenue codes, those codes will be specified.

To view this information, enter the HCPCS code and the locality. Ordinarily, the locality code is 01. The specific locality can be found on the CMS Fee Schedules - General Information website, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo.

New HCPC Information Inquiry – MAP1E01

```
MAP1E01           MEDICARE CLAIMS OFFICE -
        SC              NEW HCPC INFORMATION INQUIRY
                                                          PAGE: 01
 CARRIER 03602  LOC 21  HCPC Q5115  MOD       IND    FEE TYPE OTHR
 EFF DT 070119  TRM DT          PROVIDER               DRUG OTHR

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

 070119        F 0




 HCPC DESCRIPTION
Injection, rituximab-abbs, biosimilar, (truxima), 10 mg


       PROCESS COMPLETED  ---   PLEASE CONTINUE
 PRESS PF3-EXIT PF5-UP PF6-DOWN PF11-RIGHT
```

The example above uses HCPC Q5115.

FIELD	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: D = Discharge Date F = From Date R = Receipt Date

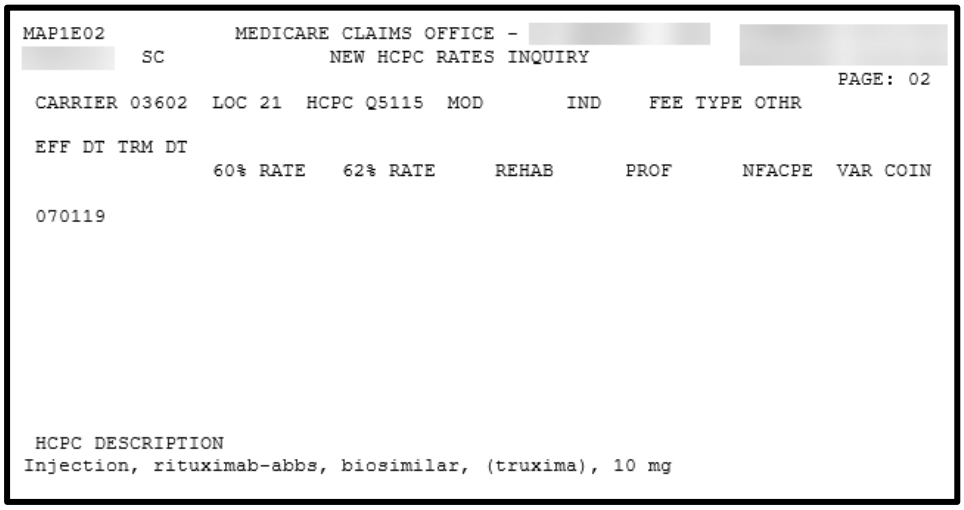
FIELD	DESCRIPTION
OVR	The override code instructs system in applying the services to the beneficiary deductible and coinsurance. Valid values are: 0 = Apply deductible and coinsurance 1 = Do not apply deductible 2 = Do not apply coinsurance 3 = Do not apply deductible or coinsurance 4 = No need for total 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 ‘ ‘ = Default value
OPH	Outpatient Hospital Indicator - This field identifies the outpatient hospital indicator that is received from CMS in the physician fee schedule abstract test file. This is a one-position alphanumeric field, with six occurrences. The valid values are: ' ' = Default value 0 = Fee is applicable 1 = Fee is not applicable
CAT	Category Code - This field identifies the CMS category of the DME equipment. This is a one-position alphanumeric field. The valid values are: 1 = Inexpensive or other routinely purchased DME 2 = DME items requiring frequent maintenance and substantial servicing 3 = Certain customized DME items 4 = Prosthetic and orthotic devices 5 = Capped rental DME items 6 = Oxygen and oxygen equipment

FIELD	DESCRIPTION
PCTC	Professional Component/Technical Component - This field identifies the PC/TC indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) services Supplemental Fee Schedule. The valid values are: 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 Unit Value. The valid values are 1-199.
TYP	Identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. This is a one-position alphanumeric field. The value values are: M = Originated from MPFS database files ‘ ' = Did not originate from the MPFS database files NOTE: 'M' indicates the claim is considered an MPFS claim and is edited based on the zip code of the provider master address record. If it’s an 'M' and the plus four flag of the 5-digit ZIP code record is a '1', then the provider master address must contain a valid 4-digit extension. The carrier and locality on the provider master address record and the carrier and locality of the ZIP code file must match. Otherwise, the claim receives an edit.

FIELD	DESCRIPTION
MSI DESCRIPTOR	MSI - This field identifies the Multiple Service Indicator.
ALLOWABLE REVENUE CODES	The allowable revenue code(s) that this particular HCPC code may use in billing. This is a four-position alphanumeric field and can have up to ten occurrences. The fourth digit of the revenue code may be stored with an 'X' indicating that it is a variable. For example, by storing the revenue code '029X', the system allows this HCPC code with any revenue code that begins with '029'. By leaving this field blank, the system allows a HCPC code on any revenue code.
HCPC DESCRIPTION	The narrative description of the HCPC code.

Press [F11] to move to additional rate information, which is contained on MAP1E02.

New HCPC Rates Inquiry – MAP1E02



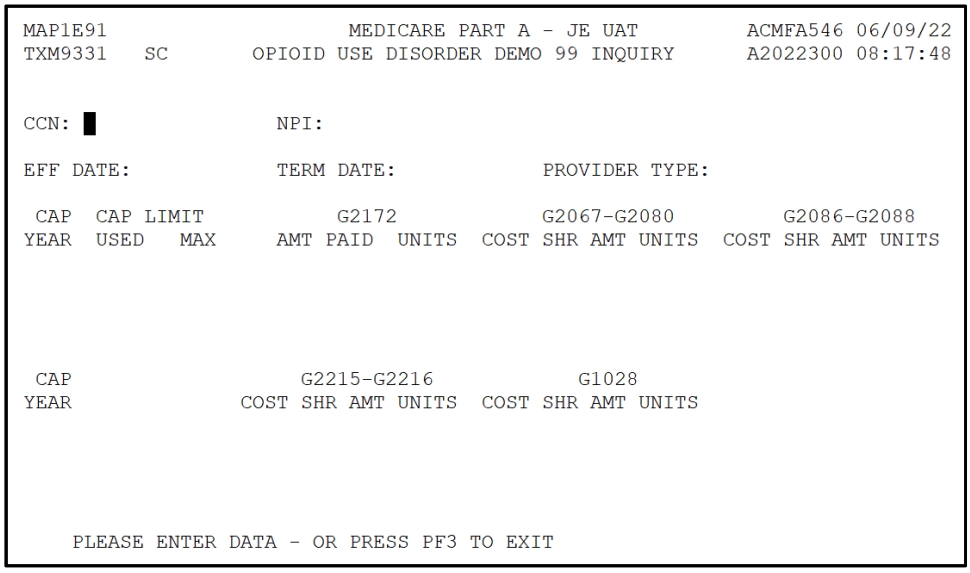
FIELD	DESCRIPTION
CARRIER	The Carrier number assigned to the HCPC being displayed. The payment allowances for HCPCS paid on a fee schedule are determined by the local Carrier and supplied to the intermediary/ A/B MAC.
LOC	The locality within the state where the provider is located.
HCPC	The Common Procedure Code being reviewed.
MOD	HCPC modifier. This identifies multiple fees based on the presence or absence of a valid modifier.
IND	Not used.
EFF DATE	The National Drug Code (NDC) effective date.

FIELD	DESCRIPTION
TRM DATE	The National Drug Code (NDC) termination date.
60% RATE	The rate the system uses for calculating reimbursement for the lab HCPCS codes. The system displays 60% of the total charges.
62% RATE	The rate the system uses for calculating reimbursement for the lab HCPCS codes. The system displays 62% of the total charges.
REHAB	The rate the system uses for calculating reimbursement for the HCPCS code when rehabilitation services are billed.
PROF	The rate the system uses for calculating reimbursement for the HCPCS code when professional services are billed by Method II CAHs.
NFACPE	NFACPE - This field identifies the Non-Facility PE RVU Rate.
VAR COIN	The Variable Coinsurance rate for the applicable lab code.
NEW	Purchase Price New - This field identifies the price for the DME item if it was purchased new.
RENTAL	Monthly Rental Amount - This field identifies the monthly rental charge in dollars for this particular DME HCPC code.
USED	Purchase Price Used - This field identifies the price for the DME item if it was purchased used.

OUD DEMO 99 – OPTION 1F

The OUD DEMO 99 option was added as an inquiry function for providers who are participating in the Opioid Use Disorder Treatment Demonstration Model. This new function includes the new Opioid Use Disorder Demo 99 screen MAP1E91, which is searchable using a provider CCN and NPI combination. The Effective Date, Term Date and Provider Type information will appear below. In the middle of the screen are columns with Provider CAP information and the amounts and number of claims paid for OUD Model HCPCS, listed by CAP year.

Opioid Use Disorder DEMO 99 Inquiry – MAP1E91



FIELD	DESCRIPTION
CCN	CMS Certification Number
NPI	National Provider Identifier
EFF DATE	Effective Date
TERM DATE	Term Date
PROVIDER TYPE	Provider Type
CAP YEAR	CAP Year
CAP LIMIT USED	Current number of claims billing HCPC G2172 for that Provider in that CAP Year
CAP LIMIT MAX	Maximum number of claims billing HCPC G2172 that can be billed for that Provider in that CAP Year
G2172 AMT PAID	Total Amount Paid for HCPC G2172
G2172 CLMS	Total Amount Paid for HCPC G2172
G2067-G2080 COST SHR AMT	Total Cost Sharing Amount for HCPCS G2067-G2080
G2067-G2080 CLMS	Total Claims Paid for HCPCS G2067-G2080

FIELD	DESCRIPTION
G2086-G2088 COST SHR AMT	Total Cost Sharing Amount for HCPCS G2086-G2088
G2086-G2088 CLMS	Total Claims Paid for HCPCS G2086-G2088
G2215-G2216 COST SHR AMT	Total Cost Sharing Amount for HCPCS G2215-G2216
G2215-G2216 CLMS	Total Claims Paid for HCPCS G2215-G2216

CHAPTER FOUR – CLAIMS ENTRY

This section provides information on entering UB-04s, electronic Roster Bills, and the ESRD CMS Form 382 (ESRD Selection Form) in the Direct Data Entry (DDE) format.

Note: The Claims and Attachments Entry Menu (Main Menu option 02) includes options for completing Home Health, Hospice and NOE/NOA forms as well as Home Health and DME History attachments. However, the only options that should be selected for DDE transmission to Noridian at this time are the Inpatient, Outpatient and SNF claims entry, Roster Bill entry and the ESRD form.

Claim and Attachment Entry Menu – MAP1703

```
MAP1703                    MEDICARE PART A -
                    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
```

Claims Entry – Options 20, 22, and 24

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

Enter the NPI on claims page 3.

The 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, type over the default with the correct type of bill.

The "UB-04 X-REF" field on the documentation below directs you to the UB-04 field that corresponds with the DDE field. The UB-04 data elements and definitions can be found in the CMS IOM Publication 100-04, Claims Processing Manual, Chapter 25 webpage, http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf.

When entering information, remember to [TAB] among the fields until you have completed the screen. To move on to the next screen/page, press [F8].

Depending on the TOB, the cursor may skip fields that are not required.

If you press [F3] while you are in the middle of entering your claim, you will lose all the information you just keyed and the system will take you back to the menu screen. Only the information that was entered since you last suspended a claim by pressing the [F9] key will be lost.

Not all fields appearing on the screens need to be completed. They are being included in this information for reference only. In many cases, the type of bill entered will drive edits that will cause the tab key to automatically move to the next required field. In the chart below, those fields that are required or situationally required will be identified with an "R" or "S". For additional information about entry requirements, refer to the instructions in the CMS IOM Publication 100-04, Claims Processing Manual, Chapter 25 webpage, http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf.

