

Chapter Two – Direct Data Entry (DDE) and Chapter Three – Inquiry Menu

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Opioid Use Disorder DEMO 99 Inquiry – MAP1E91 120

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

```
MAP1701
MAIN MENU
01 INQUIRIES
02 CLAIMS/ATTACHMENTS
03 CLAIMS CORRECTION
04 ONLINE REPORTS

ENTER MENU SELECTION:

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

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/Group 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

MAPI702	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
		LOUD 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

```

MAP1751          MEDICARE PART A - JE UAT
SC              ELIGIBILITY DETAIL INQUIRY

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

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

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

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

PLEASE ENTER DATA - MID, LN, FN, SEX, DOB AND ELIG FROM/THRU.
PRESS PF3-EXIT  PF8-NEXT PAGE
    
```

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.

FIELD	DESCRIPTION
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
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.

FIELD	DESCRIPTION
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.
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          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT
SC              ELIGIBILITY DETAIL INQUIRY
RI 1  MAMMO DT  000000000
                PART B DATA
SRV YR 25  MEDICAL EXPENSE    257.00  BLD DED REM 3  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.
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	<p>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:</p> <p>Position 1 H</p> <p>Position 2 & 3 State Code</p> <p>Position 4 & 5 Plan number within the state</p>

FIELD	DESCRIPTION
OPT CD	<p>This field identifies whether the current Plan services are restricted or unrestricted. Valid values are:</p> <p>Unrestricted—</p> <p>1 = Intermediary to process all Part A and B provider claims.</p> <p>2 = MA Plan to process claims for directly provided service and for services from Providers with effective arrangements. Intermediary to process all other claims.</p> <p>Restricted—</p> <p>A = Intermediary to process all Part A and B provider claims.</p> <p>B = MA Plan to process claims only for directly provided services.</p> <p>C = MA Plan to process all claims.</p>
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	<p>Specific Hospice election period. Valid values are:</p> <p>1 = The first time a beneficiary uses Hospice benefits.</p> <p>2 = The second time a beneficiary uses Hospice benefits.</p>
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          MEDICARE PART B - 20 UNIT          MEDICARE BENEFIT
          SC          CDRSHIP 13.46.24

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  ACMFAS22 09/19/25
          SC          ACCEPTED
MID          NM          IT V  DB          SX F
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 0000 0000  IPPE/G0403 SRV  SRV
COLO/G0104 010198 010198  PROS/G0103 0000 0000  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  HEV/      092816 092816  AWV /G0439 0000 010111
FOBT/82270 010107 010107  SETS/93668 0072  CCBB/G0327 070121  APRP/G0465
IPPE/G0344 SRV  SRV  AUDG/      070123 070123  COLO/74263 010125 010125
IPPE/G0366 SRV  SRV  HIVP/      093024 093024
IPPE/G0367 SRV  0000  HIVS/      093024 093024
IPPE/G0368 0000  SRV  HBPV/      093024 093024
DIAB/82947 010105 010105
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	<p>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:</p> <p>PTB = Beneficiary not entitled to Part B</p> <p>RCVD = Beneficiary already received service</p> <p>DOD =Beneficiary not eligible due to DOD</p> <p>GDR = Beneficiary not eligible due to sex</p> <p>AGE = Beneficiary not eligible due to age</p> <p>SRV = Beneficiary not eligible for the service</p> <p>VAC = Beneficiary already vaccinated</p> <p>0000 = Service not applicable</p>
PROF D	<p>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:</p> <p>PTB = Beneficiary not entitled to Part B</p> <p>RCVD = Beneficiary already received service</p> <p>DOD = Beneficiary not eligible due to DOD</p> <p>GDR = Beneficiary not eligible due to sex</p> <p>AGE = Beneficiary not eligible due to age</p> <p>SRV = Beneficiary not eligible for the service</p> <p>VAC = Beneficiary already vaccinated</p> <p>0000 = Service not applicable</p>

Beneficiary/CWF Screen – MAP175M

```

MAP175M          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT  ACMFA522 09/19/25
          SC          ACCEPTED
MID          NM          IT V  DB          SX F
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/          100914
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
BEHV/G0442          101411 BONE/0555T
BEHV/G0443          SVC    BONE/0556T
BEHV/G0444 101411 101411 BONE/0557T
BEHV/G0446 110811 110811 BONE/0558T
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/          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	<p>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.</p> <p>Note: When there is not a date, one of the following messages display to explain why the beneficiary is not eligible.</p> <p>Value – Description:</p> <p>PTB - Beneficiary not entitled to Part B</p> <p>RCVD - Beneficiary already received service</p> <p>DOD - Beneficiary not eligible due to DOD</p> <p>GDR - Beneficiary not eligible due to sex</p> <p>AGE - Beneficiary not eligible due to age</p> <p>SRV - Beneficiary not eligible for the service</p> <p>VAC - Beneficiary already vaccinated</p> <p>0000 - Service not applicable</p>
PROF D	<p>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.</p> <p>Note: When there is not a date, one of the following messages display to explain why the beneficiary is not eligible.</p> <p>Value – Description:</p> <p>PTB - Beneficiary not entitled to Part B</p> <p>RCVD - Beneficiary already received service</p> <p>DOD - Beneficiary not eligible due to DOD</p> <p>GDR - Beneficiary not eligible due to sex</p> <p>AGE - Beneficiary not eligible due to age</p> <p>SRV - Beneficiary not eligible for the service</p> <p>0000 - Service not applicable</p>

