

Chapter Four – UB-04 Entry, Inpatient, Outpatient, SNF, Roster Billing, ESRD

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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 correspond 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), <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), <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.

Note: 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

```

MAP1711  PAGE 01      MEDICARE PART A - 
          SC          INST CLAIM ENTRY
MID █     TOB █     S/LOC S █ OSCAR SV:  UB-FORM
NPI      TRANS HOSP PROV          PROCESS NEW MID
PAT. CNTL#:          TAX# /SUB:          TAXO. CD:
STMT DATES FROM          TO          DAYS COV          N-C          CO          LTR
LAST          FIRST          MI          DOB
ADDR 1          2
3          4          CARR:
5          6          LOC:
ZIP          SEX          MS          ADMIT DATE          HR          TYPE          SRC          D          HM          STAT
COND CODES 01 02 03 04 05 06 07 08 09 10
OCC CDS/DATE 01          02          03          04          05
          06          07          08          09          10
SPAN CODES/DATES 01          02          03
04          05          06          07
08          09          10          FAC. ZIP
DCN
          V A L U E C O D E S - A M O U N T S - A N S I MSP APP IND
01          02          03
04          05          06
07          08          09
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
  
```

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

FIELD	UB-04 X-REF	DESCRIPTION
R = Required S = Situational A = System Filled		
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	UB-04 X-REF	DESCRIPTION
R = Required S = Situational A = System Filled		
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 1 200.00 FMR
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	UB-04 X-REF	DESCRIPTION
R = Required S = Situational A = System Filled		
OCE MED REV RSNS - A	(Not Applicable)	<p>This field identifies the edit returned from the OPPS version of OCE. The valid values are:</p> <p>11 = Non-covered service submitted for review (condition code 20).</p> <p>12 = Questionable covered service.</p> <p>30 = Insufficient services on day of partial hospitalization.</p> <p>31 = Partial hospitalization on same day as electro convulsive therapy or type T procedure.</p> <p>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.</p> <p>33 = Partial hospitalization claim spans more than three days with insufficient number of days having mental health services.</p>
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)	<p>Complex Manual Medical Review Indicator – This field identifies if all services on the claim received complex manual medical review. The valid values are:</p> <p>'' = The services did not receive manual medical review (default value).</p> <p>Y = Medical records received. This service received complex manual medical review.</p> <p>N = Medical records were not received. This service received routine manual medical review.</p>
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)	<p>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:</p> <p>'' = The NCD edits are not bypassed, (default value)</p> <p>Y = The line has been reviewed for medical necessity and bypasses the NCD edits.</p> <p>D = The line has no covered charges and bypass's the NCD edits.</p>
NCD DOC - A	(Not Applicable)	<p>National Coverage Determination Documentation Indicator – identifies whether the documentation was received for the medically necessary service. The valid values are:</p> <p>Y = The documentation supporting the medical necessity was received.</p> <p>N = The documentation supporting the medical necessity was not received, (default value.)</p>

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-10-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 -		NDC CD PAGE 01	
SC		INST CLAIM ENTRY		PROVIDER		RETURN	
MID	TOB 111	S/LOC S	B0100	PROVIDER	HIPPS1	HIPPS2	MOLDX
CL	NDC FIELD	NDC QUANTITY	QUALIFIER	HIPPS1	HIPPS2	MOLDX	
1	L		F	M	SC		
LLR NPI							
LLO NPI							
2	L		F	M	SC		
LLR NPI							
LLO NPI							
3	L		F	M	SC		
LLR NPI							
LLO NPI							
4	L		F	M	SC		
LLR NPI							
LLO NPI							
5	L		F	M	SC		
LLR NPI							
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	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	UB-04 X-REF	DESCRIPTION
R = Required S = Situational A = System Filled		
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	UB-04 X-REF	DESCRIPTION
R = Required S = Situational A = System Filled		
LLR NPI	(Not Applicable)	Line Level Rendering Physician NPI
LLO NPI	(Not Applicable)	Line Level Ordering Physician NPI

Claims Entry Screen 3 – MAP1713

```

MAP1713 PAGE 03 MEDICARE PART A -
SC INST CLAIM INQUIRY
MID TOB S/LOC S PROVIDER
NDC CD OFFSITE ZIP ADJ MBI IND
CD ID PAYER OSCAR RI AB EST AMT DUE
A
B
C 0.00
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAG CODES 01 02 03 04 05
06 07 08 09 END OF POA IND
ADMITTING DIAGNOSIS E CODE HOSPICE TERM ILL IND
IDE GAF PRV
PROCEDURE CODES AND DATES 01 02
03 04 05 06
ESRD HRS 00 ADJ REAS CD REJ CD NONPAY CD ATT TAXO
ATT PHYS NPI L F M SC
OPR PHYS NPI 0000000000 L F M SC
OTH OPR NPI L F M SC
REN PHYS NPI 0000000000 L F M SC
REF PHYS NPI 0000000000 L F M SC
<== REASON CODES
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF11-RIGHT
    
```