Unless otherwise specified, dates are entered in MMDDYY format.

When entering numbers, it is not necessary to enter the leading zeros in fields with room for multiple characters; the numbers will right justify automatically. For example, it is not necessary to enter 00005.00, simply enter 5.00 and the data will zero fill from the beginning to fill the available spaces.

Transmitting Data

When you have completed the UB-04 claim screens, press [F9] to update 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.

, mNote: Because many of the UB-04 fields are interrelated, the edits cannot always determine which field is in error; it can only determine that the logic among the related field does not work. If the data in the field corresponding to the edit is correct, check other related fields for missing or incorrect data.

Correcting Reason Codes

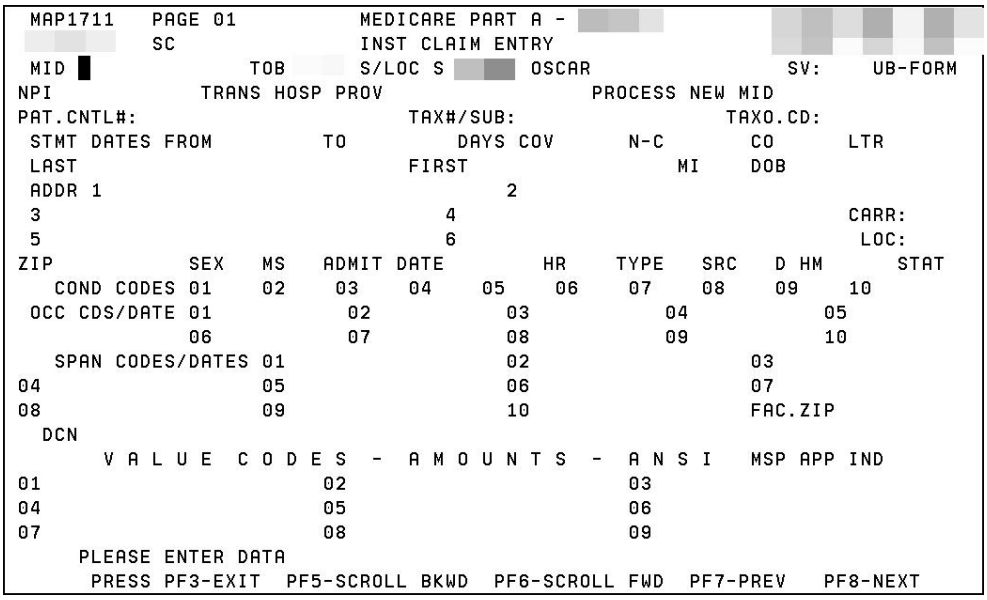
When a reason code appears in the lower left corner of the screen, press [F1] to see an explanation of the reason code. After reviewing the explanation, press [F3] to return to your claim and make the necessary corrections. If more than one reason code appears, continue this process until all reason codes are eliminated and the claim is successfully captured by the system.

If more than one reason code is present, pressing the [F1] key will always bring up the explanation of the first reason code unless the cursor is positioned over one of the other reason codes, or unless a new reason code is typed over the first one on the reason code narrative screen. 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.

Cancel Method

If, after beginning to enter claim data, you decide that you do not wish to continue keying the claim information, press [F3]. This action will delete the claim transmission from DDE and return you to the Claims and Attachments submenu.

Claims Entry Screen 1 – MAP1711



FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
SV - S	(Not Applicable)	Suppress View - This field allows a claim to be suppressed. Use this field ONLY for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03).
MID - R	60	The beneficiary's Medicare ID number.
TOB - R	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
OSCAR - R	51	The provider number of the facility that is billing for the services provided. If your access identification number is assigned to multiple provider numbers, check this field to be sure the correct number appears.
UB-FORM	(Not Applicable)	UB Form - This field identifies the type of claim form. A = UB-04
NPI - R	56	The National Provider Identifier number.
TRANS HOSP PROV - A	(Not Applicable)	The identification number of the institution which rendered services to the beneficiary /patient. It is system generated for external operators that are directly associated with one provider.
PROCESS NEW MID - S	60	Process New Medicare ID Number. Use this field ONLY in for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03).

PATIENT STAY INFORMATION

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
PAT.CNTL# - R	3	Patient Control Number - the patient's number assigned by the provider.
FED TAX NO/SUB - A	5	Federal Tax Number - the number assigned to the provider by the Federal Government for tax reporting purposes. Also known as a tax identification number (TIN) or an employer identification number (EIN).
TAXO.CD - R	81	The Health Care Provider Taxonomy Code - 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 FROM - R	6	Statement Dates From - the beginning service date of the period included on this claim.
TO - R	6	Statement Dates To – the ending service date of the period included on this claim.
DAYS COV – R - Inpatient	39	Days Covered - the number of days covered by Medicare.
N-C – R – Inpatient	39	Non-Covered Days - the number of days not covered by Medicare.
CO - S	39	Coinsurance Days – the covered inpatient Medicare days occurring exhaustion of the paid in full days.
LTR - S	39	Lifetime Reserve Days - Under the Medicare program, each beneficiary has a lifetime reserve of 60 LRD additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.

PATIENT INFORMATION

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
LAST - R	8	Last Name - the patient's last name at the time services were rendered. Enter the patient name as it appears on the Medicare card.
FIRST - R	8	First Name - the patient's first name. Enter the patient name as it appears on the Medicare card.
MI	8	Middle Initial - the patient's middle initial. Not Required.
ADDR - R	9	Address - This field identifies the patient's street address including the house number, post office box number, and/or apartment number, the patient's city address, and the patient's state address abbreviation.
CARR - A	(Not Applicable)	Carrier – the identification number of the Medicare carrier as designated by the CMS. The carrier and locality information are associated with the nine-digit service facility zip code on the claim.
LOC - A	(Not Applicable)	Locality – the specific locality of a provider in a state under the carrier's jurisdiction.
ZIP - R	9	ZIP Code - the patient's ZIP code address.
DOB - R	10	Date of Birth - the patient's date of birth.
SEX - R	11	Sex - This field identifies the patient's sex as recorded at the time services were rendered. The valid values are: F = Female M = Male U = Unknown

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
MS	(Not Applicable)	Marital Status - the patient's marital status at the time services were rendered. Not Required. The valid values are: S = Single M = Married X = Legally separated D = Divorced W = Widowed U = Unknown

ADMISSION DATA

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
ADMIT DATE - R - Inpatient	12	Admission Date - the date of the patient's admission to this provider.
HR	13	Admission Hour.
TYPE - R - Inpatient	14	Admission Type - the priority of admission. The valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
SRC - R	15	Source of Admission - the way a patient was referred to the hospital for admission. The valid values are: 1 = physician referral 2 = Clinical referral 4 = Transfer from a hospital 5 = Transfer from a SNF (Skilled Nursing Facility) 6 = Transfer from another health care facility 7 = Emergency room 8 = Court/law enforcement 9 = Information not available B = Transfer from another Home Health Agency C = Readmission to the same Home Health Agency D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer E = Transfer from Ambulatory Surgical Facility F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
D HM	16	Discharge Hour and Minutes.
STAT - R	17	Patient Status - the code indicating the patient's status at the ending service date in the period.
COND CODES - S	18-28	Condition Codes - the codes used to identify conditions relating to the claim that may affect payer processing.
OCC CDS/DATE - S	31-34	Occurrence Codes and Dates - identifies a significant event relating to payment of this claim.

FIELD R = Required S = Situational A = System filled	UB-04 X-REF	DESCRIPTION
SPAN CODES/DATES - S	35-36	Occurrence Span Codes and Dates (From/Through) - identify events that relate to the payment of the claim. The date identifies the commencement and ending of an event that relates to the payment of the claim.
FAC.ZIP - S	(Not Applicable)	Facility Zip Code – This field identifies the provider or subpart zip code.
DCN - A	(Not Applicable)	Adjusting Document Control Number - This field displays the identification number of which the claim being processed is adjusting.
VALUE CODES/AMOUNTS - S	39-41	Value codes and Amounts - code that identifies data, usually of a monetary nature, that is necessary for processing the claim. The value amount entered in a monetary format with whole numbers to the left of the delimiter.
ANSI - A	(Not Applicable)	ANSI codes associated with the value code amount. The ANSI codes and amounts are forwarded to the financial system for remittance processing.
MSP APP IND - A	(Not Applicable)	MSP Apportion Indicator - This field identifies to the MSP PAY module whether the system apportions the primary payer's amount and the OTAF amounts (if present). The valid values are: ' ' = Apportion N = Do not apportion.

Claims Entry Screen 2 – MAP1712

```
MAP1712   PAGE 02          MEDICARE PART A - JE UAT          ACMFA546 09/06/23
KXB1907   SC              INST CLAIM INQUIRY                A2023400 17:05:17
                                                    REV CD PAGE 01
MID              TOB 771  S/LOC P B9997  PROVIDER
UTN                  PROG       REP PAYEE    RRB EXCL IND    PROV VAL TYPE
CL  REV  HCPC MODIFS   RATE      TOT UNITS  COV UNITS   TOT CHARGE  SERV DATE
                                                       NCOV CHARG  RED IND
 1 0521 G0467                   0000000001 0000000001       200.00 112022

 2 0521 99213                   0000000001 0000000001       300.00 112022

 3 0001                                                     500.00




37192                                                        <== REASON CODES
     PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

If additional revenue lines are needed, press [F6] to go to additional entry screens.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MID - A	60	The beneficiary's Medicare ID number.
TOB - A	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER - A	51	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
CL - R	(Not Applicable)	Claim Line Number - This field identifies the line number of the revenue code.
REV - R	42	Revenue Code - This field identifies the code for a specific accommodation or service that was billed on the claim. NOTE: When correcting a claim under the Claims Correction or Adjustment Menus, to delete a Revenue Code line, place a 'D' in the first position of the affected line, position the cursor on the page number field, press [ENTER]. To add a Revenue Code line, pass the 0001 line, add the Revenue Code, position the cursor on the page number field, press [ENTER].
HCPC - S	44	Health Care Common Procedure Coding - identifies certain medical procedures or equipment for special pricing. The field also is used to report HIPPS codes for Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) claims.
MODIFS - S	44	Common Procedure Coding System Modifier - This field identifies the HCPCS modifier codes. If more than two modifiers are needed, additional modifiers can be entered on the line item detail screen.
RATE - S	44	Rate - a per unit cost for a particular revenue code line item.
TOT UNT – R	44	Total Units - Units of service is a quantitative measure of service rendered by revenue category.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
COV UNT - S	44	Covered Units - Units of service is a quantitative measure of service rendered by revenue category.
TOT CHARGES	47	Total Charges - identifies the total amount of charges for a particular revenue line identifying a specific service for the current period.
NCOV CHARGES	47	Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line.
SERV DT	45	Line Item Date of Service.

Claims Entry Screen 2A Line-Item Detail – MAP171D

This screen contains information explaining how each line item was processed. If space is needed for additional HCPCS code modifiers, they can be entered on this page. Access this code from the charge screen, claims entry screen 2, by pressing [F2].

Line-Item Detail – MAP171D

```
MAP171D   PAGE 02          MEDICARE PART A - JE UAT          ACMFA546 09/06/23
KXB1907   SC               INST CLAIM INQUIRY                A2023400 17:09:58
DCN                          MID                RECEIPT DATE 120622  TOB 771
STATUS P  LOCATION B9997     TRAN DT 120922     STMT COV DT 112022   TO 112022
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
   1    HCPC/MOD IN    SERV                              -----REASON-CODES------
 REV  HCPC MODIFIERS   DATE  COV-UNT   COV-CHRG   ADR
0521 G0467            112022                        FMR
                                   1       200.00
ORIG                       ORIG REV          MR      ODC
OCE OVR 0 CWF OVR   NCD OVR   NCD DOC   NCD RESP   NCD#          OLUAC
        NON         NON       DENL  OVER ST/LC MED ------------ANSI-----------
LUAC  COV-UNT    COV-CHRG    REAS  CODE OVER  TEC ADJ GRP ------REMARKS------