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.

```

MAP1755
SC                ACCEPTED

CLAIM  NAME      D.O.B.  SEX  INTER
PROV  PROV IND
APP DT  REASON CD 1  DATE/TIME  REQ ID  BDMS
DISP CD  TYPE  CENT  D.O.B  D.O.D
A:CURR-ENT DT 040181  TERM DT  PRI-ENT DT  TERM-DT
B:CURR-ENT DT 040181  TERM DT  PRI-ENT DT  TERM-DT

LIFE: RSRV  PYSCH

CURRENT  BENEFIT PERIOD DATA
FRST BILL DT  LST BILL DT  HSP FULL DAYS  HSP PART DAYS
SNF FULL DAYS  SNF PART DAYS  INP DED REMAIN  0.00  BLD DED PNTS 0
PRIOR  BENEFIT PERIOD DATA
FRST BILL DT  LST BILL DT  HSP FULL DAYS  HSP PART DAYS
SNF FULL DAYS  SNF PART DAYS  INP DED REMAIN  0.00  BLD DED PNTS 0

CURR B: YR  CASH  BLOOD  PSYCH  PT  OT
PRIR B: YR  CASH  BLOOD  PSYCH  PT  OT

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

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	<p>Provider Indicator – This field identifies the provider number indicator. This is a one-position alphanumeric field. The valid values are:</p> <p>' ' = The provider number is a Legacy or OSCAR number</p> <p>N = The provider number is an NPI number</p>
APP DT	The date the beneficiary was admitted to the hospital (Application date).
REASON CD	<p>Reason Code – Indicates the reason for the inquiry. Valid values are:</p> <p>1 = Status inquiry</p> <p>2 = Inquiry relating to an admission</p>
DATE/TIME	The date and time in Julian YYDDHHMMSS format.
REQ ID	Requested ID – Identifies the person submitting inquiry.
DISP CD	<p>The CWF disposition code assigned to a claim when it is processed through a CWF host site. Valid values include:</p> <p>01 = Part A inquiry approved; beneficiary has never used Part A services (Type 3 reply).</p> <p>02 = Part A inquiry approved; beneficiary has had some prior utilization.</p> <p>03 = Part A inquiry rejected.</p> <p>04 = Qualified approval; may require further investigation.</p> <p>05 = Qualified approval; according to CMS’s records, this inquiry begins a new benefit period.</p>
TYPE	Identifies the type of CWF reply. Valid value: 3 = Accept
CENT D.O.B	<p>Century of the Beneficiary/beneficiary’s date of birth. Valid values are:</p> <p>8 = 18th Century</p> <p>9 = 19th Century</p>
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

```

MAP1756
SC
ACCEPTED

DATA IND 0000000000 NAME ZIP

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

OTHER ENTITLEMENTS OCCURRENCE CD/DATE 0 / 0
ESRD CD/DATE /

CAT DATA: PSYCH DISCHG IND 0 DAYS USED BLOOD

YR APP MET BLD CO FL FRM TO
IND INT ADM FRM TO APP
ADJ IND CALC DED CMS DT
YR APP MET BLD CO FL FRM TO
IND INT ADM FRM TO APP
ADJ IND CALC DED CMS DT

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PAGE PF8-NEXT PAGE
    
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FIELD	DESCRIPTION
	<p>Data Indicators – Valid position values are:</p> <p>Pos. 1 – Part B Buy-In 0 = Does not apply 1 = State buy-in involved</p> <p>Pos. 2 – Alien indicator 0 = Does not apply 1 = Alien non-payment provision may apply</p> <p>Pos. 3 – Psych Pre-Entitlement 0 = Does not apply 1 = Psychiatric pre-entitlement reduction applied</p> <p>Pos. 4 – Reason for Entitlement 0 = Does not apply 1 = Psychiatric pre-entitlement reduction applied</p> <p>Pos. 5 – Part A Buy-In 0 = No Part A Buy-In 1 = Part A Buy-In</p> <p>Pos. 6 – Rep Payee Indicator 0 = Does not apply 1 = Selected for GEP Contract 2 = Has Rep Payee 3 = Both Conditions Apply</p> <p>DATA IND Pos. 7-10 – Not used at this time</p>
NAME	Displays last name, first name, and middle initial of the beneficiary.
ZIP	Zip Code of the residence of the beneficiary.
PLAN: ENR CD	<p>Number of periods of MA Plan enrollment code.</p> <p>Valid values include:</p> <p>0 = Zero periods of enrollment 1 = One period of enrollment 2 = Two periods of enrollment 3 = More than two periods of enrollment</p>

