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

## Introduction

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

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

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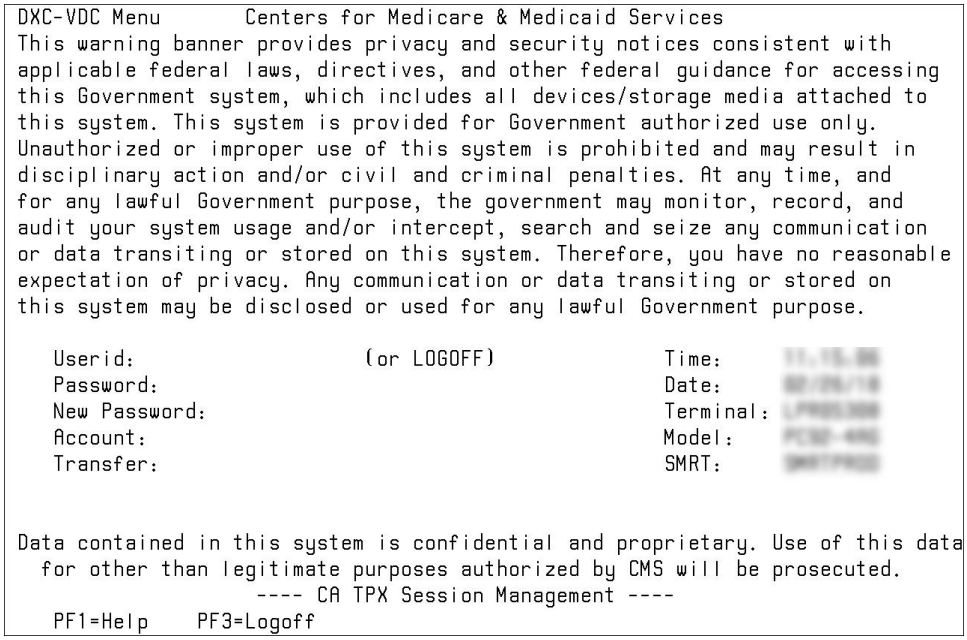
# CHAPTER ONE – GETTING STARTED IN DDE

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

## Signing On

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




### Sign-on Screen 1

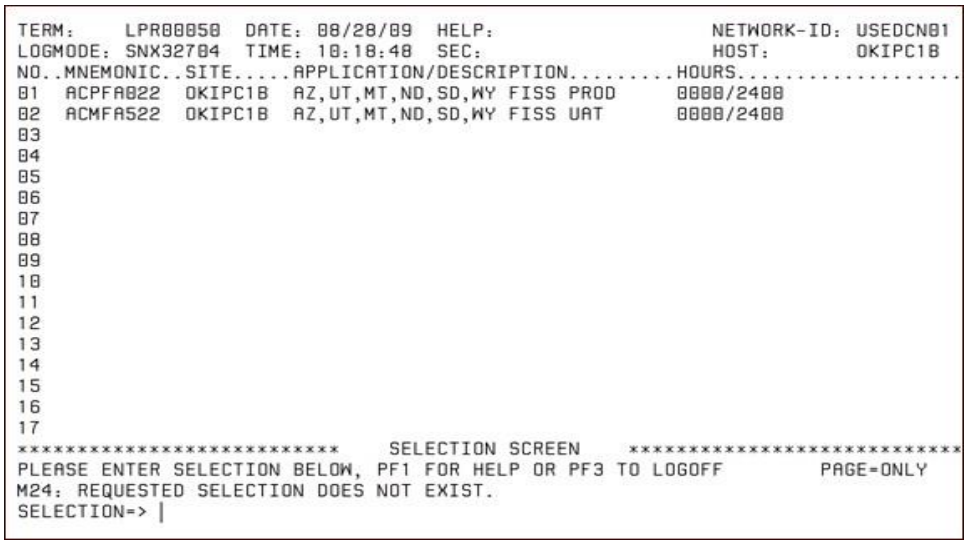
USERID: Type your DDE RACF User ID and press [TAB]. You have three tries to be successful before your login will be disabled.

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

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

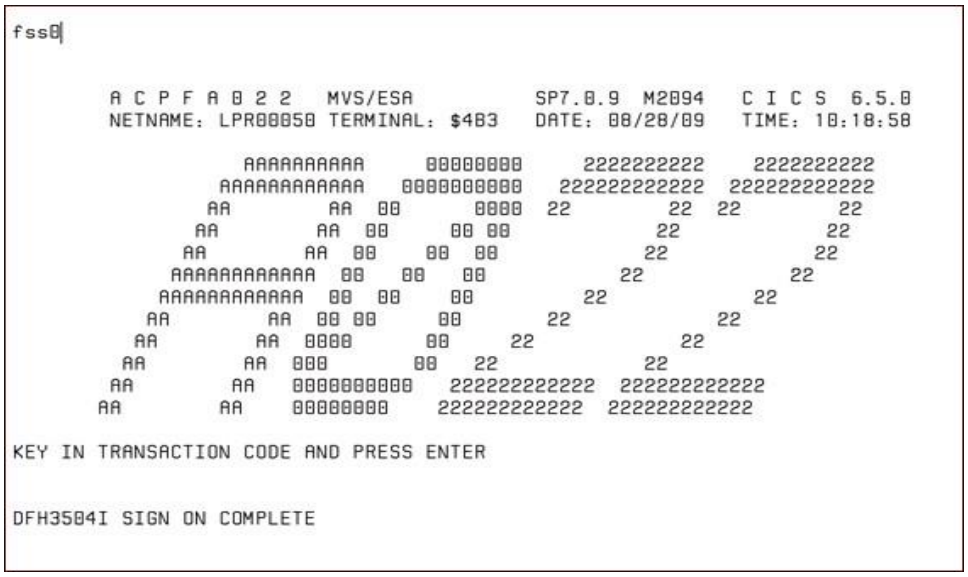
Your password will expire every 30 days for this screen. For security purposes, when your password is typed in, it will not appear on the screen.

### Sign-on Screen 2




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

### Sign-on Screen 3




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

## Signing Off

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

## How To Change Your Password

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

The following guidelines apply:

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

xix. NEW
xx. NOV
xxi. OCT
xxii. PASS
xxiii. ROS
xxiv. SEP
xxv. SIGN
xxvi. SYS
xxvii. TEST
xxviii. TSO
xxix. VALID
xxx. VTAM
xxxi. XXX
xxxii. 1234

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

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

## Menu Selections

Asterisked (*) options may not be applicable.