 TOTAL                          LINE ITEM REAS CODES
37192                                                    <== REASON CODES
     PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
UNTITLED	(Not Applicable)	The revenue line number from the claim charge screen.
DCN - A	(Not Applicable)	Document Control Number assigned by DDE.
MID - A	60	The beneficiary's Medicare ID number.
RECEIPT DATE -A	(Not Applicable)	The date the claim was received.
TOB - A	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOCATION - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
TRAN DT - A	(Not Applicable)	Transaction date – system assigned.
STMT COV DT -A	6	Statement Covers From date.
TO - A	6	Statement Covers To date.
PROVIDER ID - A	51	The identification number of the Provider submitting the claim.
BENE NAME - A	8	The name of the Beneficiary.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
NONPAY CD - A	(Not Applicable)	The reason for Medicare's decision not to make payment.
GENER HARDCOPY - A	(Not Applicable)	This field instructs the system to generate a specific type of hard copy document.
MR INCLD IN COMP - A	(Not Applicable)	Composite Medical Review Included In The Composite Rate - For ESRD bills, this field identifies if the claim has been denied because the service should have been included in the Comp Rate. The valid value is: Y = The claim has been denied
CL MR IND - A	(Not Applicable)	Complex Manual Medical Review Indicator – This field identifies if all services on the claim 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 medical review.
TPE-TO-TPE - A	(Not Applicable)	Tape-to-Tape Flag - This field identifies the tape-to-tape flag (if applicable).
WAIV IND - A	(Not Applicable)	Waiver Indicator - This field identifies whether the provider has a presumptive waiver status. The valid values are: Y = The provider does have a waiver status. N = The provider does not have a waiver status
MR REV URC - A	(Not Applicable)	Medical Review Utilization Review Committee Reversal - This field indicates whether an SNF URC Claim has been reversed. The valid values are: P = Partial reversal F = Full reversal, the system reverses all charges and days

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
DEMAND - A	(Not Applicable)	Medical Review Demand Reversal - This field identifies if a SNF demand claim has been reversed. The 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 - A	(Not Applicable)	Reject Code - The reason code for which the claim is being denied.
MR HOSP RED - A	(Not Applicable)	Medical Review Hospice Reduced - This field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. The valid values are: ' ' = Not reduced Y = Reduced
RCN IND - A	(Not Applicable)	Reconsideration Indicator - This field used only for home health claims. The valid values are: A = Finalized count affirmed B = Finalized no adjustment count (pay per waiver) R = Finalized count reversal (adjustment) U = Reconsideration
MR HOSP-RO - A	(Not Applicable)	Medical Review Regional Office Referred - This field identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. The valid values are: ' ' = Not referred Y = Referred
ORIG UAC - A	(Not Applicable)	Original User Action Code - the original user action code.
MED REV RSNS - A	(Not Applicable)	Medical Review Reasons - a specific error condition relative to medical review.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
OCE MED REV RSNS - A	(Not Applicable)	This field identifies the edit returned from the OPPS version of OCE. The valid values are: 11 = Non-covered service submitted for review (condition code 20). 12 = Questionable covered service. 30 = Insufficient services on day of partial hospitalization. 31 = Partial hospitalization on same day as electro convulsive therapy or type T procedure. 32 = Partial hospitalization claim spans three 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 three days with insufficient number of days having mental health services.
REV - A	42	Revenue Code - the code for a specific accommodation or service.
HCPC - A	44	HCPCS/CPT code describing service provided.
MODIFIERS - S	44	The HCPCS modifier codes.
SERV DATE - A	45	The line item date of service.
COV-UNT - A	46	The covered units billed by revenue code.
COV-CHRG - A	47	The total amount of covered charges for the revenue line.
ADR REASON CODES - A	(Not Applicable)	Additional Development Reason - the ADR reason codes uses to create the appropriate reason code narrative on ADR letters.
FMR REASON CODES - A	(Not Applicable)	Focused Medical Review Suspense Codes - This field identifies when a claim is edited in the system, based on a Medical Policy parameter.
ODC REASON CODES - A	(Not Applicable)	Original Denial Reason Codes.
ORIG - A	44	Original HCPC and Modifiers Billed.
ORIG REV - A	42	Original Revenue Code.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MR - A	(Not Applicable)	Complex Manual Medical Review Indicator – This field identifies if all services on the claim 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 medical review.
OCE OVR - A	(Not Applicable)	OCE Override - This field overrides the way the OCE module controls the line item.
CWF OVR - A	(Not Applicable)	CWF Home Health Override.
NCD OVR - A	(Not Applicable)	National Coverage Determinations Override Indicator - This field identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. The valid values are: ' ' = The NCD edits are not bypassed, (default value) Y = The line has been reviewed for medical necessity and bypasses the NCD edits. D = The line has no covered charges and bypass's the NCD edits.
NCD DOC - A	(Not Applicable)	National Coverage Determination Documentation Indicator – identifies whether the documentation was received for the medically necessary service. The valid values are: Y = The documentation supporting the medical necessity was received. N = The documentation supporting the medical necessity was not received, (default value.)

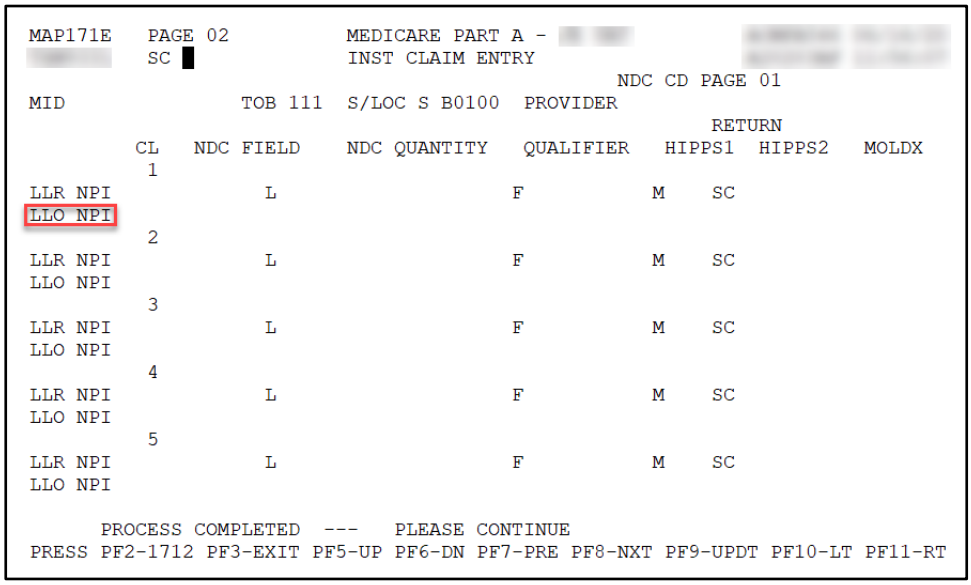
FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
NCD RESP - A	(Not Applicable)	National Coverage Determination Response Code –The valid values are: ' ' = Set to space for all lines on resubmitted RTP'D claims 0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria. 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 # - A	(Not Applicable)	National Coverage Determination Number.
OLUAC - A	(Not Applicable)	Original Line User Action Code.
LUAC - A	(Not Applicable)	Line User Action Code.
NON COV-UNT - A	(Not Applicable)	Non-Covered Units - Units of service is a quantitative measure of service rendered by revenue category.
NON COV-CHRG - A	48	Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
DENIAL REAS - A	(Not Applicable)	Denial Reason - the cause of denial for the revenue code line.
OVER CODE - A	(Not Applicable)	ANSI Override Code - the override code that allows the operator to manually override the system generated ANSI codes.
ST/LC OVER - A	(Not Applicable)	Status Location Override - the override of the reason code file status when a line item has been suspended.
MED TEC - A	(Not Applicable)	Medical Technical Denial Indicator - This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. The valid values are: M = Medial 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
ANSI ADJ - A	(Not Applicable)	ANSI Adjustment Reason Code.
ANSI GRP - A	(Not Applicable)	ANSI Group Code.
ANSI REMARKS - A	(Not Applicable)	ANSI Remarks Code.
TOTAL - A	(Not Applicable)	The total of all revenue code non-covered units and charges present on MAP171D.
LINE ITEM REASON CODES - A	(Not Applicable)	Line Item Reason Code - This field identifies the reason code that is assigned out of the system for suspending the line item.

Claims Entry Screen 2B – National Drug Code (NDC) Information MAP 171E

Hospitals subject to OPPS must include NDC information for drugs coded with HCPCS code C9399, and all hospital outpatient departments who serve patients who are dually eligible for Medicare and Medicare need to include the NDC, corresponding amounts and qualifiers on crossover claims. This information is added on MAP 171E in the corresponding line item of the drug code, which can be accessed from the charge screen, MAP1217, by pressing [F11], or from MAP171A by pressing [F10]. To return to the charge screen, press [F10]. The newest addition to this screen is the LLO NPI field, which displays the NPI of the Ordering physician.

National Drug Code Information – MAP171E



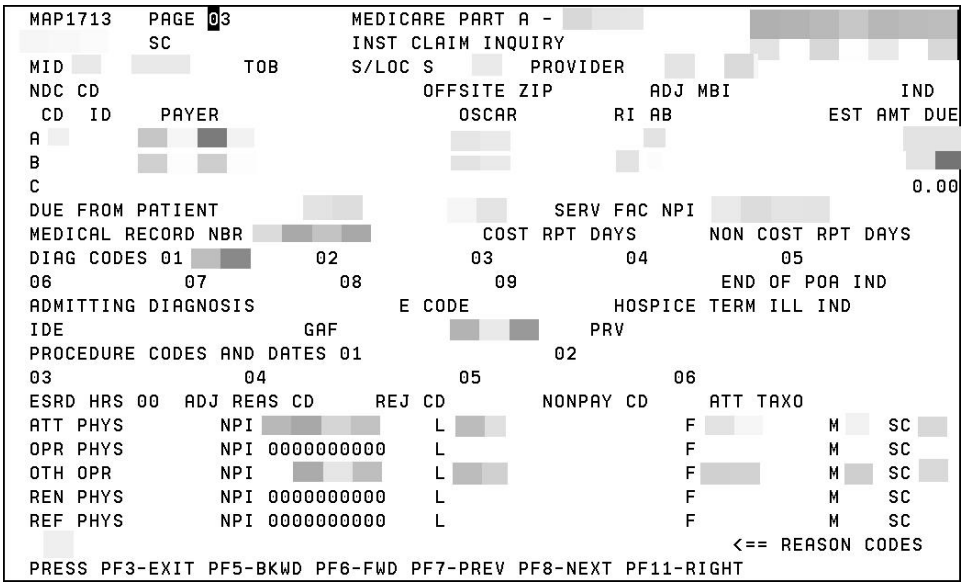
```
MAP171E   PAGE 02          MEDICARE PART A -
          SC               INST CLAIM ENTRY
                                                NDC CD PAGE 01
MID              TOB 111   S/LOC S B0100   PROVIDER
                                                    RETURN
          CL   NDC FIELD    NDC QUANTITY   QUALIFIER   HIPPS1  HIPPS2   MOLDX
           1
LLR NPI              L                    F           M    SC
LLO NPI
           2
LLR NPI              L                    F           M    SC
LLO NPI
           3
LLR NPI              L                    F           M    SC
LLO NPI
           4
LLR NPI              L                    F           M    SC
LLO NPI
           5
LLR NPI              L                    F           M    SC
LLO NPI

      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DN PF7-PRE PF8-NXT PF9-UPDT PF10-LT PF11-RT
```

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MID - A	60	The beneficiary's Medicare ID number.
TOB - A	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER - A	51	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
CL - A	(Not Applicable)	Code line number.
NDC FIELD - R	(Not Applicable)	National Drug Code- 11 digit number. Only one NDC will cross to the secondary payer; providers will need to supply any additional NDCs directly to the secondary payer.
NDC QUANTITY - R	(Not Applicable)	The quantity amount of the drug represented by the NDC code, based on HCPCS description and the amount distributed to the patient. Enter the decimal point if necessary. If there is not a dollar amount, enter a zero before the decimal.
QUALIFIER - R	(Not Applicable)	NDC Qualifier – The valid values are: F2 = International Unit FR = Gram ML = Milliliter UN = Units
MOLDX - S	(Not Applicable)	Molecular Diagnostic Services – Enter the DEX Z-Code™ identifier

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
LLR NPI	(Not Applicable)	Line Level Rendering Physician NPI
LLO NPI	(Not Applicable)	Line Level Ordering Physician NPI

Claims Entry Screen 3 – MAP1713



Lines A, B and C under the CD, ID, Payer, Oscar, RI, AB, and EST AMT DUE fields correspond to the primary, secondary, or tertiary payer ranking.