CURRENT PLAN

FIELD	DESCRIPTION
CUR ID	<p>Current MA Plan ID code assigned by CMS.</p> <p>Position Description 1 H or 1-9</p> <p>2 & 3 State code</p> <p>4 & 5 Plan number within the state</p>
OPT	<p>MA Plan Option Code. Valid values are:</p> <p>Unrestricted</p> <p>1 = Intermediary to process all Part A and Part B provider claims</p> <p>2 = MA Plan to process claims for directly provided services from providers with effective arrangements, intermediary to process all other claims</p> <p>Restricted</p> <p>A = Intermediary to process all claims.</p> <p>B = MA Plan to process claims for directly provided services.</p> <p>C = MA Plan to process all claims.</p>
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	<p>Prior Health ID code assigned by CMS:</p> <p>1 H or 1-9</p> <p>2 & 3 State code</p> <p>4 & 5 Plan number within the state</p>

FIELD	DESCRIPTION
OPT	<p>MA Plan Option Code. Valid values are:</p> <p>Unrestricted</p> <p>1 = Intermediary to process all Part A and Part B provider claims</p> <p>2 = MA Plan to process claims for directly provided services from providers with effective arrangements, intermediary to process all other claims</p> <p>Restricted</p> <p>A = Intermediary to process all claims.</p> <p>B = MA Plan to process claims for directly provided services.</p> <p>C = MA Plan to process all claims.</p>
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	<p>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:</p> <p>1 = Worker's Compensation Coverage</p> <p>2 = Black Lung</p> <p>A = Working Aged beneficiary or spouse covered by Employer Group Health Plan (EGHP)</p> <p>B = End Stage Renal Disease (ESRD) beneficiary in 30-month coordination period and covered by employer health plan</p> <p>C = Medicare has made a conditional payment pending final resolution</p> <p>D = Automobile no-fault or other liability insurance involvement</p> <p>E = Workers' Compensation</p> <p>F = Veteran's Administration program, public health service or other federal agency program</p> <p>G = Working disabled beneficiary or spouse covered by Employer Group Health Plan</p> <p>H = Black Lung</p> <p>I = Veteran's Administration Program Occurrence Codes Date Definition</p> <p>1 or 2: Date is the effective date of applicable program involvement.</p> <p>A - I: Date is the date of previous claim where Medicare was determined to be secondary.</p>

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
	<p>The yearly data indicators:</p> <p>POS 1</p> <p>0 = Not Used</p> <p>2 = Clerical Involvement</p> <p>3 = Religious Non-Medical Healthcare Institution/SNF Usage</p> <p>4 = Both 1 and 2</p> <p>POS 2</p> <p>0 = Not Used</p> <p>1 = Through date is interim</p> <p>POS 3-4</p>
IND	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	<p>The type of adjustment made. Valid values are:</p> <p>0 = No Adjustment</p> <p>1 = Downward Adjustment</p> <p>2 = Upward Adjustment</p>
CALC DED	The amount of deductible calculated.
CMS DATE	The date the claim was processed by CMS.