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

**Main Menu**

01 Inquiries

02 Claims/Attachments

03 Claims Correction

04 Online Reporting

**Inquiry Menu**

10 Beneficiary/CWF

11 DRG (Pricer/Grouper)

12 Claim Summary

13 Revenue Codes

14 HCPC Codes

15 DX/PROC Codes ICD-9

16 Adjustment Reason Codes

17 Reason Codes

88 Invoice No/DCN translator

19 ZIP Code File

1A OSC Repository Inquiry

56 Claim Count Summary*

67 Home Health Payment Totals*

68 ANSI Reason Codes*

FI Check History

1B DX/PROC Codes ICD-10

1C CMHC Payment Totals

1D Prov Practice Addr Quer

1E New HCPC Screen

1F OUD DEMO 99

**Claims Entry Menu**

***Claims Entry:***

20 Inpatient

22 Outpatient 24 SNF

26 Home Health*

28 Hospice*

49 NOE/NOA*

87 Roster Bill Entry

***Attachment Entry:***

41 Home Health*

54 DME History*

57 ESRD CMS-382 Form

**Claims Corrections Menu**

***Claims Correction:***

21 Inpatient

23 Outpatient

25 SNF

27 Home Health*

29 Hospice*

***Claim Adjustment:***

30 Inpatient

31 Outpatient

32 SNF

33 Home Health*

35 Hospice*

***Claim Cancels:***

50 Inpatient

51 Outpatient

52 SNF

53 Home Health*

55 Hospice*

***Attachments:***

42 Pacemaker*

43 Ambulance*

45 Home Health*

Online Reports Menu

R1 Summary of Reports R2 View a Report

R3 Credit Balance Report – CMS 838

## Navigation

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

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

## PF Function Keys

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

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

## Standards And Conventions

| ITEMS | DESCRIPTION |
|---|---|
| ARROWS | Use the arrow keys to move one character at a time in any direction within a field. |
| TAB | Press [TAB] to move forward between fields. Some keyboards may be equipped with a “back tab” key. If yours doesn’t, hold down [SHIFT] key and press [TAB] to move backward between fields. Tabbing backwards is helpful if the cursor is at the top of the screen and you need to move to the bottom of the screen. |
| CTRL R (RESET) | If your screen “freezes up” or “locks up”, hold down the [CTRL] key and press “R” to reset the screen if your keyboard does not have a [RESET] key.<br>Note: Do not use this key combination if the clock symbol “X :” or X SYSTEM displays at the bottom of the screen. This lets you know the system is processing your request. |
| CURSOR | The cursor is the flashing underline that shows you where you are on the screen. |
| NUMBERS | In the examples in this manual, an “X” indicates a place holder for any number 0-9. For example, 42X represents 420 through 429. |
| X : or X SYSTEM | When this symbol displays at the bottom of the screen, the system is processing your request. Do not press keys until this goes away. |
| END KEY | The end key is used to exit or clear a field. |
| HOME | The home key is used to move the cursor to a DDE-defined home field on the screen. |

# Claim Status/Location

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

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

### Digit 1 – STATUS

| CHARACTER | DEFINITION |
|---|---|
| A | Active |
| D | Deny |
| F | Force |
| I | Inactive |
| M | Manual Move |
| P | Paid |
| R | Reject |
| S | Suspense |
| T | Return to Provider |
| U | Return to QIO |

### Digit 2 – PROCESSING TYPE

| CHARACTER | DEFINITION |
|---|---|
| B | Batch |
| M | Manual |
| O | Offline |

### Digits 3 and 4 – DRIVER LOCATION

| CHARACTER | DEFINITION |
|---|---|
| 01 | Status/Location |
| 02 | Control |
| 04 | UB-04 Data |
| 05 | Consistency (I) |
| 06 | Consistency (II) |
| 15 | Administrative |
| 25 | Duplicate |
| 30 | Entitlement |
| 35 | Lab |
| 40 | ESRD |

| CHARACTER | DEFINITION |
|---|---|
| 50 | Medical Policy |
| 55 | Utilization |
| 60 | ADR |
| 65 | PPS/Pricer |
| 70 | Payment |
| 75 | Post Payment |
| 80 | MSP Primary |
| 85 | MSP Secondary |
| 90 | CWF |
| 99 | Session Term |
| AA-ZZ | Customer Defined |

### Digits 5 and 6 – LOCATION

| CHARACTER | DEFINITION |
|---|---|
| 00 | 00 – Batch Process |
| 01 | 01 – CWF |
| 02 | 02 – ADJ Orbit |
| 10 | 10 – Inpatient |
| 11 | 11 – Outpatient |
| 12 | 12 – Special Claims |
| 13 | 13 – Medical Review |
| 14 | 14 – Program Integrity |
| 16 | 16 – MSP |
| 18 | 18 - Production QC |
| 19 | 19 - System Research |
| 21 | 21 – Waiver |
| 65 | 65 – Non-DDE Pacemaker |
| 66 | 66 – DDE Pacemaker |
| 67 | 67 – DDE Home Health |
| 96 | 96 – Payment Floor |
| 97 | 97 – Final Online |
| 98 | 98 – Final Offline |
| 99 | 99 – Final Purged |
| 22 through 64;<br>68 through 79;<br>AA through ZZ | Customer Defined |

## Common Status/Location Codes

| Indicator | Name | Description |
|---|---|---|
| D | Deny | Claim is denied and a redetermination must be done. |
| I | Inactive | Claim has been inactivated and no longer is available to be updated. |
| P | Paid | Claim is paid (includes approved claims where no payment is due, i.e., total charges have been applied to deductible). |
| R | Reject | Claim has been rejected and must either be adjusted or resubmitted. |
| S | Suspense | Claim is processing through the FISS system. Claims in this status cannot be modified by the provider until they have been moved to a “T” status or until they have completed processing. |

| Indicator | Name | Description |
|---|---|---|
| T | Return to Provider | Claim has been returned to provider (RTP) for corrections or further information. |
| B | Batch | Claim is in process and could be going through Common Working File (CWF) or sitting on the payment floor. |
| M | Manual | Claim is in a suspense location and needs to be resolved either by adjudication staff or with an automated edit. |
| O | Offline | Claim is offline and will need to be retrieved if changes are needed. |