FIELD	DESCRIPTION
MID	The beneficiary's Medicare ID number.
TOB	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.

FIELD	DESCRIPTION
STATUS	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
OFFSITE ZIPCD	Identifies offsite Clinic/Outpatient department zip codes. It determines the claim line HPSA/PSA bonus eligibility.

FIELD	DESCRIPTION
CD	Payer Code – Valid values are: 1 = Medicaid secondary 2 = Blue Cross secondary 3 = Other secondary 4 = None A = Working Aged (value code 12) B = ESRD beneficiary in 18-month coordination period with (value code 13) C = Conditional Payment D = Auto no-fault (value code 14) E = Workers Compensation (value code 15) F = Public Health of Federal Agency (value code 16) G = Disabled (value code 43) H = Black Lung (value code 41) I = Veterans Administration (value code 42) L = Liability (value code 47) Z = Medicare
ID	Payer ID - not used at this time.
PAYER	Payer name identifying each payer organization from which the provider might expect some payment.
OSCAR	The provider number of the facility that is billing for the services provided.
RI	Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are: R = Restricted or modified release N = No release
AB	Assignment of Benefits – identifies whether or not the provider has a signed form authorizing the third-party payer to pay the provider. The valid values are: Y = Yes N = No

FIELD	DESCRIPTION
EST AMT DUE	Estimated Amount Due - This field identifies the amount estimated by the provider to be still due from the indicated payer (estimated responsibility less prior payments).
DUE FROM PATIENT	Due from Patient - Entry only in Prior Payments portion of this field.
MEDICAL RECORD NBR	Identifies the number assigned to the patient's medical/health record by the provider.
COST RPT DAYS	Cost Report Days - This field identifies the number of days claimable as Medicare patient days for inpatient and SNF types of bills. The system calculates this field and generates the applicable data.
NON COST RPT DAYS	Non-Cost Report Days - This field identifies the number of days not claimable as Medicare patient days.
DIAGNOSIS CODES	The ICD-9-CM code(s) describing the principal diagnosis (first code) and additional conditions (codes two through nine) that co-exist at the time of admission or develop subsequently. Each diagnosis code is a six-position alphanumeric field, with two additional positions with the 7th being blank, and the 8th position is the first character of the Present On Admission (POA) Indicator for every principal and secondary diagnosis effective with discharges. The POA Indicator identifies whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The valid values for the POA Indicator are: Y = Yes, Present at the time of inpatient admission. N = No, not present at the time of inpatient admission. U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission. W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not. 1 = Unreported/not used, exempt from POA reporting – This code is the equivalent code of a blank on the UB04, however, it is determined that blanks are undesirable when submitting the data via the 4010A1. ' ' = Not acute care, POA's do not apply
END OF POA INDICATOR	End of POA Indicator – 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 diagnoses. X = The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' = Not acute care, POA's do not apply

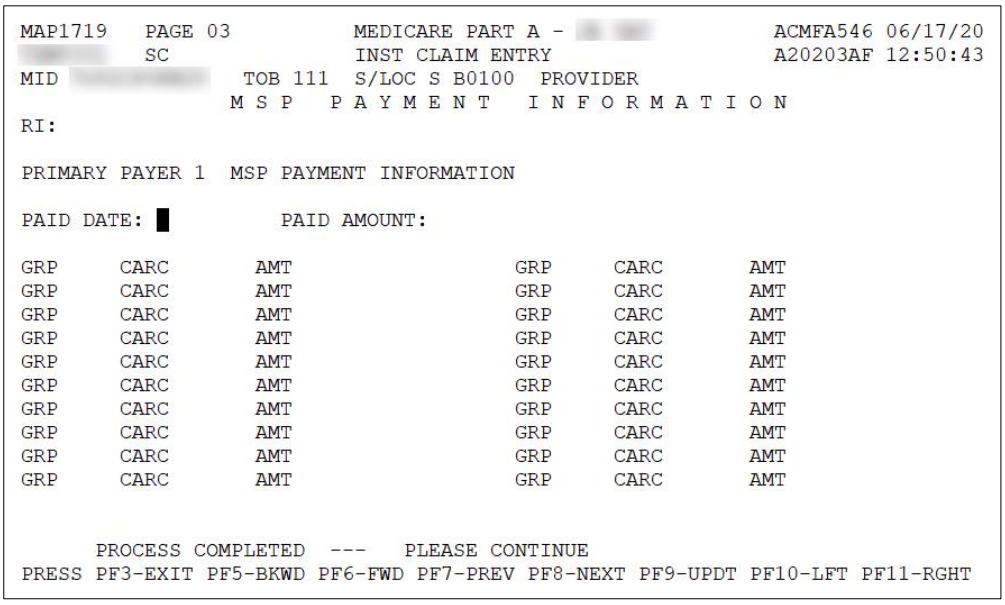
FIELD	DESCRIPTION
ADMITTING DIAGNOSIS	The ICD-9-CM code describing the inpatient condition at the time of the admission.
E-CODE	The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
HOSPICE TERM ILL IND	Identifies whether or not a hospice patient has a terminal illness. It is only used for hospice claims.
IDE	Investigational Device Exemption Number (IDE) – the IDE authorization number assigned by the FDA.
PROCEDURE CODES AND DATES	Identifies the principal procedure (first code) and other procedures (codes two through six) performed, and dates on which they occurred. This field is required for inpatient claims where a surgical procedure is performed.
ESRD HOURS	End Stage Renal Disease Hours - the number of hours of certain dialysis treatments such as peritoneal.
ADJUSTMENT REASON CODE	Identifier for the type of adjustment being performed. Enter “16” in the SC field in the upper left corner of the screen to access a listing of codes.
REJECT CODE	The reason code for which the claim is being non-medically denied.
NON PAY CODE	The reason for Medicare's decision not to make payment.
ATT PHYS	Attending Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Attending physician’s NPI number.
LN	Attending physician’s last name.
FN	Attending physician’s first name.
MI	Attending physician’s middle initial.
SC	Specialty Code - This field identifies the specialty code.
OPER PHYS	Operating Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Operating physician’s NPI number.
LN	Operating physician’s last name.
FN	Operating physician’s first name.
MI	Operating physician’s middle initial.

FIELD	DESCRIPTION
SC	Specialty Code - This field identifies the specialty code.
OTH PHYS	Other Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Other physician's NPI number.
LN	Other physician's last name.
FN	Other physician's first name.
MI	Other physician's middle initial.
SC	Specialty Code - This field identifies the specialty code.
OTH PHYS	Other Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician.
NPI	Other physician's NPI number.
LN	Other physician's last name.
FN	Other physician's first name.
MI	Other physician's middle initial.
SC	Specialty Code - This field identifies the specialty code.
REN PHYS	Rendering Physician/UPIN Code - This field identifies the physician identification number or the UPIN number of the rendering licensed physician.
NPI	Rendering Physician NPI Number– This field identifies the National Provider Identifier number.
L	Last Name - This field identifies the last name of the rendering physician
F	First Name - This field identifies the first name of the rendering physician
M	Middle Initial - This field identifies the middle initial of the rendering physician.
SC	Specialty Code - This field identifies the specialty code.
REF PHYS	Referring Physician/UPIN Code - This field identifies the physician identification number or the UPIN number of the referring licensed physician.
NPI	Referring Physician NPI Number– This field identifies the National Provider Identifier number.
L	Last Name - This field identifies the last name of the referring physician
F	First Name - This field identifies the first name of the referring physician

FIELD	DESCRIPTION
M	Middle Initial - This field identifies the middle initial of the referring physician.
SC	Specialty Code - This field identifies the specialty code.

Claims Entry Screen 3 – MAP1719

The new DDE screen MAP1719 – MSP Payment Information – is used for claim level adjustments and the Coordination of Benefits (COB) payer paid amounts. To access MAP1719, press F11 from page 3 (MAP1713). MAP1719 can display up to two MSP Payment information records. Press F6 from this page to access the second record (if applicable).



FIELD	DESCRIPTION
RI	Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are: R = Restricted or modified release N = No release
PAID DATE	The date that the provider received payment from Primary Payer 1. This is a six-position alphanumeric field in MMDDYY format. PF6 and PF7 to scroll forward and backward between the screen for Primary Payer 1 and Primary Payer 2.
PAID AMOUNT	The payment the provider received from Primary Payer 1. This is an eleven-position numeric field in 999999999.99 format.

FIELD	DESCRIPTION
GRP	ANSI group codes. This is a two-position alphanumeric field, with 20 occurrences.
CARC	ANSI CARC codes. This is a four-position alphanumeric field, with 20 occurrences.
AMT	The dollar amount associated with the group/CARC combination. This field is an eleven-position numeric field in 999999999.99 format, with 20 occurrences.

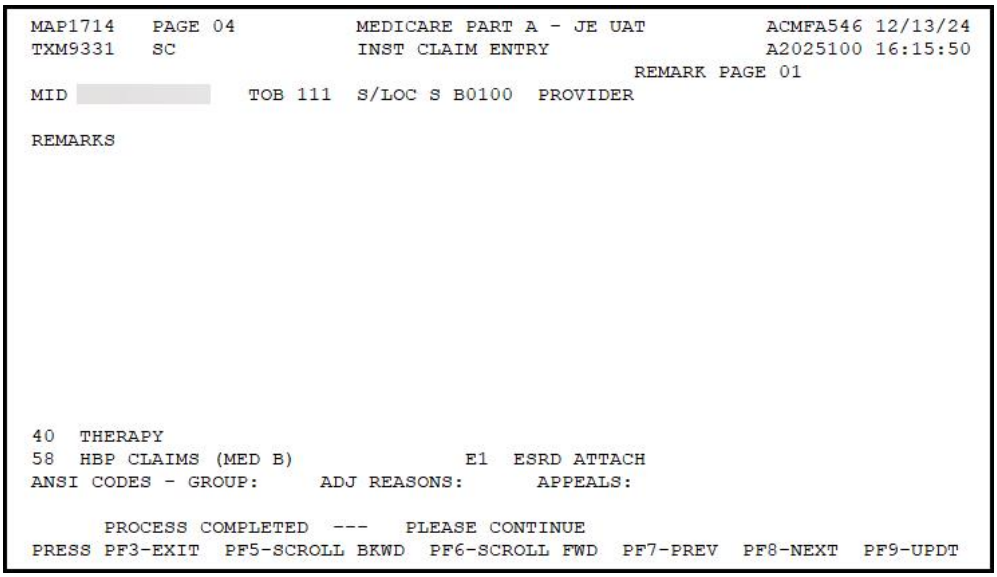
Claims Entry Screen 3 – MAP171F

```
MAP171F   PAGE 03          MEDICARE PART A -              ACMFA546 06/16/20
          SC               INST CLAIM ENTRY               A20203AF 14:29:33

MID                  TOB 131  S/LOC S B0100  PROVIDER
      P R O V I D E R   P R A C T I C E   L O C A T I O N   A D D R E S S

ADDRESS 1:

ADDRESS 2:

CITY     :                                  STATE:      ZIP:









      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT PF11-RIGHT
```

FIELD	DESCRIPTION
MID	The Health Insurance Claim (HIC) Number or Medicare Beneficiary Identifier (MBI) assigned to the beneficiary by CMS. This is a twelve-position alphanumeric field.
TOB	The type of bill. This is the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field.
S	The status of the claim (e.g., good, suspended, inactive). The location field is subsequent. This is a one-position alphanumeric field.
LOC	the location of where the claim resides in the system. This is a five-position alphanumeric field.
ADDRESS 1	The Service Facility address 1. This is a 55-position alphanumeric field.
ADDRESS 2	The Service Facility Address 2. This is a 55-position alphanumeric field.
CITY	The Service Facility City. This is a 30-position alphanumeric field.