Beneficiary/CWF Screen – MAP1757

```

MAP1757
SC
ACCEPTED
HH-REC CN NM IT DB SX
MAMMO RSK MAMMO DATES TECHCOM PROCOM
      0000 0000
      0000 0000
      0000 0000
TRANSPLANT INFO: COV IND TRAN IND DIS DATE
                  000000
                  000000
                  000000
EPISODE EPISODE DOEBA DOLBA
START END
00000000 00000000 00000000 00000000
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PAGE PF8-NEXT PAGE
  
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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

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MAP1758
SC  ACCEPTED
HOSPICE INFO FOR PERIODS 1 AND 2:
PERIOD  1ST  ST DATE  PROV  INTER
OWNER CHANGE ST DATE  PROV  INTER
2ND ST DATE  PROV  INTER  TERM DATE
OWNER CHANGE ST DATE  PROV  INTER
1ST BILLED DT  LAST BILLED DT
DAYS BILLED  REVO IND

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

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

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MAP175C      MEDICARE CLAIMS OFFICE - 
SC          ACCEPTED

HOSPICE INFO FOR PERIODS 3 AND 4:

PERIOD  1ST  ST DATE      PROV      INTER
OWNER CHANGE ST DATE 0000000  PROV      INTER
2ND ST DATE          PROV      INTER    TERM DATE
OWNER CHANGE ST DATE          PROV      INTER
1ST BILLED DT        LAST BILLED DT
DAYS BILLED          REVO IND

PERIOD  1ST  ST DATE      PROV      INTER
OWNER CHANGE ST DATE 0000000  PROV      INTER
2ND ST DATE          PROV      INTER    TERM DATE
OWNER CHANGE ST DATE          PROV      INTER
1ST BILLED DT        LAST BILLED DT
DAYS BILLED          REVO IND

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

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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
    
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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.

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MAP175L          MEDICARE PART A - 
  SC          HOME HEALTH CERTIFICATION

REQ DATE      MID          DOB
  NAME

REC  HCPCS    FROM DATE    REC  HCPCS    FROM DATE

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

MAP175N	SC	MEDICARE PART A -			
MID		NM	IT	DB	SX
HCPC CODE	TECH CODE	RISK CD	DATE CCYYMMDD	DATE CCYYMMDD	DATE CCYYMMDD
P3000	TECH	N	01/01/2017		

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.

MAP175O	MEDICARE PART A -			
MID	SC	NAME	INITIAL	DOB
				SEX
MCCM DATA				
PROV	START	TERM	TRANSFER	
NUMBER	DATE	DATE	DATE	

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.

MAP175P	SC	MEDICARE PART A -			
MID	NAME	INITIAL	DOB	SEX	
	ELECTION START DATE	RECEIPT DATE	REVOICATION DATE	REV IND	PROVIDER NUMBER
	00000000	00000000	00000000	0	
	00000000	00000000	00000000	0	
	00000000	00000000	00000000	0	
	00000000	00000000	00000000	0	

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.
REVOICATION 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.

MAP175Q	MEDICARE PART A -
SC	PBRO AUXILIARY DETAILS
MID	NAME INITIAL DOB SEX
PROF-HCPCS	ACT-SOE-DT ACT-EOE-DT PROF-DIAG-CD RENDERING-NPI TAX-ID-NBR
TECH-HCPCS	TEMP-SOE-DT TEMP-EOE-DT TECH-DIAG-CD CCN/TIN

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

MAP1759	MEDICARE A ONLINE SYSTEM	
SC	ACCEPTED	
	MSP DATA PAGE OF	
EFFECTIVE DATE:	SUBSCRIBER NAME:	
TERMINATION DATE:	POLICY NUMBER:	
MSP CODE:	INSURER TYPE:	
	PATIENT RELATIONSHIP:	
	REMARKS CODES:	
INSURER INFORMATION		
NAME:	GROUP NO:	
ADDRESS:	NAME:	
EMPLOYER DATA		
NAME:	EMPLOYEE ID:	
ADDRESS:	EMPLOYEE INFO:	

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	<p>The type of insurance coverage. Valid values are:</p> <ul style="list-style-type: none"> 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-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

```

MAP1781
DRG/PPS INQUIRY
DIAGNOSES: 1 2 3 4 5
             6 7 8 9 POA
PROCEDURES: 1 2 3 4 5
             6 7 8 9 NPI
SEX C-I DISCHARGE STATUS DT PROV
REVIEW CODE TOTAL CHARGES DOB OR AGE
APPROVED LOS COV DAYS LTR DAYS PAT LIAB
RETURNED FROM GROUPER: GROUPER VERSION
DRG INIT MAJOR DIAG CAT RETURN CODE
PROC CD USED DIAG CD USED SEC DIAG USED
RETURNED FROM PRICER: PRICER VERSION
RTN CD WAGE INDEX OUTLIER DAYS
AVG# LENGTH OF STAY OUTLIER DAYS THRESHOLD
OUTLIER COST THRES INDIRECT TEACHING ADJ#
TOTAL BLENDED PAYMENT HOSPITAL SPECIFIC PORTION
FEDERAL SPECIFIC PORTION DISP# SHARE HOSPITAL AMT
PASS THRU PER DISCHARGE OUTLIER PORTION
PTPD + TEP STANDARD DAYS USED
LTR DAYS USED PROV REIMB