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

| Driver Location | Description |
|---|---|
| PB9996 | Claims have completed processing and are being held in the payment floor. |
| PB9997 | Claims have completed and have been released for payment. |
| PB9998 | Claims have been finalized and no longer are online. These claims will have to be retrieved by Noridian before they can be worked. |
| SB6000/SB6001 | Medical Review has sent out Additional Documentation Requests (ADRs) but the requested information has not yet been received. |
| SMSDEN/SMDENY; SM5XXX | Claims in these locations either are waiting to be reviewed by MR or have been reviewed and corrections need to be made by internal staff. MR staff will release claims for processing. |
| SB90FX-SB90M; SB9000 and SB9099 | Claims are processing through CWF to verify patient information, days available, overlapping services, etc. as well as posting claim number (ICN) to file. |
| SMMADJ | Claims are hitting Medicare Secondary Payer (MSP) edits and have suspended for Noridian staff to work. |
| SMSPRX | Claims are processing through edits that have been automated. |
| SM0201 | Claims in this location are adjustment or cancel claims to claims with medically denied lines. Adjudication staff verifies from the remarks why changes are being made or why the claim is being cancelled. |
| SM0401 | Claims in this location are adjustment or cancel claims to claims with medically approved lines. Remarks are verified by adjudication staff. (Similar to SM0201) |
| SM0501 | Claims in this location typically are no pay claims where remarks need to be verified to determine liability or remove denial information if claim is being adjusted to pay. |
| SM0601 | SNF claims in this location are editing because the days billed need to be verified with days remaining or with the units billed with revenue code 0022. Non-SNF claims are suspended in this location because professional services are being billed incorrectly. |
| SM1501 | Claims in this location need name and dosage for unlisted drugs. Bilateral and non-covered procedures need appropriate remarks so claim can process correctly. |
| SM2501 | Claims are duplicate or overlapping with the same date of service to other claims already in the system. Adjudication will verify if the services truly are duplicates or should be billed together on the same claim. |
| SM3001 | Claims are past the appropriate guidelines for timely filing and need remarks as to why they are being submitted late. Claims meeting CMS guidelines will be approved and processed past these edits. |
| SM3501 | Claims in this location need to be updated with the appropriate pricing by Noridian or will be returned to the provider to verify if the HCPC used is valid. |
| SM4001 | ESRD claims typically editing out for too many runs billed within the appropriate month. |
| SM5501 | INPT claims where adjudication needs to verify the days billed with the days actually remaining in CWF. Also LTR and co-insurance days need appropriate value codes and amounts. |

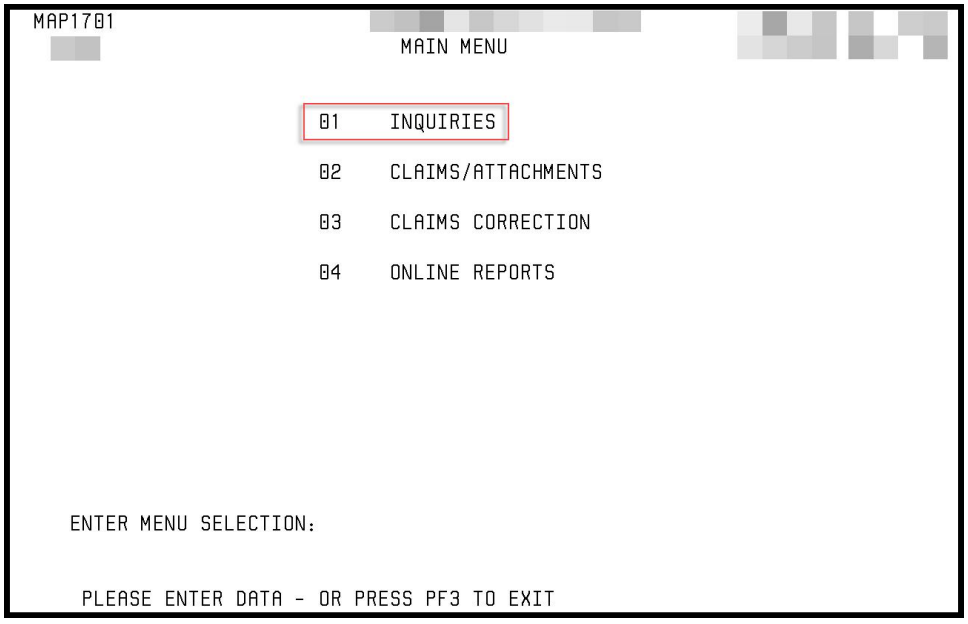
| Driver Location | Description |
|---|---|
| SM6501 | Claims in this location need to be edited for appropriate cost outlier billing. |
| SM7001 | These are adjustment claims being reviewed by adjudication staff to verify the correct condition code was used for the adjustment claim. |
| SM9001 | Claims in this location are editing for CWF related issues. Benefit days available, claims overlapping with other outpatient or inpatient claims, as well as HMO information are all reasons why claims may be in this location. |
| SM9501 | Claims in this location have all non-covered lines. Adjudication staff verifies if the same reason code is on all the lines and rejects/denies the claim accordingly. |
| TB9996 | Claims in this location have errors that need to be addressed by the provider and are being moved to the provider's RTP location. They will be available for correction the following day. |
| TB9997 | Claims in this location need to be corrected by the provider. Be sure to check the remarks page for comments. |

# CHAPTER TWO – DIRECT DATA ENTRY (DDE)

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

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

## Main Menu – MAP1701



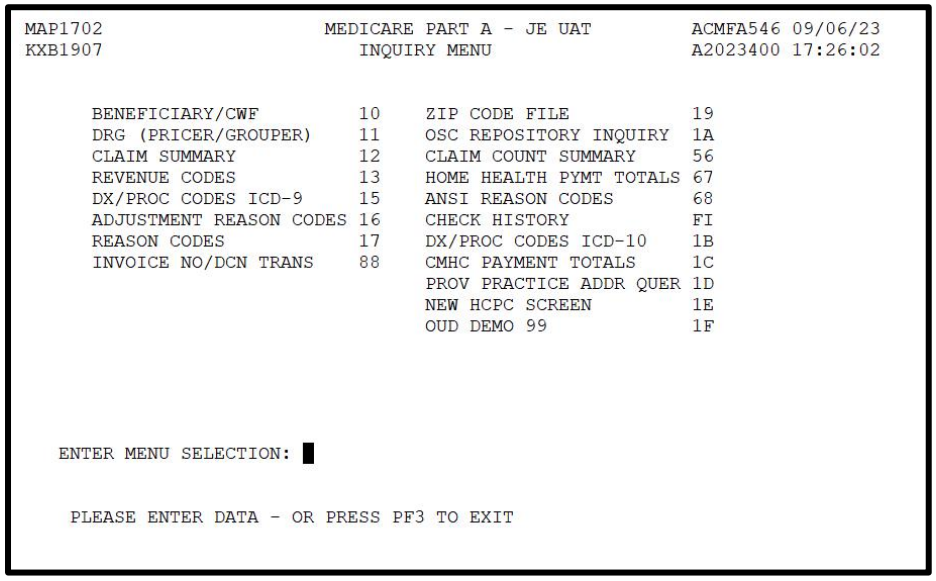

# CHAPTER THREE – INQUIRY MENU

The submenus on the Inquiry Menu allow the user to:

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

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

## Inquiry Menu – MAP1702




### 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 -
        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. |
| TRANSFER HIC | This field is not used in DDE. |

| FIELD | DESCRIPTION |
|---|---|
| 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:<br>8 = 1800s<br>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. |