FIELD	DESCRIPTION
STATE	The Service Facility State. This is a two-position alphanumeric field.
ZIP	The Service Facility Zip. This is a 15-position alphanumeric field.

Claims Entry Screen 4 – MAP1714



Remarks can be entered by provider staff (and by Noridian staff) and are used to add clarifying information. They become part of the permanent claim record. It is not necessary to use complete sentences, but the information should be easily understandable, and any abbreviations should be commonly used. Add your initials and the date the remarks are added to each entry.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MID	60	The beneficiary's Medicare ID number.
TOB - A	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER - A	51	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
REMARKS - A	(Not Applicable)	Information submitted by providers or contractor staff to provide permanent comments regarding special considerations that affect adjudicating the claim. Common abbreviations are acceptable. End each entry with your initials and the date. Addition space is available by pressing [F6].
ZIP - A	(Not Applicable)	Identifies the zip code.
40 THERAPY	(Not Applicable)	Therapy Attachment – not used.
41 HOME HEALTH	(Not Applicable)	Home Health Attachment – not used.
58 HBP CLAIMS	(Not Applicable)	Hospital-based Physician Attachment – not used.
ANSI CODES-GROUP - A	(Not Applicable)	General category of payment adjustment. Used for claims submitted in an ANSI automated format only.

FIELD R = Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
ADJ REASONS - A	(Not Applicable)	Claim adjustment standard reason code identifying the detailed reason the adjustment was made. This is a three- position alphanumeric field. See Claims Entry Screen 3 for explanation.
APPEALS – A	(Not Applicable)	ANSI Appeals Codes - This field identifies codes for inpatient or outpatient.

Claims Entry Screen 5 – MAP1715

```
MAP1715   PAGE 05          MEDICARE PART A -
          SC               INST CLAIM INQUIRY

MID                  TOB    S/LOC S      PROVIDER
INSURED NAME REL CERT-SSN-MID  SEX GROUP NAME   DOB   INS GROUP NUMBER
A
B
C

TREAT. AUTH. CODE


TREAT. AUTH. CODE


TREAT. AUTH. CODE


                                                    <== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

The information on this screen gives beneficiary and subscriber information for the primary, secondary, or tertiary payers.

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MID - A	60	The beneficiary's Medicare ID number.
TOB - A	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied I = Inactive P = Paid R = Rejected S = Suspended T = Returned to Provider
LOC - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER - A	51	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.
INSURED NAME - R	58	The individual in whose name the insurance is carried, as qualified by the payer organization. If Medicare is primary, enter the beneficiary's last name, first name, and middle initial on Line A. Name must be the same as one the patient's Medicare card or other Medicare notice. Line A = primary payer Line B = secondary payer Line C = tertiary payer
REL - R	59	Patient Relationship to Insurer – Enter the HIPAA relationship codes (these cross-reference to CWF codes); If Medicare is primary, the valid values are: HIPAA Code = 18 CWF Code = 1 Relationship = Self

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
CERT-SSN- MID - R	60	Identifies the insurer assigned beneficiary number. Line A = primary payer Line B = secondary payer Line C = tertiary payer
SEX - R	11	The sex of the beneficiary. Line A = primary payer Line B = secondary payer Line C = tertiary payer
GROUP NAME - S	61	Name of the group or plan through which the insurance is provided to the insured. Line A = primary payer Line B = secondary payer Line C = tertiary payer
DOB - S	(Not Applicable)	The insured's date of birth. Line A = primary payer Line B = secondary payer Line C = tertiary payer
INS GROUP NUM.- S	62	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. Line A = primary payer Line B = secondary payer Line C = tertiary payer
TREAT AUTH CODE	(Not Applicable)	HHPPS Treatment Authorization Code – used for home health claims.

Claims Entry Screen 6 – MAP1716

MAP1716 contains the Medicare Secondary Payer (MSP) address information, payment data, and pricer data information.

```
MAP1716   PAGE 06          MEDICARE PART A - JE UAT          ACMFA546 09/06/22
TXM9331   SC               INST CLAIM INQUIRY                A2022400 16:44:45

MID [redacted]   TOB 117  S/LOC T B9997  PROVIDER [redacted]
           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 100720  PROVIDER PAYMENT          .00   PAID BY PATIENT
REIMB RATE         RECEIPT DATE 100620  PROVIDER INTEREST
CHECK/EFT NO             CHECK/EFT ISSUE DATE           PAYMENT CODE
PIP PAY AS CASH            PRICER DATA             HOSPICE PRIOR DYS
DRG 949  OUTLIER AMT   119718.59  TTL BLNDED PAYMT            FED SPEC
INIT DRG 0949   GRH ORIG REIMB AMT       .00    NET INL
TECH PROV DAYS      TECH PROV CHARGES               IOCE OPPS FLAG
 OTHER INS ID             CLINIC CODE        IOCE CLM PR FL
32901 32907                                              <== REASON CODES
          PRESS PF3-EXIT  PF7-PREV PAGE
```

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MID - A	60	The beneficiary's Medicare ID number.
TOB - A	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
STATUS - A	(Not Applicable)	Status - This field identifies the condition of the claim: D = Denied P = Paid R = Rejected S = Suspended T = Returned to Provider I = Inactive

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
LOC - A	(Not Applicable)	Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions.
PROVIDER - A	51	If there is a one-to-one relationship between the NPI and provider number, the provider number will appear.

MSP ADDITIONAL INSURER INFORMATION

FIELD R= Required S = Situational A = System Filled	DESCRIPTION
1ST INSURERS ADDRESS 1	These fields are not used when Medicare is the primary payer.
1ST INSURERS ADDRESS 2	These fields are not used when Medicare is the primary payer.
CITY	These fields are not used when Medicare is the primary payer.
ST	These fields are not used when Medicare is the primary payer.
ZIP	These fields are not used when Medicare is the primary payer.
2ND INSURERS ADDRESS 1	These fields are not used when Medicare is the primary payer.
2ND INSURERS ADDRESS 2	These fields are not used when Medicare is the primary payer.
CITY	These fields are not used when Medicare is the primary payer.
ST	These fields are not used when Medicare is the primary payer.
ZIP	These fields are not used when Medicare is the primary payer.

PAYMENT DATA

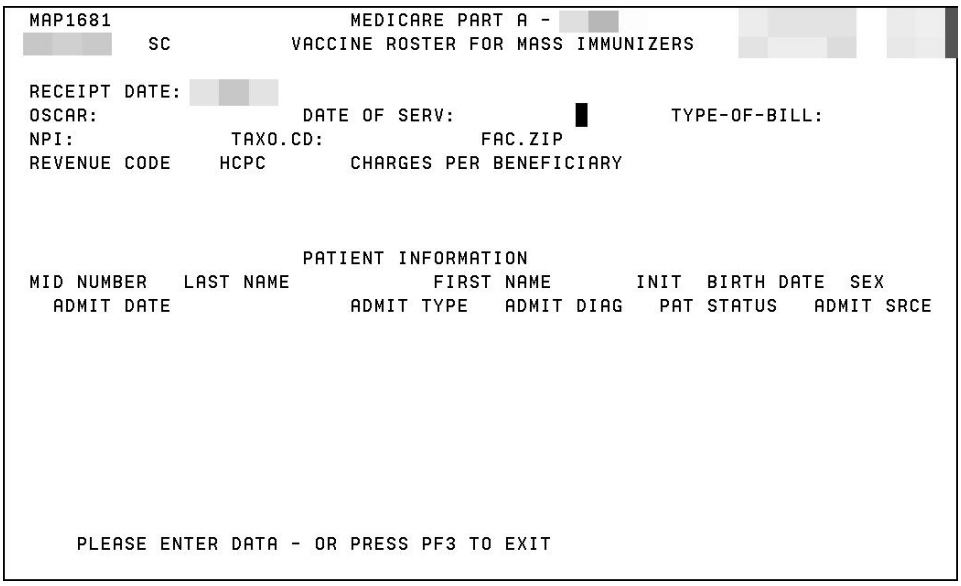
FIELD R= Required S = Situational A = System Filled	DESCRIPTION
DEDUCTIBLE – A	The amount of deductible for which the beneficiary/patient is liable.
COIN – A	The amount of coinsurance for which the beneficiary/patient is responsible.
CROSSOVER IND - A	This field identifies the Medicare payer on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. The valid values are: 1 = Primary 2 = Secondary 3 = Tertiary
PARTNER ID - A	The trading partner identification number.
NO TITLE - A	The production COBA Trading Partner(s) that did not receive the claim due to claim errors. the valid values are: ' ' = Crossed Over N = Not crossed over due to claim data errors
PAID DATE - A	The scheduled payment date of the claim or the date the provider is actually reimbursed.
PROVIDER PAYMENT - A	The provider payment amount.
PAID BY PATIENT	This field is not used by FISS.
REIMB RATE - A	The per diem amount to be paid for providers reimbursed on per diem reimbursement or percentage of reimbursement if the provider's type of reimbursement is based on a percentage of charges.
RECEIPT DATE - A	The date the claim was received by the Medicare Intermediary.
PROVIDER INTEREST - A	The amount of interest paid to the provider for late payment on clean claims.
CHECK/EFT NO - A	The identification number of the check or electronic funds transfer.

FIELD R= Required S = Situational A = System Filled	DESCRIPTION
CHECK/EFT ISSUE DATE - A	The date the check was issued or the date the electronic funds transfer occurred.
PAYMENT CODE - A	The payment method of the check or electronic funds transfer. The valid values are: ACH = Automated Clearing House or Electronic Funds Transfer CH = Check NON = Non-payment Data
DRG - A	Diagnosis Related Group Code – the Diagnosis Related Group code assigned by the CMS grouper program using length of stay, covered days, sex, age, diagnosis and procedure codes, discharge date, and total charges.
INIT DRG - A	Initial Diagnosis Related Group Code.
OUTLIER AMT - A	Capital Outlier Payment – This field identifies the outlier portion of the PPS payment for capital and the PPS dollar threshold for a cost outlier
TTL BLENDED PAYMENT – A	This field is not used by FISS.
FED SPEC - A	This field is not used by FISS.
GRH ORIG REIMB AMT - A	Gramm Rudman Original Reimbursement Amount – the amount reduced from the provider's reimbursement as mandated by Gramm/Rudman/Hollings legislation.
NET INL	Internal use.
TECH PROV DAYS - A	The days present on the benefit savings record or the days reflected in the occurrence span '77' if the benefit savings record is not present.
TECH PROV CHARGES - A	The charges present on the benefit savings record.
IOCE OPPS FLAG	Identifies OPPS claims.
OTHER INS ID	This field not used by FISS.
CLINIC CODE	This field not used by FISS.

FIELD R= Required S = Situational A = System Filled	DESCRIPTION
	IOCE Claim Processed Flag 0 - Claim is processed. 1 - Claim could not be processed (edits 23, 24, 46*, TOB 83x or other invalid bill type). 2 - Claim could not be processed (claim has no line items). 3 - Claim could not be processed (edit 10 - condition code 21 is present). 4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted.
IOCE CLM PR FL	9 - Fatal error; OCE cannot run - the environment cannot be set up as needed.

Roster Billing – Option 87 – MAP1681

Providers have the option of submitting claims for influenza vaccine and its administration via the Roster Bill screens rather than the usual claim entry screens. By doing so, the facility and service information is entered only once per screen, and the beneficiary-specific information for five patients can be added per screen and up to 10 patients per record. Only one date of services may be used per record.



FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
RECEIPT DATE	(Not Applicable)	The date the claim was received by the Medicare Intermediary
OSCAR	51	The provider number of the facility that is billing for the services provided. If your access identification number is assigned to multiple provider numbers, check this field to be sure the correct number appears.
DATE OF SERV - R	(Not Applicable)	Date of Service. Note: If the type of bill is 12X or 22X, the date of service must be the inpatient date of discharge.
TOB - R	4	Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care.
NPI	(Not Applicable)	The National Provider Identifier number.
TAXO.CD	(Not Applicable)	The Health Care Provider Taxonomy Code.
FAC.ZIP	(Not Applicable)	The provider or subpart zip code.
REVENUE CODE	(Not Applicable)	Revenue code - Use code 0636 for the vaccine and 0771 for the vaccine administration.
HCPC	(Not Applicable)	Common Procedure Code - This field identifies the HCPC code. The valid values are: G0008 Q0124 90724
CHARGES PER BENEFICIARY	(Not Applicable)	The Influenza vaccine or administration charge for each beneficiary entered.

PATIENT INFORMATION

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
MID - R	60	The beneficiary's Medicare ID number.
LAST NAME - R	8	Last Name - the patient's last name at the time services were rendered.
FIRST NAME - R	8	First Name - the patient's first name.
INIT	8	Middle Initial - the patient's middle initial.
BIRTH DATE - R	10	Date of Birth - the patient's date of birth.
SEX - R	11	Sex - This field identifies the patient's sex as recorded at the time services were rendered. The valid values are: M = Male F = Female U = Unknown
ADMIT DATE - R	12	Admission Date – the date of the patient's admission to this provider. Field available only for bill types 12X and 22X. S = Single M = Married X = Legally separated D = Divorced W = Widowed U = Unknown

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
ADMIT TYPE - R	14	Admission Type - the priority of admission. The valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center Field available only for types of bill 12X and 22X.
ADMIT DIAG - R	69	Enter the ICD-9-CM V- diagnostic code for Influenza vaccines. Field available only for types of bill 12X and 22X.
PAT STATUS - R	17	Patient Status - the code indicating the patient's status at the ending service date in the period. Field available only for types of bill 12X and 22X.

FIELD R= Required S = Situational A = System Filled	UB-04 X-REF	DESCRIPTION
ADMIT SOURCE - R	15	Source of Admission - the way a patient was referred to the hospital for admission. The valid values are: 1 = Physician referral 2 = Clinical referral 4 = Transfer from a hospital 5 = Transfer from a SNF (Skilled Nursing Facility) 6 = Transfer from another health care facility 7 = Emergency room 8 = Court/law enforcement 9 = Information not available B = Transfer from another Home Health Agency C = Readmission to the same Home Health Agency D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer E = Transfer from Ambulatory Surgical Facility F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program Field available only for types of bill 12X and 22X.

ESRD CMS-382 Form – MAP1391

Per CMS CR 7064, providers no longer need to submit the ESRD CMS-382 form for Method I or Method II; however, the DDE functionality remains. Providers are encouraged to review the following CMS resources for current ESRD guidance.

- CMS IOM Publication 100-04, Chapter 20, Section 30.8.3, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf
- CMS IOM Publication 100-04, Chapter 8, Section 100.2, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf

Choose one of the following functions:

- E = Entry
- U = Update
- I = Inquire

Select a function and type in the Medicare ID number. Press the [ENTER] key.