PLEASE ENTER DATA, PF3-EXIT, PF6-FWD, PF8-COST DISC, PF11-RIGHT, ENT-PROC
    
```

FIELD	DESCRIPTION
DIAGNOSIS	<p>Diagnosis Codes - This field identifies up to nine ICD-10-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:</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, POAs do not apply.</p>
POA	<p>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:</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>
PROCEDURES	<p>Procedure Codes - The ICD-10-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.</p> <p>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.</p>

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	<p>Indicates the code used in calculating the standard payment. Valid values are:</p> <p>00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers</p> <p>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</p> <p>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</p> <p>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</p> <p>04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers</p> <p>05 = Pay transfer with cost – Pays transfer with cost outlier approved</p> <p>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</p> <p>07 = Pay without cost – Calculates the standard payment without cost portion</p> <p>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</p> <p>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</p>
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	<p>Identifies the category in which the DRG resides. Valid values are:</p> <p>01 = Diseases and Disorders of the Nervous System</p> <p>02 = Diseases and Disorders of the Eye</p> <p>03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat</p> <p>04 = Diseases and Disorders of the Respiratory System</p> <p>05 = Diseases and Disorders of the Circulatory System</p> <p>06 = Diseases and Disorders of the Digestive System</p> <p>07 = Diseases and Disorders of the Hepatobiliary System and Pancreas</p> <p>08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue</p> <p>09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast</p> <p>10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders</p> <p>11 = Diseases and Disorders of the Kidney and Urinary Tract</p> <p>12 = Diseases and Disorders of the Male Reproductive System</p> <p>13 = Diseases and Disorders of the Female Reproductive System</p> <p>14 = Pregnancy, Childbirth, and the Puerperium</p> <p>15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period</p> <p>16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders</p> <p>17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms</p> <p>18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites)</p> <p>19 = Mental Diseases and Disorders</p> <p>20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders</p> <p>21 = Injuries, Poisonings, and Toxic Effects of Drugs</p> <p>22 = Burns</p> <p>23 = Factors Influencing Health Status and Other Contacts with Health Services</p> <p>24 = Multiple Significant Trauma</p> <p>25 = Human Immunodeficiency Viral Infections</p>

FIELD	DESCRIPTION
PROC CD USED	ICD-10-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-10-CM diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	ICD-10-CM diagnosis code used by the Grouper program for calculation.

RETURNED FROM PRICER

FIELD	DESCRIPTION
GROUVER 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

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MAP1741          MEDICARE PART A - ██████████ ██████████ ██████████
██████ SC      CLAIM SUMMARY INQUIRY
                NPI
                PROVIDER          S/LOC          TOB
MID            FROM DATE          TO DATE          DDE SORT
OPERATOR ID ██████████
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).

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

Claim Screen 1 – MAP1711

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MAP1711 PAGE 01 MEDICARE PART A -
SC INST CLAIM INQUIRY
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 R DOB
ADDR 1 2
3 4 CARR:
5 6 LOC:
ZIP SEX MS ADMIT DATE HR TYPE SRC 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
<== REASON CODES
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT
  
```

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

ADMISSION DATA

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

FIELD	DESCRIPTION
SRC	<p>Source of Admission - the way a patient was referred to the hospital for admission. The valid values are:</p> <ul style="list-style-type: none"> 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.

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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

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

```

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	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	<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>
TPE-TO-TPE	Tape-to-Tape Flag - This field identifies the tape-to-tape flag (if applicable).
WAIV IND	<p>Waiver Indicator - This field identifies whether the provider has their presumptive waiver status. The valid values are:</p> <p>Y = The provider does have their waiver status.</p> <p>N = The provider does not have their waiver status</p>
MR REV URC	<p>Medical Review Utilization Review Committee Reversal - This field indicates whether an SNF URC Claim has been reversed. The valid values are:</p> <p>P = Partial reversal</p> <p>F = Full reversal, the system reverses all charges and days</p>
DEMAND	<p>Medical Review Demand Reversal - This field identifies if a SNF demand claim has been reversed. The valid values are:</p> <p>P = Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal.</p> <p>F = Full reversal, the system reverses all charges and days.</p>
REJ CD	Reject Code - The reason code for which the claim is being denied.
MR HOSP RED	<p>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:</p> <p>' ' = Not reduced</p> <p>Y = Reduced</p>
RCN IND	<p>Reconsideration Indicator - This field used only for home health claims. The valid values are:</p> <p>A = Finalized count affirmed</p> <p>B = Finalized no adjustment count (pay per waiver)</p> <p>R = Finalized count reversal (adjustment)</p> <p>U = Reconsideration</p>

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 OPSS 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	<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	OCE Override - This field overrides the way the OCE module controls the line item.
CWF OVR	CWF Home Health Override.
NCD OVR	<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 bypasses the NCD edits.</p>
NCD DOC	<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	DESCRIPTION
NCD RESP	<p>National Coverage Determination Response Code –The valid values are: ' ' = Set to space for all lines on resubmitted RTP'D claims</p> <p>0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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 LABOR NON-LABOR
PAT -> 37.55
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

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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	<p>Professional Component/Technical Component - the PC/TC indicator PC/TC HPSA Payment Policy</p> <p>Pay the Health Professional Shortage Area (HPSA) bonus.</p> <p>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.</p> <p>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.</p> <p>Professional component only, pay the HPSA bonus.</p> <p>Technical component only, do not pay the HPSA bonus.</p> <p>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.</p> <p>Incident codes, do not pay the HPSA bonus.</p> <p>Laboratory physician interpretation codes, pay the HPSA bonus.</p> <p>Physical therapy service, do not pay the HPSA bonus.</p> <p>Physician interpretation codes, pay the HPSA bonus.</p> <p>Concept of PC/TC does not apply, do not pay the HPSA bonus</p>

FIELD	DESCRIPTION
CAH INCEN IN	<p>CAH Incentive Indicator, identifies whether a claim line is eligible for a specific type of bonus.</p> <p>1=HPSA 2=PSA 3=HPSA AND PSA 4=HSIP 5=HPSA and HSIP 6=PCIP 7=HPSA and PCIP ' '=Not applicable</p>
HCCP TYPE	<p>HCCP Type –identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. The value values are:</p> <p>M = Originated from MPFS database files ' ' = Did not originate from the MPFS database files</p>
COINSURANCE	Identifies the Variable Coinsurance Percentage used for Drug HCPCSs.
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	<p>ESRD Reduction Amount / Psychiatric Reduction Amount / Hemophilia Blood Clotting Factor Amount</p> <p>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).</p> <p>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.</p>
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	<p>Denial Indicator - This field identifies the MSPPAY module that an insurer primary to Medicare has denied this line item. The valid values are:</p> <p>" = Not denied</p> <p>D = Denied</p>

FIELD	DESCRIPTION
OCE FLAGS	<p>OCE Flags- This field identifies 10 flags, two alphanumeric positions each.</p> <p>Flag 1 – Status Indicator</p> <p>Flag 2 – Payment Indicator</p> <p>Flag 3 – Discounting Formula Number</p> <p>Flag 4 – Line Item Denial or Rejection</p> <p>Flag 5 – Packaging</p> <p>Flag 6 – Payment Adjustment</p> <p>Flag 7 – Payment Method</p> <p>Flag 8 – Line Item Action</p> <p>Flag 9 – Composite Adjustment</p> <p>Flag 10 – Payment Adjustment</p> <p>Refer to the Noridian Quick Reference Billing Guide for code definitions.</p>
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 OPSS 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 Medicaid 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, 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