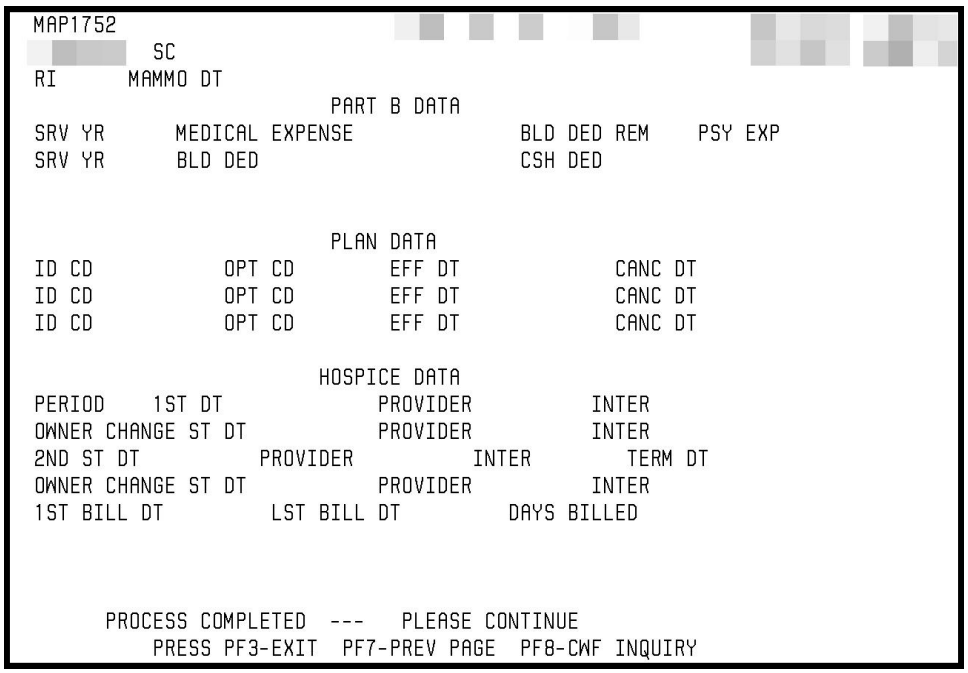
### CURRENT BENEFIT PERIOD DATA

| FIELD | DESCRIPTION |
|---|---|
| FRST BILL DT | The beginning date of benefit period. |
| LST BILL DT | The ending date of benefit period. |
| 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:<br>Y = Date is through date of interim bill / utilization day<br>N = Discharge date / not a utilization day |

## Beneficiary/CWF Screen – MAP1752




| 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 | 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:<br>Position 1 H<br>Position 2 & 3 State Code<br>Position 4 & 5 Plan number within the state |

| FIELD | DESCRIPTION |
|---|---|
| OPT CD | This field identifies whether the current Plan services are restricted or unrestricted. Valid values are:<br>Unrestricted—<br>1 = Intermediary to process all Part A and B provider claims.<br>2 = MA Plan to process claims for directly provided service and for services from Providers with effective arrangements. Intermediary to process all other claims.<br>Restricted—<br>A = Intermediary to process all Part A and B provider claims.<br>B = MA Plan to process claims only for directly provided services.<br>C = MA Plan to process all claims. |
| EFF DT | The effective date for the MA Plan benefits. |
| CANC DT | The termination date for the MA Plan benefits. |

**HOSPICE DATA**

| FIELD | DESCRIPTION |
|---|---|
| PERIOD | Specific Hospice election period. Valid values are:<br>1 = The first time a beneficiary uses Hospice benefits.<br>2 = The second time a beneficiary uses Hospice benefits. |
| 1ST DT | First Hospice Start Date of the beneficiary's effective period (1-4) with the hospice provider. |
| PROVIDER | A 13-character alphanumeric field that identifies each hospice provider. |
| INTER | A 6-character alphanumeric field that identifies each Intermediary number for the hospice provider (1-4). |
| OWNER CHANGE ST DT | The Change of Ownership Start Date field will display the start date of a change of ownership within the period for the first provider. |
| PROVIDER | The number of the Medicare hospice provider. |
| INTER | The Intermediary number for the hospice provider. |
| 2ND ST DT | A 6-character field that identifies the start date for each 2nd hospice period (1-4). |
| PROVIDER | A 13-character alphanumeric field that indicates the identification number of the 2nd hospice provider. |
| 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                    [redacted]
[redacted]   SC

CLAIM              NAME          DOB         SEX    INTER

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

                        REQUIRED DATA NOT ENTERED

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

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

## Beneficiary/CWF Screen – MAP175J

```
 MAP175J                  MEDICARE PART A - JE UAT          ACMFA546 06/07/23
 NAK3378   SC                      ACCEPTED                  A2023300 13:22:59
 MID                NM          IT   DB          SX
PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D
CARD/80061 010105 010105   DIAB/82951 010105 010105   AAA /      070107 070107
CARD/82465 010105 010105   PCBE/G0101 070101 010113   PTWR/G9143 080309 080309
CARD/83718 010105 010105                              IPPE/G0402 SRV    SRV
CARD/84478 010105 010105   PROS/G0102 GDR    GDR      IPPE/G0403 SRV    SRV
COLO/G0104 010198 010198   PROS/G0103 GDR    GDR      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/      040113 040113   CR  /      0000   0000
COLO/G0121 070101 070101   PAPT/      070101 070101   ICR /      0000   0000
FOBT/G0107 TERM   TERM     HIBC/G0445 110811 110811   AWV /G0438 0000   010111
FOBT/G0328 010123 100116   HBV/       092816 092816   AWV /G0439 0000   010111
FOBT/82270 010123 100116   SETS/93668 0072           BEHV/G0447 112911 112911
IPPE/G0344 SRV    SRV      CCBB/G0327 AGE            APRP/G0465
IPPE/G0366 SRV    SRV      AUDG/      070123 070123
IPPE/G0367 SRV    0000
IPPE/G0368 0000   SRV
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 | 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:<br>PTB = Beneficiary not entitled to Part B<br>RCVD = Beneficiary already received service<br>DOD =Beneficiary not eligible due to DOD<br>GDR = Beneficiary not eligible due to gender<br>AGE = Beneficiary not eligible due to age<br>SRV = Beneficiary not eligible for the service<br>VAC = Beneficiary already vaccinated<br>0000 = Service not applicable |
| PROF D | This field identifies the date the beneficiary is eligible for coverage of the professional portion of preventive service charges. When there is not a date, one of the following messages display to explain why the beneficiary is not eligible:<br>PTB = Beneficiary not entitled to Part B<br>RCVD = Beneficiary already received service<br>DOD = Beneficiary not eligible due to DOD<br>GDR = Beneficiary not eligible due to gender<br>AGE = Beneficiary not eligible due to age<br>SRV = Beneficiary not eligible for the service<br>VAC = Beneficiary already vaccinated<br>0000 = Service not applicable |

## Beneficiary/CWF Screen – MAP175M

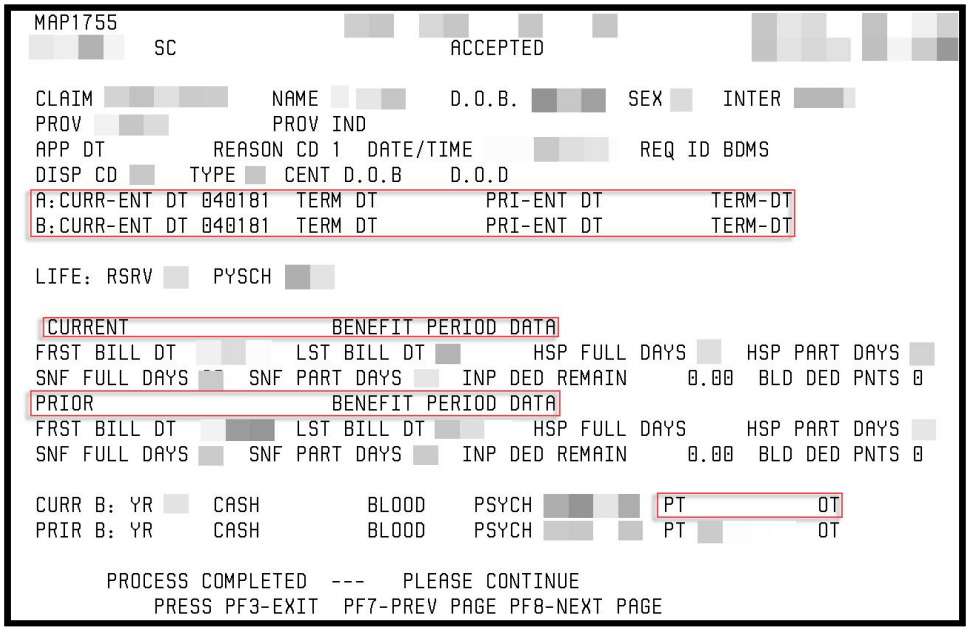
```
 MAP175M                    MEDICARE PART A - JE UAT          ACMFA546 06/09/22
 TXM9331   SC                      ACCEPTED                   A2022300 10:47:47
 MID                 NM          IT   DB           SX
PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D
TELH/99231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