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	<p>Status - This field identifies the condition of the claim:</p> <p>D = Denied</p> <p>I = Inactive</p> <p>P = Paid</p> <p>R = Rejected</p> <p>S = Suspended</p> <p>T = Returned to Provider</p>
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	<p>Payer Code – Valid values are:</p> <ul style="list-style-type: none"> 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	<p>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:</p> <ul style="list-style-type: none"> R = Restricted or modified release N = No release
AB	<p>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:</p> <ul style="list-style-type: none"> 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	<p>The ICD-10-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:</p> <p>Y = Yes, Present at the time of inpatient admission.</p> <p>N = No, not present at the time of inpatient admission.</p> <p>U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission.</p> <p>W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.</p> <p>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.</p> <p>' ' = Not acute care, POA's do not apply</p>
END OF POA INDICATOR	<p>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:</p> <p>Z = The end of POA indicators for principal and, if applicable, other diagnoses.</p> <p>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.</p> <p>' ' = Not acute care, POA's do not apply</p>

FIELD	DESCRIPTION
ADMITTING DIAGNOSIS	The ICD-10-CM code describing the inpatient condition at the time of the admission.
E-CODE	The ICD-10-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).

```

MAP1719  PAGE 03          MEDICARE PART A - ██████          ACMFA546 06/17/20
          SC              INST CLAIM ENTRY          A20203AF 12:50:43
MID ██████  TOB 111  S/LOC S B0100  PROVIDER
          MSP  PAYMENT  INFORMATION
RI:
PRIMARY PAYER 1  MSP PAYMENT INFORMATION

PAID DATE: █          PAID AMOUNT:

GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT
GRP  CARC  AMT          GRP  CARC  AMT

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT
  
```

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

```

MAP1714  PAGE 04      MEDICARE PART A - JE UAT      ACMFA546 12/13/24
TXM9331  SC          INST CLAIM ENTRY      A2025100 16:15:50
                                     REMARK PAGE 01
MID [REDACTED]  TOB 111  S/LOC S B0100  PROVIDER
REMARKS

40 THERAPY
58 HBP CLAIMS (MED B)          E1 ESRD ATTACH
ANSI CODES - GROUP:      ADJ REASONS:      APPEALS:

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-UPDT
  
```

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	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	UB-04 X-REF	DESCRIPTION
R = Required S = Situational A = System Filled		
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

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

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 ██████████ TOB 117 S/LOC T B9997 PROVIDER ██████████
MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
CITY ST ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
CITY ST ZIP
PAYMENT DATA --- DEDUCTIBLE COIN CROSSOVER IND
PARTNER ID

PAID DATE 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 OPPTS FLAG
OTHER INS ID CLINIC CODE IOCE CLM PR FL
32901 32907 <== REASON CODES

PRESS PF3-EXIT PF7-PREV PAGE
    
```

FIELD	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	DESCRIPTION
R= Required S = Situational A = System Filled	
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 OPPTS FLAG	Identifies OPPTS claims.
OTHER INS ID	This field not used by FISS.
CLINIC CODE	This field not used by FISS.

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

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.

```

MAP1681          MEDICARE PART A - 
SC              VACCINE ROSTER FOR MASS IMMUNIZERS

RECEIPT DATE:   OSCAR:          DATE OF SERV:   TYPE-OF-BILL:
NPI:            TAXO.CD:        FAC.ZIP
REVENUE CODE    HCPC           CHARGES PER BENEFICIARY

PATIENT INFORMATION
MID NUMBER      LAST NAME      FIRST NAME      INIT  BIRTH DATE  SEX
ADMIT DATE      ADMIT TYPE     ADMIT DIAG      PAT STATUS  ADMIT SRCE

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

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.
H CPC	(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	UB-04 X-REF	DESCRIPTION
R= Required S = Situational A = System Filled		
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-10-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	<p>Source of Admission - the way a patient was referred to the hospital for admission. The valid values are:</p> <p>1 = Physician referral</p> <p>2 = Clinical referral</p> <p>4 = Transfer from a hospital</p> <p>5 = Transfer from a SNF (Skilled Nursing Facility)</p> <p>6 = Transfer from another health care facility</p> <p>7 = Emergency room</p> <p>8 = Court/law enforcement</p> <p>9 = Information not available</p> <p>B = Transfer from another Home Health Agency</p> <p>C = Readmission to the same Home Health Agency</p> <p>D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer</p> <p>E = Transfer from Ambulatory Surgical Facility</p> <p>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.</p>

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), <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), <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:
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.