```

MAP171E  PAGE 02          MEDICARE PART A - 
SC      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          1          L          F          M      SC
LLR NPI
LLO NPI
2          2          L          F          M      SC
LLR NPI
LLO NPI
3          3          L          F          M      SC
LLR NPI
LLO NPI
4          4          L          F          M      SC
LLR NPI
LLO NPI
5          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	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

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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
  
```

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	<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

FIELD	DESCRIPTION
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> <p>Y = Yes benefits assigned</p> <p>N = No benefits assigned</p>
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>

FIELD	DESCRIPTION
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>
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 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).

```

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
          M S P   P A Y M E N T   I N F O R M A T I O N
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
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.
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

```

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.
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.

```

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 ████████  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
  
```

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

```

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
  
```

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	HPPPS 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.

```

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	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 ADDRESS 2	The second street address line of the beneficiary's second insurer and is used to indicate the post office box, 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 OPPTS FLAG	Identifies OPPTS claims.
OTHER INS ID	This field not used by FISS.
CLINIC CODE	This field not used by FISS.
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>

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.

```

REPORT: 001                                PVDR NO : 
DATE :                                     ADDITIONAL DEVELOPMENT REQUEST  BILL TYPE: 131
CASE ID:

```

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATIONS AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. YOU MUST RETURN A COPY OF THIS LETTER IN FRONT OF THE REQUESTED INFORMATION TO ENSURE THAT THE DOCUMENTATION IS ROUTED APPROPRIATELY.

FAX# 1-701-277-7858 OR MAIL TO:
 MEDICARE PART A ADR
 900 42ND STREET S
 FARGO ND 58108 6724

```

PATIENT CNTRL NBR:                         DUE DATE:
MEDICAL REC NO:                             DCN:
MEDICARE ID:                                PATIENT NAME:
FROM DATE:                                  THRU DATE:  OPR/MED ANALYST:
TOTAL CHARGES:                              ORIG REQ DT:  CLM RCPT DT:
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT PF9-UPDT

```

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:
          EFF-DT TRM-DT    EFF-DT TRM-DT    EFF-DT TRM-DT    EFF-DT TRM-DT
          TOB          -----          -----          -----          -----
          -----          -----          -----          -----

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-10-CM diagnosis and procedure codes, along with the effective and termination dates.

Enter 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-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-10 CODE	The specific ICD-10 code to be viewed.
DESCRIPTION	A description of ICD-10 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
SC          ADJUSTMENT REASON CODES INQUIRY
           SELECTION SCREEN          MNT:
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 HPPS 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

```

MAP1822
SC ADJUSTMENT REASON CODE UPDATE SCRIN INQUIRY
MNT:
CLAIM TYPES :
I = INPATIENT/SNF, O = OUTPATIENT, H = HOME HEALTH/CORF, A = ALL CLAIMS
PLAN CODE:          REASON CODE   : AA      HIGLAS REASON CODE   : AA
                    CLAIM TYPE    : A
                    NARRATIVE
This change is due to an automated adjustment.

PRESS PF3-EXIT PF7-PREV PAGE
  
```

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

```

MAP1881          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT
SC              REASON CODES INQUIRY
MNT:           090321
PLAN REAS  NARR  EFF    MSN    EFF    TERM    EMC    HC/PRO  PP  CC
IND  CODE  TYPE  DATE    REAS    DATE    DATE    ST/LOC  ST/LOC  LOC  IND
1   17701  E    122289                T      T

TPTP A    B    NPCD A    B    HD  CPY A    B    NB  ADR    CAL  DY    C/L  C
-----NARRATIVE-----
PRINCIPAL DIAGNOSIS CODE AND ADMITTING DIAGNOSIS CODE (IF
PRESENT) MUST BE THREE TO SIX POSITIONS LEFT JUSTIFIED WITH NO
DECIMAL POINTS.  THE FOLLOWING CONDITIONS WILL BE VALIDATED BY
THE MEDICARE CODE EDITOR; ALL ERRORS MUST BE CORRECTED PRIOR TO
RUNNING THE MEDICARE GROUPER PROGRAM.
ERROR CODE    EXPLANATION
17601         INVALID DIAGNOSIS OR PROCEDURE CODE
17602         INVALID FOURTH OF FIFTH DIGIT (ICD9CM)
17603         E-CODE AS PRINCIPLE DIAGNOSIS
17604         DUPLICATE OF PRINCIPAL DIAGNOSIS
17605         AGE CONFLICTS WITH THE DIAGNOSIS
17606         SEX CONFLICTS WITH THE DIAGNOSIS
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
    
```