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

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

## Beneficiary/CWF Screen – MAP1755

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



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

## PART A

| FIELD | DESCRIPTION |
|---|---|
| CURR-ENT DT | Current Part A benefits entitlement date. |
| TERM DT | Termination date for Part A benefits. |
| PRI-ENT DT | Prior entitlement date for Part A benefits. |
| 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. |
| HSP FULL DAYS | The number of regular hospital full days the beneficiary has remaining in the current benefit period. |
| HSP PART DAYS | The number of hospital coinsurance days the beneficiary has remaining in the current benefit period. |
| SNF FULL DAYS | The number of SNF full days the beneficiary has remaining in the current benefit period. |
| SNF PART DAYS | The number of SNF coinsurance days the beneficiary has remaining in the current benefit period. |
| INP DED REMAIN | The amount of inpatient deductible remaining to be met by the beneficiary for the benefit period. |
| BLD DED PNTS | The number of blood deductible pints remaining to be met by the beneficiary for the benefit period. |

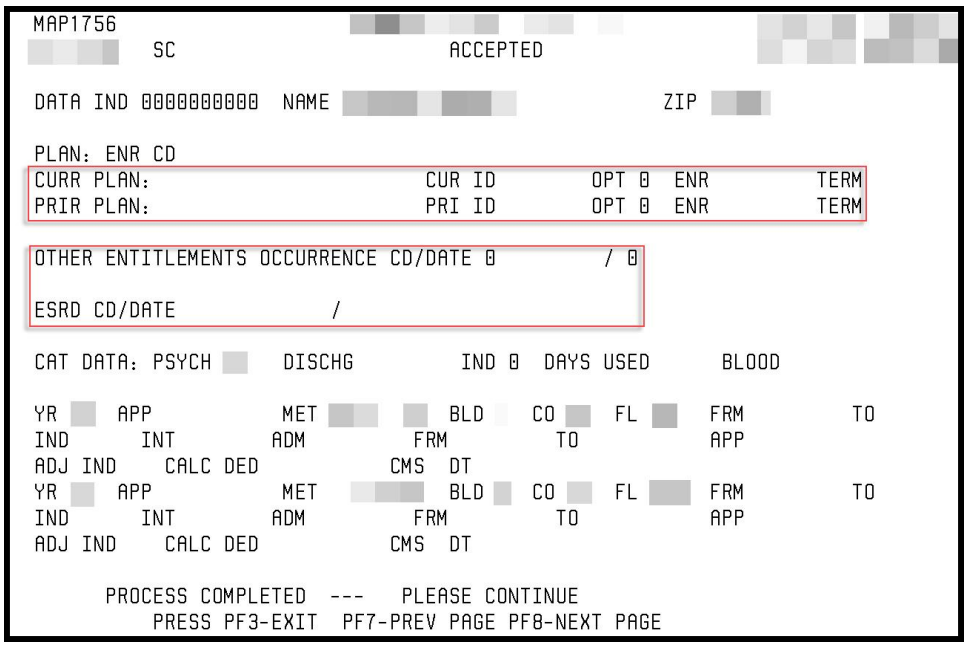
**CURRENT B**

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

**PRIOR B**

| FIELD | DESCRIPTION |
|---|---|
| YR | The prior Medicare Part B year. |
| CASH | The Part B cash deductible remaining to be met in the prior year. |
| BLOOD | The Part B blood deductible pints remaining to be met in the prior year. |
| PSYCH | The remaining psychiatric limit in the prior year. |
| PT | Physical therapy/speech language pathology dollars remaining in the prior year. |
| OT | Occupational therapy dollars remaining in the prior year. |

## Beneficiary/CWF Screen – MAP1756




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

## CURRENT PLAN

| FIELD | DESCRIPTION |
|---|---|
| CUR ID | Current MA Plan ID code assigned by CMS.<br>Position Description 1 H or 1-9<br>2 & 3 State code<br>4 & 5 Plan number within the state |

| FIELD | DESCRIPTION |
|---|---|
| OPT | MA Plan Option Code. Valid values are:<br>Unrestricted<br>1 = Intermediary to process all Part A and Part B provider claims<br>2 = MA Plan to process claims for directly provided services from providers with effective arrangements, intermediary to process all other claims<br>Restricted<br>A = Intermediary to process all claims.<br>B = MA Plan to process claims for directly provided services.<br>C = MA Plan to process all claims. |
| ENR | The enrollment date of the Plan benefits in MMDDYY format. |
| TERM DT | The termination date of the Plan benefits in MMDDYY format. |