```
 MAP1391                    MEDICARE PART A -
      SC                    ESRD  CMS-382  INQUIRY
                                                        MNT:

 MID:                 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
```

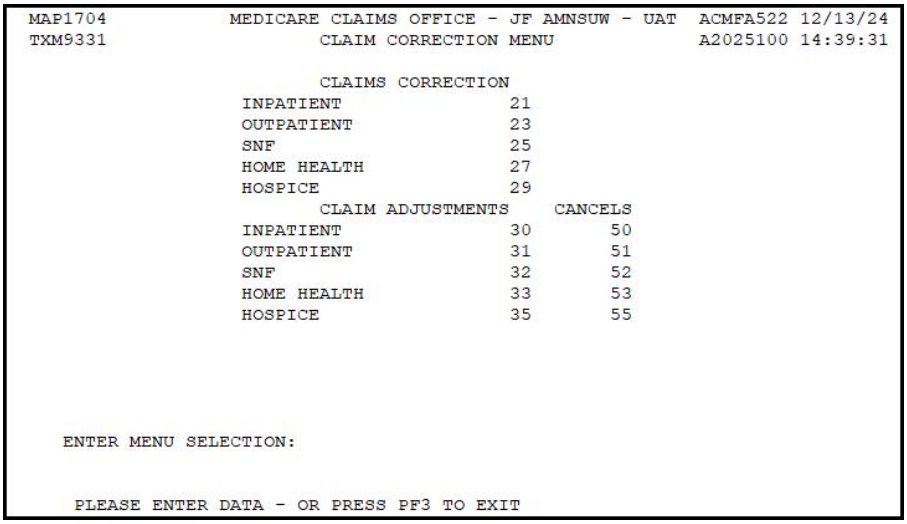
FIELD	DESCRIPTION
OP	The last operator who created or revised (F9'd) this file.
DT	The date this code was last saved (F9'd).
MID	The beneficiary's Medicare ID number.
METHOD	The method of home dialysis selected by the beneficiary. The valid values are: 1 = Method I - The beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits claims for services they render. 2 = Method II - The beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and the beneficiary is responsible for submitting their own claims to the carrier for reimbursement.
382 EFFECTIVE DATE	The date the Beneficiary's ESRD Method Selection becomes effective on the (CMS-382) form.

FIELD	DESCRIPTION
FUNCTION	The specific function to be conducted on the CMS-382 option. The valid values are: E = Entry I = Inquiry U = Update
LN	Last Name - the patient's last name at the time services were rendered
FN	First Name - the patient's first name
MI	Middle Initial - the patient's middle initial
DOB	Date of Birth - the patient's date of birth
SEX	Sex - This field identifies the patient's sex as recorded at the time services were rendered. The valid values are: F = Female M = Male U = Unknown
PROV	The provider number of the facility that is billing for the services provided.
NPI	The National Provider Identifier number
TAXO CD	The Health Care Provider Taxonomy Code
FAC ZIP	The provider or subpart zip code.
DIALYSIS TYPE	The type of dialysis services the beneficiary has selected on the ERSD Beneficiary Selection Form CMS-382) in form locator 9. The valid values are: 1 = Hemodialysis 2 = Continuous ambulatory peritoneal dialysis (CAPD) 3 = Continuous cycling peritoneal dialysis 4 = Peritoneal dialysis
NEW SELECTION OR CHANGE	This field indicates an exception to other ERSD data. The valid values are: Y = Entered on initial selection or for exceptions such as when the option year is equal to the year of the select date. N = Entered for a change in selection, i.e., option year is one year greater than the year of select date.

FIELD	DESCRIPTION
OPTION YR	The year that a beneficiary selection or change is effective. A selection change becomes effective on January 1st of the year following the year in which the ESRD beneficiary signed the selection form.
CWF ICN #	When an ESRD maintenance transaction is transmitted to CWF, FISS assigns an internal control number (ICN) and inserts this number on the ESRD Remarks screen.
CONTRACTOR	The carrier or intermediary responsible for a particular ESRD maintenance file.
CWF TTRANS DATE	The date an ESRD maintenance transaction was transmitted to CWF.
CWF MAINT DATE	The date that a CWF response was applied to a particular ESRD record.
TIMES TO CWF	The number of times a particular ESRD maintenance transaction has been transmitted to CWF.
CWF DISP CODE	The specific disposition code that has been received from CWF for a particular ESRD maintenance transaction.
REMARK NARRATIVE	Data that was entered in the method field. System generated. The valid values are: M1 = Method 1 M2 = Method 2
382-EFFECTIVE DATE	The effective date of the Method Selection. This date is system calculated and is based on whether the selection or change is equal to one of the following values: Y = The 382 effective date is equal to the 382 effective date. N = The 382 effective date is January 1 of the following year.
TERM DATE	The projected termination date for a particular beneficiary relative to dialysis coverage under the Medicare Program.

CHAPTER FIVE – CLAIMS CORRECTIONS – MAP1704

The Claims and Attachment Corrections menu, option 03 on the Main Menu, is used to access claims already in the system that need to be revised.



Corrections under the Claims Corrections section of this menu are made to claims that have been submitted, but are incomplete or contain data that fails edits, and must be returned to the provider (RTP'd).

Corrections under the Claims Adjustments and Cancel options are made to claims that have been processed and completed previously.

Options available from this menu are:

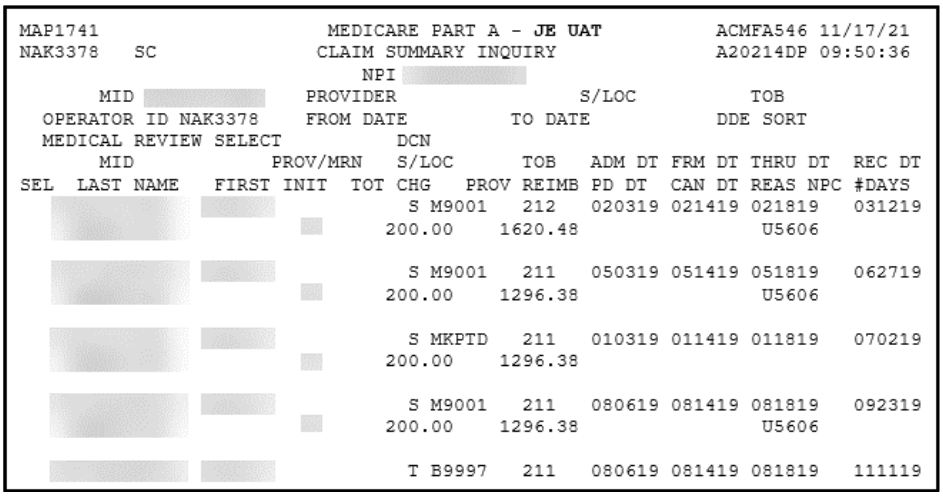
- Claims Correction
  - Inpatient – 21
  - Outpatient – 23
  - SNF – 25
  - Home Health – 27
  - Hospice – 29
- Claim Adjustment
  - Inpatient – 30
  - Outpatient – 31
  - SNF – 32
  - Home Health – 33
  - Hospice – 35
  - Cancel
  - Inpatient – 50
  - Outpatient – 51
  - SNF – 52
  - Home Health – 53
  - Hospice – 55

Attachments options shown on the menu are not used.

General Information

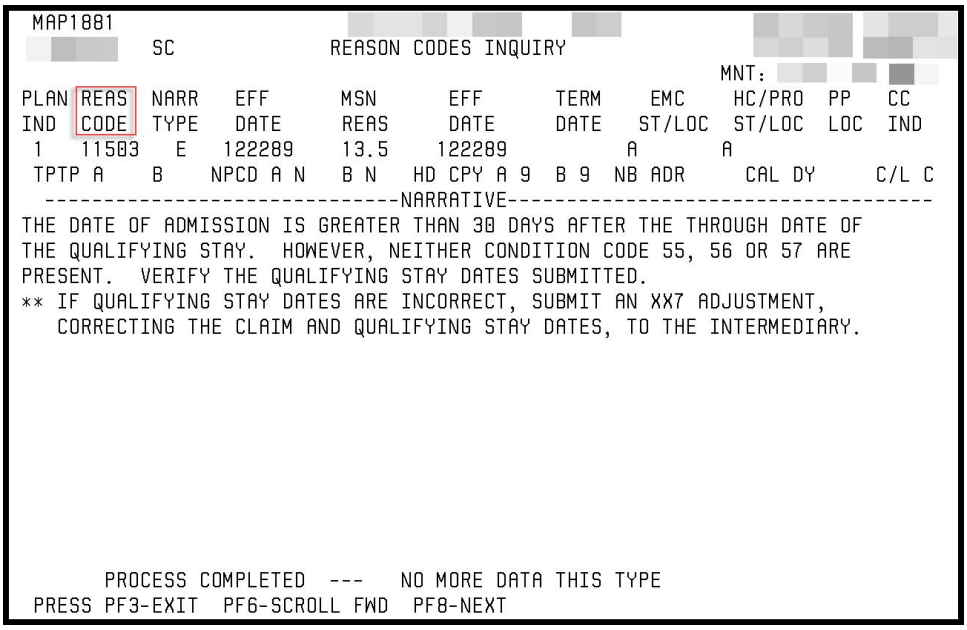
When you select an option from the Claims and Attachment Corrections menu, the same Claims Summary Inquiry screen you would see under the Claims Inquiry menu; however, you must access it through the Corrections menu in order to make changes to claims. The system will assign edits and auto-fill certain fields appropriate to that option.

Claim Summary Inquiry – MAP1741



Once a claim has been selected, you can view the Reason Code narrative by entering "17" in the SC field in the upper left corner of the screen, or by using the [F1] key. If you want to look up more than one reason code, simply type another code over the first and press [ENTER]. When you are ready to return to the claim, press [F3] once.

Reason Code Inquiry – MAP1881



Correcting Revenue Code Lines

When making changes to a revenue code line in either claims that have been RTP'd or claims that need to be adjusted, follow these procedures:

- To delete an entire Revenue Code line:
  - [TAB] to the line and 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 0001 total charge line.
  - Type the new Revenue Code information.
  - Press [HOME] to go to the Page Number field, press [ENTER]. The system will re-sort the Revenue Codes into numerical order.
  - Correct the total charge amount of 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
  - Press [ENTER]. The system will align the numbers and insert the decimal point.

- Correct the 0001 total charge line, if necessary.

- Any time changes are needed to a line item, delete and rekey the line items to ensure the system holds the changes.

Claims Correction – RTP Claims

Claims listed under the Claims Correction options cannot be processed as submitted, so they are assigned a Status code "T" and are Returned to Provider (RTP'd). Ordinarily, claims will remain in this status for 60 days; if they have not been corrected by the end of the suspense time, they will be purged from the system. While in the "T" status, these claims are not considered live claims, so it is very important to check for RTP'd claims on a daily or other frequent basis to maintain cash flow.

RTP'd claims can be corrected online through the Claims Correction menu, or they can be corrected in the provider's billing system and resubmitted through the normal batch submission process. The correction method depends on several factors, i.e., if there are several claims with the same error such as a disallowed HCPCS code or missing modifiers, it probably would be more efficient to make the changes in your billing system and retransmit the claims in the next batch cycle. On the other hand, if the error doesn't affect several claims, it may faster to correct it online. If claims are being resubmitted through the batch process, they should be suppressed in Claims Corrections so they won't inadvertently be corrected online and create a duplicate claim.

As discussed in the claims entry instructions, the reason code assigned to a claim may not be specific to the data field in error. This is because many of the UB-04 fields are interrelated, and the system cannot identify which one is wrong; it only can recognize that the logic among the related fields does not work. Because the fields are interrelated, sometimes changing data in a field will result in a new error and reason code. The online system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim will continue forward when nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the claim is successfully passes the RTP edits, it is assigned a new receipt date. That date is used to age the claim for the 14-day payment floor.

RTP'd claims normally are displayed in receipt date order. The claim sort option allows a provider to choose a different sort order. To re-sort the DDE claims, type one of the following values in the DDE SORT field and press [ENTER]:

- "M" displays claims in Medical Record order.
- "N" displays claims in the beneficiary last name order.