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.
	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
PIMR ACTIVITY CODE	SS = Prepay Complex Service Specific Review

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

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

MAPHDCN		MEDICARE PART A			
INVOICE NUMBER/DCN TRANSLATOR					
PLEASE ENTER UP TO 5 DCNS ON THE LEFT OR 5 DCNS ON THE RIGHT. PRESS PF9. THE EQUIVALENT DCNS WILL BE DISPLAYED IN THE OPPOSITE FIELD.					
F I S S	D C N	INVOICE NUMBER			
█	_____	_____			
	_____	_____			
	_____	_____			
	_____	_____			
	_____	_____			
MSG: PLEASE ENTER DATA - OR PRESS PF3 TO EXIT					
PF1=	PF2=	PF3=END	PF4=	PF5=	PF6=
PF7=	PF8=	PF9=PROCESS	PF10=	PF11=	PF12=

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.

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

MAP11A1	PG	MEDICARE PART A -
SC		DDE OSC REPOSITORY INQUIRY
PROVIDER 050335	MID	ADMIT DATE
DOCUMENT CONTROL NUMBER	OSC FROM DATE TO DATE	OSC FROM DATE TO DATE
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT		

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

```

MAP1371
SC CLAIM SUMMARY TOTALS INQUIRY
PROVIDER S/LOC CAT
NPI
S/LOC CAT CLAIM COUNT TOTAL CHARGES TOTAL PAYMENT

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

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

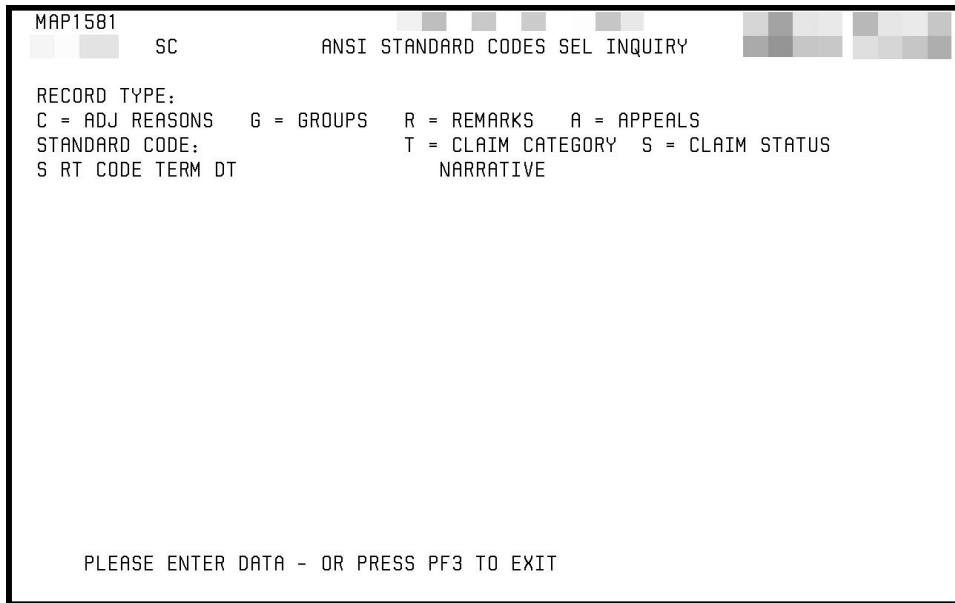
Noridian currently does not process home health claims. To access home health claim information, sign into the DDE applications available through the Medicare contractor who processes those claims.

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

```

MAP1582          MEDICARE PART A - 
SC █          ANSI STANDARD REASON CODES INQUIRY 
                                     MNT: SYSTEM  10/06/10

RECORD TYPES ARE:
C = ADJ REASONS  G = GROUPS  R = REMARKS  A = APPEALS
                  T = CLAIM CATEGORY S = CLAIM STATUS
RECORD TYPE   : █          TERM DT   : █
STANDARD CODE : █          EFF DT    : █

NARRATIVE:

PREGNANCY INDICATOR

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

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

MAP1B01 SC CHECK HISTORY

PROV	NPI	CHECK #	DATE	AMOUNT

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

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

```

MAP1C31
SC          ICD-10-CM CODE INQUIRY
DIAG/PROC:  STARTING ICD 10 CODE:
D/P ICD 10 CODE  SEQ CODE      DESCRIPTION:
          EFFECTIVE/TERM DATE

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

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	PRAC
S		EFF DT	TERM DT
		08102009	12319999
		ADDRESS	ZIP

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