## PRIOR PLAN

| FIELD | DESCRIPTION |
|---|---|
| PRI ID | Prior Health ID code assigned by CMS:<br>1 H or 1-9<br>2 & 3 State code<br>4 & 5 Plan number within the state |
| OPT | MA Plan Option Code. Valid values are:<br>Unrestricted<br>1 = Intermediary to process all Part A and Part B provider claims<br>2 = MA Plan to process claims for directly provided services from providers with effective arrangements, intermediary to process all other claims<br>Restricted<br>A = Intermediary to process all claims.<br>B = MA Plan to process claims for directly provided services.<br>C = MA Plan to process all claims. |
| ENR | The enrollment date of the MA Plan benefits for the prior year. |
| TERM | Termination date of the MA Plan benefits for the prior year. |
| OTHER ENTITLEMENTS OCCURRENCE CD/DATE | The first two occurrence codes and dates indicating another Federal Program or another type of insurance that may be the primary payer. Valid occurrence code values include:<br>1 = Worker's Compensation Coverage<br>2 = Black Lung<br>A = Working Aged beneficiary or spouse covered by Employer Group Health Plan (EGHP)<br>B = End Stage Renal Disease (ESRD) beneficiary in 30-month coordination period and covered by employer health plan<br>C = Medicare has made a conditional payment pending final resolution<br>D = Automobile no-fault or other liability insurance involvement<br>E = Workers' Compensation<br>F = Veteran's Administration program, public health service or other federal agency program<br>G = Working disabled beneficiary or spouse covered by Employer Group Health Plan<br>H = Black Lung<br>I = Veteran's Administration Program Occurrence Codes Date Definition<br>1 or 2: Date is the effective date of applicable program involvement.<br>A - I: Date is the date of previous claim where Medicare was determined to be secondary. |
| ESRD CD/ DATE | The home dialysis method and effective date in MMDDCCYY format. Valid values are:<br>1 = Beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claim.<br>2 = Beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and beneficiary submits claim to Carrier. |

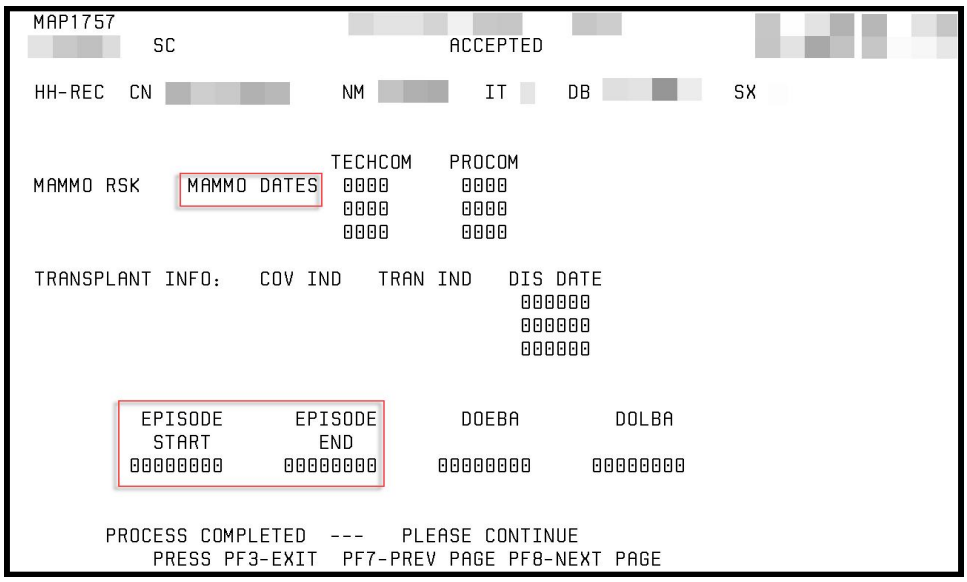
## CAT DATA

| 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:<br>0 = Initialized<br>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. |
| IND | The yearly data indicators:<br>POS 1<br>0 = Not Used<br>2 = Clerical Involvement<br>3 = Religious Non-Medical Healthcare Institution/SNF Usage<br>4 = Both 1 and 2<br>POS 2<br>0 = Not Used<br>1 = Through date is interim<br>POS 3-4<br>Reserved for future use |
| INT | The fiscal intermediary number for earliest processed hospital bill with a deductible. |
| ADM | The Admission Date for the earliest processed hospital bill with a deductible. |
| FROM | The From Date for the earliest hospital bill processed with a deductible. |
| TO | The Through Date for the earliest hospital bill processed with a deductible. |
| APP | Deductible amount applied for the earliest hospital bill processed with a deductible. |
| ADJ IND | The type of adjustment made. Valid values are:<br>0 = No Adjustment<br>1 = Downward Adjustment<br>2 = Upward Adjustment |
| CALC DED | The amount of deductible calculated. |
| CMS DATE | The date the claim was processed by CMS. |

## Beneficiary/CWF Screen – MAP1757




| FIELD | DESCRIPTION |
|---|---|
| HH-REC | The requested Home Health record. |
| CN | Displays the identification number for a claim. If an adjustment or a RTP is being processed, the DCN for the claim will appear. If this is a MSP claim the field will be blank. |
| NM | The last name of the beneficiary. |
| IT | The first initial of the beneficiary name. |
| DB | The date of birth of the beneficiary. |
| SX | Sex of the beneficiary. Valid values:<br>Y = Female<br>M = Male |
| PAP RSK | PAP Risk Indicator. Valid values are:<br>Y = Yes<br>N = No |
| PAP DATE | The date of the beneficiary's last PAP Smear. |
| MAMMO RSK | The mammography risk indicator. Valid values are:<br>Y = Yes<br>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.<br>Y = High Risk<br>N = Not High Risk |
| DT 3 | The date the RISK code was returned from CWF. |

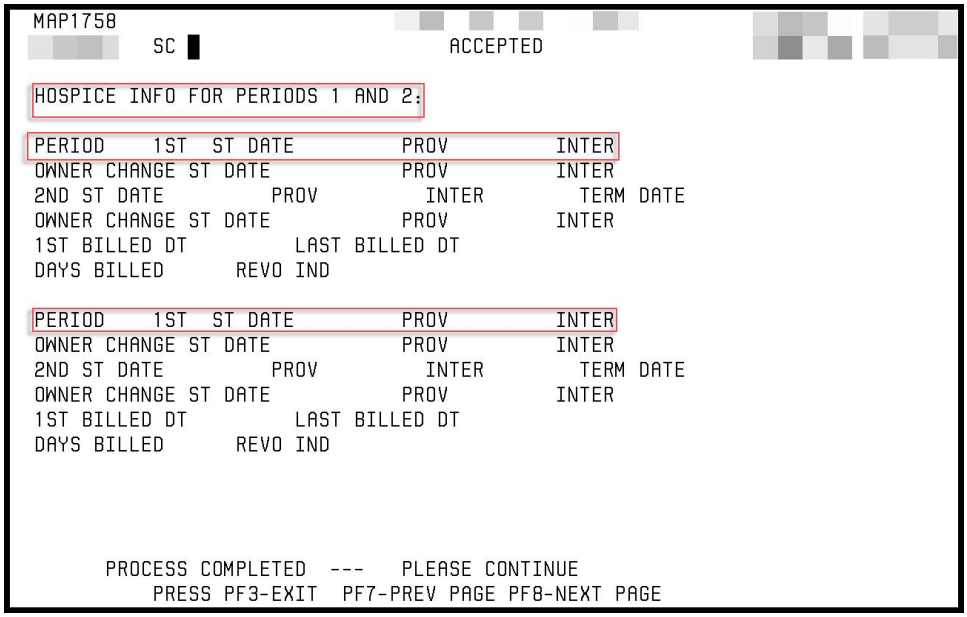
## TRANSPLANT INFO

| FIELD | DESCRIPTION |
|---|---|
| COV IND | The “Transplant Covered Indicator.” Valid values are:<br>Y = Covered Transplant<br>N = Non-covered Transplant |
| TRAN IND | The type of transplant performed. Valid values are:<br>1 = Allogeneous Bone Marrow<br>2 = Autologous Bone Marrow<br>H = Heart Transplant<br>K = Kidney Transplant<br>L = Liver Transplant |
| DIS DATE | The discharge date for the transplant patient. There may be up to three discharge dates displayed. |