- "H" displays claims in Medicare ID number order.
- "R" displays claims in Reason Code order.
- "D" displays claims in Receipt Date order.
- " " displays claims in TOB order.

To review RTP'd claims, select the appropriate menu option and press [ENTER]. The NPI and provider number fields will default to the main NPI/provider number assigned to your Operator

access ID, and the outpatient type of bill will default to 13X. Check these fields and make any necessary changes. If you want to re-sort the claim sequence, type the appropriate value in the DDE sort field and press [ENTER] again.

Once the selected claims appear, you can begin to make corrections. To do so, type “S” in the SEL field in front of the claim you want to correct. This will bring up the claim detail. As with the Claims Entry process, a reason code will be shown in the lower left corner of the screen. You can go to the Reason Code narrative by entering “17” in the SC field in the upper left corner of the screen or using the [F1] key. If you want to look up more than one reason code, simply type another code over the first and press [ENTER]. When you are ready to return to the claim, press [F3] once. Even though the error may be obvious, always check the Remarks area, claim page 4, for information the claim adjudicator may have entered that will help you make a correction or supply needed information.

Make the necessary changes. Remember to press [ENTER] after making changes to a screen to register the new information before pressing [F9]. (To exit without transmitting any corrections, press [F3] to return to the selection screen; any changes made to the screen will not be updated.) Suspend the claim back into processing by pressing [F9].

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.’

Claim Suppression

If an RTP’d claim is not going to be corrected through the online process, it is recommended that you suppress it from view. This will hide the claim from view in the listing of RTP’d claims so it will not inadvertently be resubmitted, however it still will appear through the Inquiry Menu option until it is purged from the system.

To suppress a claim, type “Y” in the SV field in the upper right corner of claim page 1. Press the [F9] key. The system will return to the Claim Summary Inquiry screen.

Adjustments

Adjustments are done when a previously processed claim needs to be modified and reprocessed. By using the online adjustment options, you may call up the claim to be adjusted and make the desired changes without recreating the entire claim.

Claim adjustments are limited to claims with a Status code P (paid/finalized) or R (rejected) and should not be submitted until the claims have appeared on a remittance advice. If a claim has a status code D, the claim has been medically denied and any potential changes must be made through the redetermination process. If only a portion of the claim has been denied, the line items that have not been medically denied can be adjusted. The medically denied lines also must be handled through the redetermination process.

To make an adjustment, select the appropriate option code and press [ENTER]. This will bring up the Claim Summary Inquiry screen. The outpatient type of bill will default to 13X; check this field and make any necessary changes. Enter your NPI, the Medicare ID number and dates of service. If the original claim was rejected, change the "P" in the S/LOC field to an "R".

Press [ENTER]. This will bring up a listing of the claims that meet the selection criteria. Select the claim you want to adjust by placing "S" in the SEL field in front of the claim. When the claim detail appears, the type of bill will show a 7 in the final position (xxx7).

Note: When adjusting a claim that has already been adjusted, check the Paid and Cancel Date fields to identify the most recently processed version of the claim. Only the most recent version of the claim should be adjusted.

Along with making the needed changes on the claim, you will need to indicate why you are adjusting the claim by entering a change condition code on Claim Page 1 and an Adjustment Reason code on Claim Page 3. You can access a listing of the Adjustment Reason Codes by typing "16" in the SC field in the upper left corner of the screen and pressing [ENTER]. Press [F3] to return to the claim.

More than one adjustment condition code might apply to the claim, but only one can be used. A current listing of condition codes to use for adjustments and claim cancels is maintained on the Noridian website, at:

- Jurisdiction E Condition Codes webpage:
  https://med.noridianmedicare.com/web/jea/topics/claim-submission/condition-codes
- Jurisdiction F Condition Codes webpage:
  https://med.noridianmedicare.com/web/jfa/topics/claim-submission/condition-codes

Simply start at the top of the list and choose the first one that applies to your adjustment. When you are done working on the claim, press [F9] to submit the claim, or [F3] to abandon the adjustment.

Cancels

Claim cancels are done when a previously processed claim needs to be voided and any payment for the services retracted. Cancels most commonly are done when the original claim was submitted under an incorrect Medicare ID number or NPI/provider number, when charges were erroneously added to a patient account, or when outpatient charges need to be bundled with an inpatient claim.

Claim cancels are limited to claims with a Status code P (paid/finalized) and should not be submitted until the claims have appeared on a remittance advice. If a claim has a status code D, the claim has been medically denied and any potential changes must be made through the redetermination process.

To cancel a claim, select the appropriate option code and press [ENTER]. This will bring up the Claim Summary Inquiry screen. The outpatient type of bill will default to 13X; check this field and make any necessary changes. Enter your NPI, the Medicare ID number and dates of service. Press

[ENTER]. This will bring up a listing of the claims that meet the selection criteria. Select the claim you want to cancel by placing "S" in the SEL field at the beginning of the row. When the claim detail appears, the type of bill will show an 8 in the final position (xxx8).

Note: When cancelling a claim that has already been adjusted, check the Paid and Cancel Date fields to identify the most recently processed version of the claim. Only the most recent version of the claim can be cancelled.

Because you are cancelling rather than modifying the claim, you will not be making changes to the claim. Instead, just enter a cancel condition code on claim page 1. The condition codes for cancel claims are:

- D5 = Correct Medicare ID number or provider ID number
- D6 = Repay a duplicate payment, OIG overpayment, inclusion of outpatient charges on inpatient PPS admission.

Once the condition code has been entered, press the [ENTER] key. Press [F9] to send the canceled claim in to be processed. Press [F3] to exit the claim submenus.

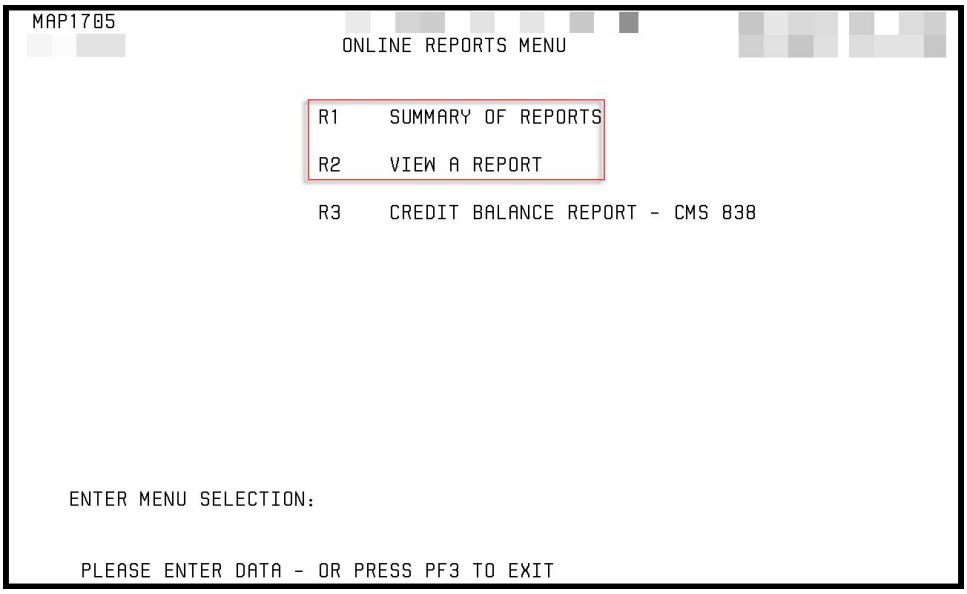
CHAPTER SIX – REPORTS

The Online Report Screens are used to allow viewing of certain provider specific reports by the DDE providers. This information is helpful in the monitoring and management of claims submission and error reduction. The reports are:

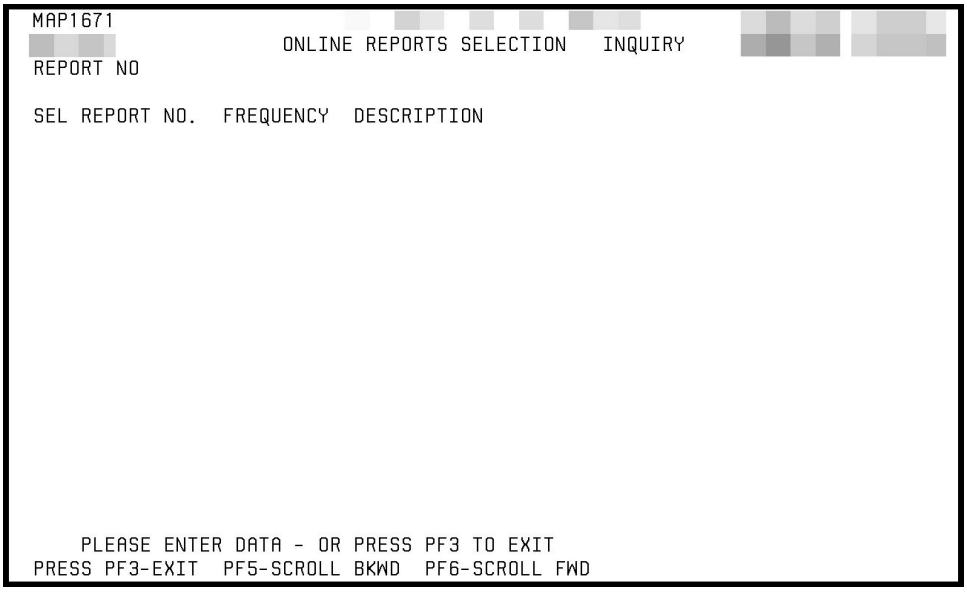
- 020 Return To Provider Summary – daily and monthly, lists RTP errors by type of bill. These claims are in status/location TB9997.
- 028 Provider Submission Reports – daily and monthly, summary of submitted claims by type of bill.
- 201 Pending, Processed, and Returned Claims – daily, weekly and monthly, 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.
- 316 Detailed Provider Submission Report – daily and weekly, lists errors on initial bills by reason code and by type of bill.

From the Online Reports Menu, type menu option "R1" for a summary of reports, or "R2" to view a report. Press [ENTER].

Online Reports Menu – MAP1705



Online Reports Selection – MAP1671



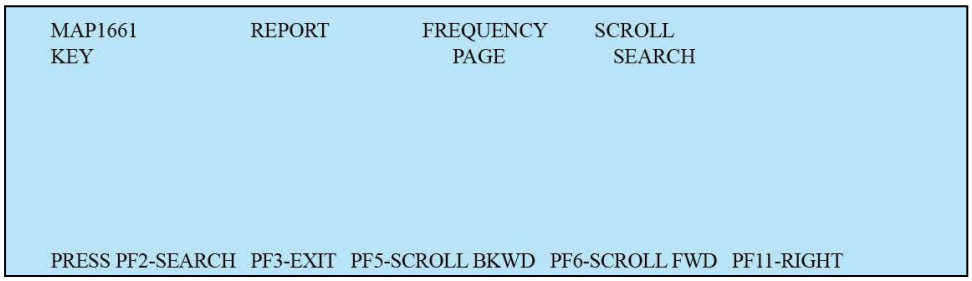
Press [ENTER] to call up a list of available reports. You may select a particular report by putting an "S" in the SEL field in front of the report and pressing [ENTER].

FIELD	DESCRIPTION
SEL	Enter an 'S' in this field to select the report number.

FIELD	DESCRIPTION
REPORT NO	The number of the report.
FREQUENCY	The frequency of the report. The valid values are: D = Daily M = Monthly W = Weekly
DESCRIPTION	The name or title of the report

Reports 020, 028, 201 and 316 appear on the Report View Inquiry screen, MAP 1661. Type in selection criteria and press [ENTER]. This information will be the same information that would have appeared if the report had been selected through MAP1671.