```

MAP1AB2          MEDICARE CLAIMS OFFICE - JF AMNSUW - UAT          ACMFA522 06/13/25
TXM9331  SC █    PROVIDER PRACTICE ADDRESS QUERY INQUIRY          A20253AF 16:52:58
                                                    MNT: PECOS    20250528

NPI █           OSCAR █

PRAC EFF DT 05012014    PRAC TERM DT 08312023    PRAC ORIG EFF DT 05012014
PRACTICE LOCATION KEY █
OTHER PRACTICE O    PECOS REC TYPE █    PECOS PBD █
TYPE OF PRACTICE PROVIDER BASED CLINIC
ADDRESS 1 █
ADDRESS 2 █
CITY HAVRE █           STATE █           ZIP █
NPI EFF DT █           01011970    NPI TERM DT █           08312023

PRESS PF3-EXIT  PF6-SCROLL FWD  PF7-PREV
    
```

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), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo>.

New HCPC Information Inquiry – MAP1E01

```

MAP1E01          MEDICARE CLAIMS OFFICE - [REDACTED]
[REDACTED] SC          NEW HCPC INFORMATION INQUIRY          [REDACTED]
                                                                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	<p>The override code instructs system in applying the services to the beneficiary deductible and coinsurance. Valid values are:</p> <p>0 = Apply deductible and coinsurance</p> <p>1 = Do not apply deductible</p> <p>2 = Do not apply coinsurance</p> <p>3 = Do not apply deductible or coinsurance</p> <p>4 = No need for total charges (used for multiple HCPC for single revenue code centers)</p> <p>5 = RHC or CORF psychiatric</p> <p>M = EGHP (may only be used on the 0001 Total line for MSP)</p> <p>N = Non-EGHP (may only be used on the 0001 Total line for MSP)</p> <p>Y = IRS/SSA data match project; MSP cost avoided</p>
FEE	<p>Displays the fee indicator received in the Physician Fee Schedule file. Valid values include: B = Bundled procedure</p> <p>R = Rehab/Audiology Function Test/CORF Services ' ' = Default value</p>
OPH	<p>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:</p> <p>' ' = Default value</p> <p>0 = Fee is applicable</p> <p>1 = Fee is not applicable</p>
CAT	<p>Category Code - This field identifies the CMS category of the DME equipment. This is a one-position alphanumeric field. The valid values are:</p> <p>1 = Inexpensive or other routinely purchased DME</p> <p>2 = DME items requiring frequent maintenance and substantial servicing</p> <p>3 = Certain customized DME items</p> <p>4 = Prosthetic and orthotic devices</p> <p>5 = Capped rental DME items</p> <p>6 = Oxygen and oxygen equipment</p>

FIELD	DESCRIPTION
PCTC	<p>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:</p> <p>PC/TC HPSA Payment Policy</p> <p>0 = Pay the Health Professional Shortage Area (HPSA) bonus.</p> <p>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.</p> <p>2 = Professional component only, pay the HPSA bonus.</p> <p>3 = Technical component only, do not pay the HPSA bonus.</p> <p>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.</p> <p>5 = Incident codes, do not pay the HPSA bonus.</p> <p>6 = Laboratory physician interpretation codes, pay the HPSA bonus.</p> <p>7 = Physical therapy service, do not pay the HPSA bonus.</p> <p>8 = Physician interpretation codes, pay the HPSA bonus.</p> <p>9 = Concept of PC/TC does not apply; do not pay the HPSA bonus.</p>
ANES BASE VAL	Identifies the Anesthesia Base Unit Value. The valid values are 1-199.
TYP	<p>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:</p> <p>M = Originated from MPFS database files</p> <p>' ' = Did not originate from the MPFS database files</p> <p>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.</p>

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

MAP1E02		MEDICARE CLAIMS OFFICE -					
SC		NEW HCPC RATES INQUIRY					
CARRIER 03602		LOC 21	HCPC Q5115	MOD	IND	FEE TYPE	OTHR
EFF DT	TRM DT	60% RATE	62% RATE	REHAB	PROF	NFACPE	VAR COIN
070119							
HCPC DESCRIPTION Injection, rituximab-abbs, biosimilar, (truxima), 10 mg							

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.

OU D 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

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MAP1E91          MEDICARE PART A - JE UAT          ACMFA546 06/09/22
TXM9331  SC      OPIOID USE DISORDER DEMO 99 INQUIRY  A2022300 08:17:48

CCN: █          NPI:

EFF DATE:      TERM DATE:      PROVIDER TYPE:

CAP  CAP LIMIT          G2172          G2067-G2080          G2086-G2088
YEAR USED  MAX        AMT PAID  UNITS  COST SHR AMT UNITS  COST SHR AMT UNITS

CAP
YEAR          G2215-G2216          G1028
              COST SHR AMT UNITS  COST SHR AMT UNITS

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

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