### HOME HEALTH

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

## Beneficiary/CWF Screen – MAP1758




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

### PERIOD 1

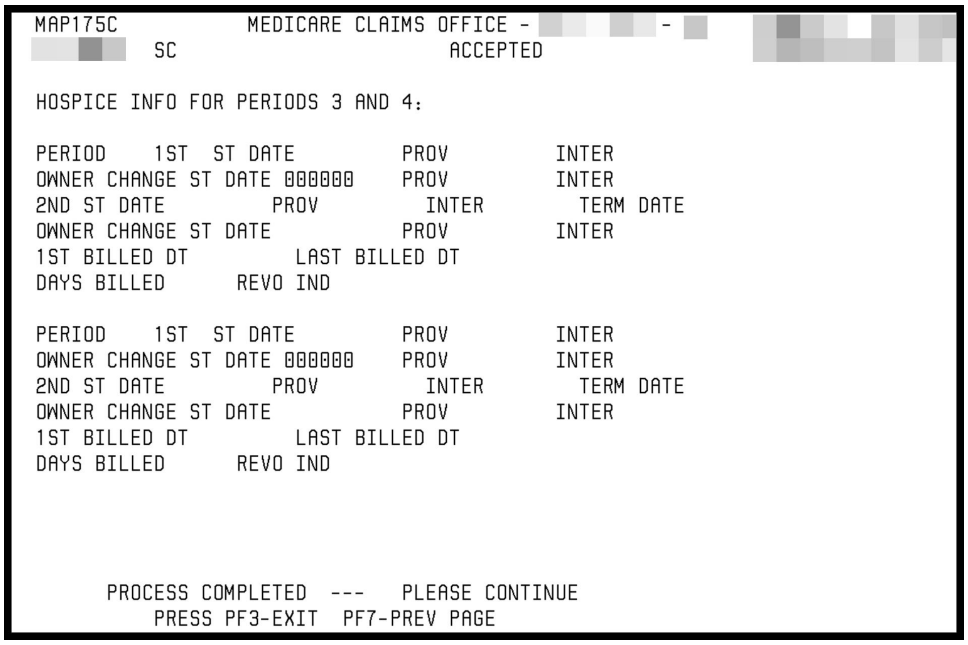
| FIELD | DESCRIPTION |
|---|---|
| PERIOD | The Hospice Benefit Period Number. Valid values are:<br>1 = First time a beneficiary uses hospice benefits<br>2 = Second time a beneficiary uses hospice benefits |
| 1ST START DATE | The beneficiary’s effective period with the hospice provider. |
| PROV | The hospice’s Medicare provider number. |

| FIELD | DESCRIPTION |
|---|---|
| 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:<br>1 = First time a beneficiary uses hospice benefits<br>2 = Second time a beneficiary uses hospice benefits |
| 1ST START DATE | The beneficiary's effective period with the hospice provider in MMDDYY format. |
| PROV | The hospice's Medicare provider number. |
| INTER | The hospice's Intermediary number. |
| OWNER CHANGE ST DATE | The start date of a change of ownership for the first provider, within the election period. |
| PROV | The number of the Medicare hospice provider. |
| INTER | The Intermediary number. |
| 2ND START DATE | The date the second benefit period began. |
| PROV | The second hospice's Medicare provider number. |
| INTER | The second hospice's Intermediary number. |
| TERM DATE | The date the hospice benefit period was terminated. |
| OWNER CHANGE ST DATE | The start date of a change of ownership within the period for the second provider. |
| PROV | The second hospice's Medicare provider number. |
| INTER | The second hospice's Intermediary number. |
| 1ST BILLED DT | The date of each earliest hospice bill date. |
| LAST BILLED DT | Each most recent hospice bill date. |
| DAYS BILLED | Number of hospice dates used for each hospice period. |
| REVO IND | The revocation indicator per hospice period. |

## Beneficiary/CWF Screen – MAP175C




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

## PERIOD 3

| FIELD | DESCRIPTION |
|---|---|
| PERIOD | The Hospice Benefit Period Number. Valid values are:<br>3 = Third time a beneficiary uses hospice benefits<br>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. |
| 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. |

| FIELD | DESCRIPTION |
|---|---|
| REVO IND | The revocation indicator per hospice period. |

**PERIOD 4**

| FIELD | DESCRIPTION |
|---|---|
| PERIOD | The Hospice Benefit Period Number. Valid values are:<br>3 = Third time a beneficiary uses hospice benefits<br>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. |
| 2ND START DATE | The date the second benefit period began. |
| PROV | The second hospice's Medicare provider number. |
| INTER | The second hospice's Intermediary number. |
| TERM DATE | The date the hospice benefit period was terminated. |
| OWNER CHANGE ST DATE | The start date of a change of ownership within the period for the second Provider. |
| PROV | The second hospice's Medicare provider number. |
| INTER | The second hospice's Intermediary number. |
| 1ST BILLED DT | The date of each earliest hospice bill date. |
| LAST BILLED DT | Each most recent hospice bill date. |
| DAYS BILLED | Number of hospice dates used for each hospice period. |
| REVO IND | The revocation indicator per hospice period. |