Report View Inquiry – MAP1661



FIELD	DESCRIPTION
REPORT NO	The number of the report.
FREQUENCY	The frequency the report is generated.
SCROLL	Used to scroll to the left or right sides of the report.
KEY	Provider number used for sorting the selected reports.
PAGE	The page number of the report being viewed.
SEARCH	This field searches for a specific field name or value.

CHAPTER SEVEN – HOW DO I....? Common Questions and Answers

Eligibility

1. How do I find out how much has been applied to the annual Part B therapy cap?

   a. Due to recent changes by CMS to improve data accuracy across systems, this information is best obtained through a HIPAA Eligibility Transaction System (HETS)-based tool such as the Noridian Medicare Portal (NMP) or the Interactive Voice Response (IVR) toll-free line. The amount, applied year-to-date, represents submitted claims; it cannot include charges for services provided but not yet billed.

2. How do I find out if a beneficiary is enrolled in a Medicare Advantage (MA) plan?
   a. This information is best obtained through a HETS-based tool such as the NMP or the IVR.
3. How do I find out if the beneficiary is enrolled in a Hospice or Home Health period that could cause my claim to reject?
   a. This information is best obtained through a HETS-based tool such as the NMP or the IVR.
4. How can I find out if a beneficiary is eligible for a preventive test that is subject to a frequency limit?
   a. Preventive services and the dates the beneficiary is eligible for coverage are best obtained through a HETS-based tool such as the NMP or the IVR.
5. How can I find out if the patient is eligible for a new benefit period or how many days are available in the current benefit period?
   a. This information is best obtained through a HETS-based tool such as the NMP or the IVR. Keep in mind that this information is based on filed claims and does not reflect days used in stays not yet filed. It is very important that you ask the patient about hospital and SNF admissions within the previous 60 days so you will be aware of stays that have not been reported yet.

For additional information on (or to register for access to) the Noridian Medicare Portal, visit the NMP website, https://www.noridianmedicareportal.com/web/nmp/home or the NMP User Guidance webpage, https://med.noridianmedicare.com/web/portalguide.

Claims

6. I see a claim with a "T" status in the Claims history, but I can't call it up under the RTP'd claims in Claims Corrections (Menu 03).
   a. If the claim has a Status/Location code TB9996, it will be moved to the RTP'd claims during the next batch cycle. Check the next day. If the claim has a Status/Location code TB9997, try adding the Medicare ID and dates of service in the selection criteria for the claims in Claims Corrections.
7. What does a status "I" mean? How do I correct the claim?
   a. Status "I" indicates the claim has been inactivated. Frequently, this means that the claim was suspended ([F9]) back into processing 3 or more times from a "T" status without be corrected properly or without adding requested information to the Remarks section. The claim cannot be corrected and will have to be submitted as a new claim. Before you do that,

be sure to check the Remarks section of the inactivated claim to find out what information needs to be added.

8. How can I see the claim detail for a claim that is shown as offline?
    a. After a period of time, claims are moved offline and can be retrieved within the timely filing period for the date of service by calling the Provider Contact Center. These claims are identified with Status/Location code PO9998.
9. My claim is getting a duplicate error, but I do not see any other claims in the claim' history with the same dates of service.
    a. Expand the date range in your search criteria when you look in the Claims history. The dates of service may overlap, but not exactly match, the dates of service of your claim. If you still don't find a conflict, call the Provider Contact Center to see if the conflicting claim is from another provider.
10. How can I find out why a service was not paid?
    a. Look at the information shown on the line item detail screen, MAP175D. The denial reason code appears on the second line from the bottom. Use [F1] to go to the reason code narrative and enter the denials reason code from the line item detail.
11. Where do I look to see when our next payment will be made?
    a. Check History, Inquiry Menu option FI, lists that last 3 checks that were issued to your provider. If you received hard copy checks, this is a way to tell what payments may be in the mail. If you already have received the payments listed there, you can look at the information shown under Status/Location PB9996 in the Claim Count Summary, Inquiry Menu option 56. All the claims that have been completed and currently are aging through the payment floor are shown on the category GT, grand total, line. Because claims move to the payment floor as soon as they complete processing, not all of the money shown in the Total Payment field for the category GT line will be paid on the next check, but at least you will be able to see what should be paid sometime within the next 14 days. You also can look up the claims in the payment floor by entering just your NPI and Status/Location code PB9996 in the Claim Summary Inquiry screen (MAP1741). When you press [ENTER], a list of all the claims currently in the payment floor will appear, including the payment dates and amounts.
12. The Status/Location code indications the claim is being held for Medicare Review. How can I tell what records are needed?
    a. Go to page 7 of the claim under the claims history found in option 12 of the Inquiry Menu. Press [F8] to see a list of the information requested. To see a complete list of claims being held pending records, enter your NPI and SB0001 in the Status/Location field on the Claim Summary Inquiry screen. Press [ENTER].
13. How can I find out if a revenue code is valid for Medicare?
    a. A listing of UB-04 revenue codes is found in the CMS Internet Only Manuals (IOM) listing webpage, http://www.cms.hhs.gov/Manuals/IOM/list.asp. To see if a revenue code is

allowed with for a particular type of bill, enter the revenue code in the Revenue Code screen under option 13 of the Inquiry Menu. A list of all bill types will appear, and if "Y" appears in the Allow field next to the type of bill, it is okay to use that revenue code for the type of claim.

14. Is there a way to find out if a HCPCS and revenue code can be used together?
    a. If a HCPCS code is limited to certain revenue codes, the revenue codes will appear in the ALLOWABLE REVENUE CODES field when a HCPCS code is entered on the HCPC Information Inquiry Screen under option 1E of the Inquiry Menu.
15. How do I enter more than two modifiers on a line?
    a. From page 2 of the Claims Entry Screens, press [F2] to go to the line item detail information. Add the additional modifiers in the MODIFIERS field on MAP171D.

Adjustment/Cancel/RTP

16. I want to correct a claim that isn't in DDE anymore. How can I do that?
    a. Typically, claims can be corrected only within the timely filing period for the dates of service. Exceptions to this are corrections needed to refund money to the Medicare program and corrections needed to allow another provider's claims to process. If claims are offline (Status/Location PO9998) or have been removed from DDE, call the Provider Contact Center for assistance.
17. I need to adjust a claim, but don't know which condition code to use. The changes fit more than one code.
    a. Use the Adjustment/Cancel Condition Code Reference Guide found at the end of Chapter 5. Start at the top and use the first condition code that describes a change in your claim.
18. Is there a way to get rid of a claim in corrections if we are not going to correct it at all or want to submit another claim through batch transmission?
    a. Claims in a Status/Location TB9997 can be suppressed by putting a "Y" in the SV field in the upper right corner of claim page 1. This will suppress the claim from view in the listing of RTP'd claims so it will not be resubmitted inadvertently, but the claim still will appear in the claims history until it is purged from the system. Claims in any other status/location cannot be suppressed.
19. How do I correct the charge information from non-covered to covered?
    a. This can be done only for line items that have not been medically denied. Please refer to the instructions in the General Information section of Chapter 5.