## Beneficiary/CWF Screen – MAP175K

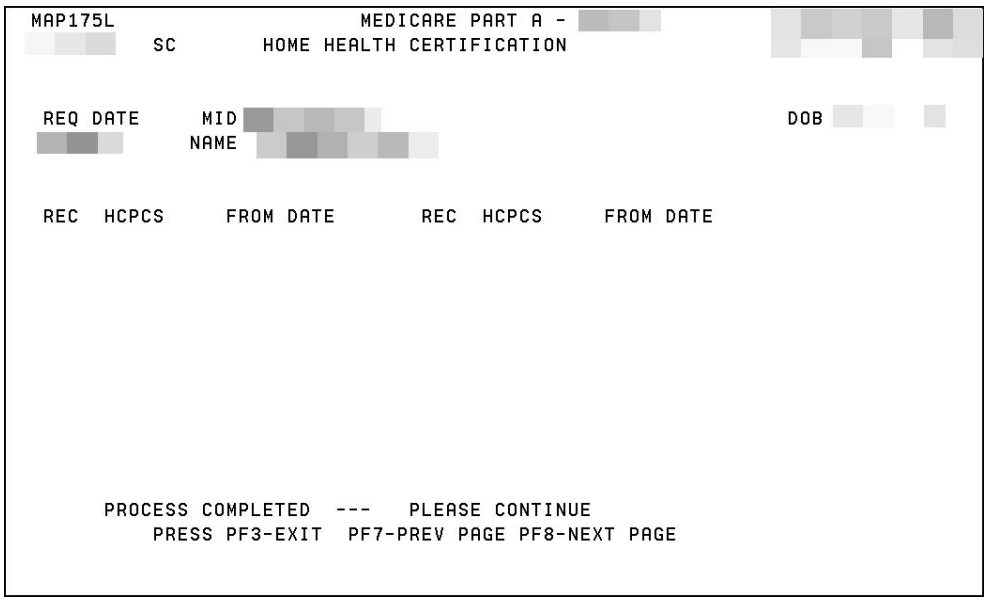
```
 MAP175K                    MEDICARE PART A -
      SC
           SMOKING AND TOBACCO USE CESSATION COUNSELING SERVICES

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









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

| FIELD | DESCRIPTION |
|---|---|
| MID | The beneficiary's Medicare ID number. |

| FIELD | DESCRIPTION |
|---|---|
| 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:<br>F = Female<br>M = Male |
| COUNSELING PERIOD | This field identifies up to five years of counseling data.<br>1 = One year<br>2 = Two years<br>3 = Three years<br>4 = Four years<br>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.<br>1 = One year<br>2 = Two years<br>3 = Three years<br>4 = Four years<br>5 = Five years |
| QT | The number of services billed for each date. |
| TP | The claim type. Valid values are:<br>0 = Outpatient<br>B = Part B |

## Beneficiary/CWF Screen – MAP175L

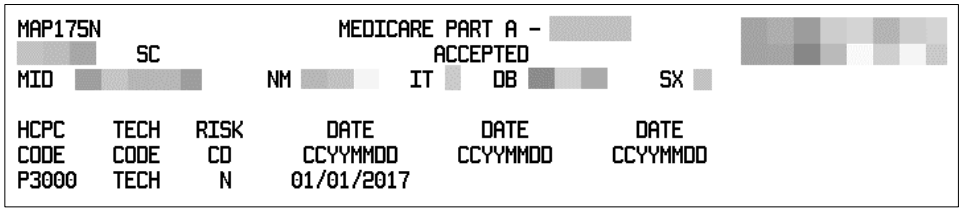
MAP175L is used for Home Health Certification Plan of Care data. It displays up to 20 occurrences of HCPC codes G0179 and G0180, with dates for certification up to nine months prior to the current date.




| FIELD | DESCRIPTION |
|---|---|
| MID | The Medicare ID number used to bill the claim. |
| DOB | The beneficiary's date of birth. |
| REQ DATE | The date of the request. |
| NAME | The full name associated with the Medicare ID number. |
| REC (LEFT COLUMN) | This field displays the Home Health Certification records one through ten on the CWF Reply Record. |
| REC (CENTER COLUMN) | This field displays the Home Health Certification records 11 through 20 on the CWF Reply Record. |
| HCPCS (BOTH COLUMNS) | This field identifies the health insurance record number. |
| FROM DATE (LEFT) | This field identifies the Home Health From Date records one through ten. |
| FROM DATE (RIGHT) | This field identifies the Home Health From Date records 11 through 20. |

## Beneficiary/CWF Screen – MAP175N

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

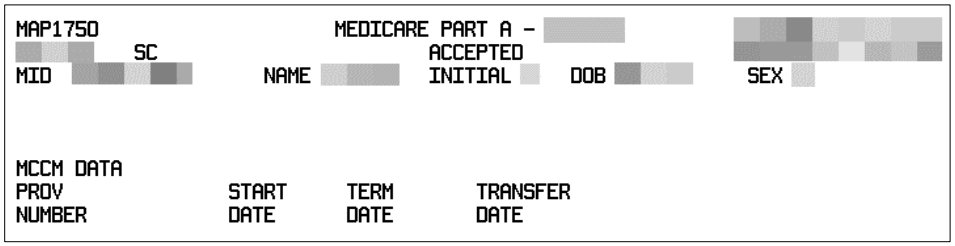



| FIELD | DESCRIPTION |
|---|---|
| MID | The Medicare ID number used to bill the claim. |
| NM | The first six digits of the last name of the beneficiary. |
| IT | The first initial of the beneficiary. |
| DB | The beneficiary's date of birth. |
| SX | The sex of the beneficiary. |
| HCPC CODE | This field displays the Home Health Certification records one through ten on the CWF Reply Record. |

| FIELD | DESCRIPTION |
|---|---|
| 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:<br>Y = High Risk<br>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. |
| DATE CCYYMMDD (RIGHT) | The date the RISK code was returned from CWF. |

## Beneficiary/CWF Screen – MAP175O

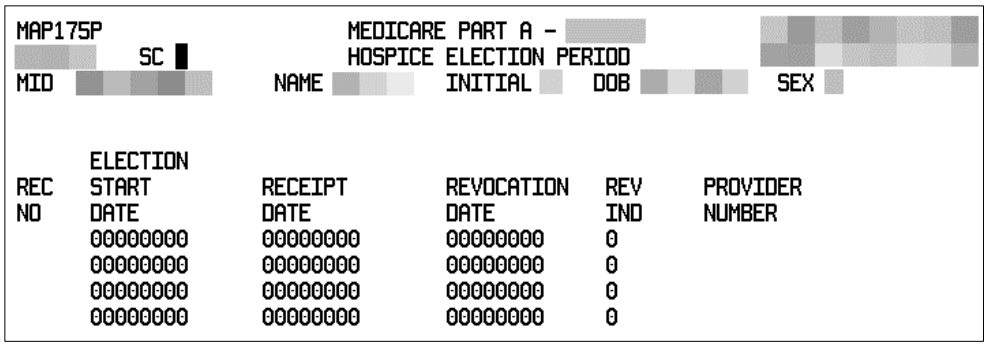
MAP175O is a Beneficiary Eligibility screen to show the MCCM auxiliary file information.




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

## Beneficiary/CWF Screen – MAP175P

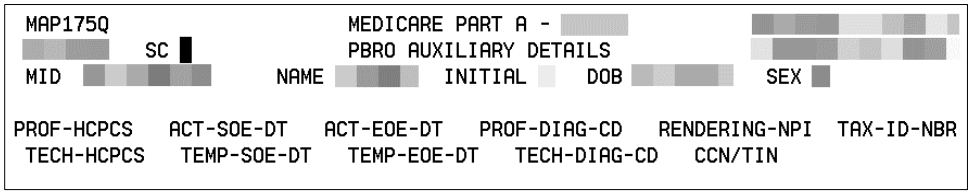
MAP175P is a Hospice Election Period screen displaying HOEP auxiliary file information. It displays the most recent four episodes.




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

## Beneficiary/CWF Screen – MAP175Q

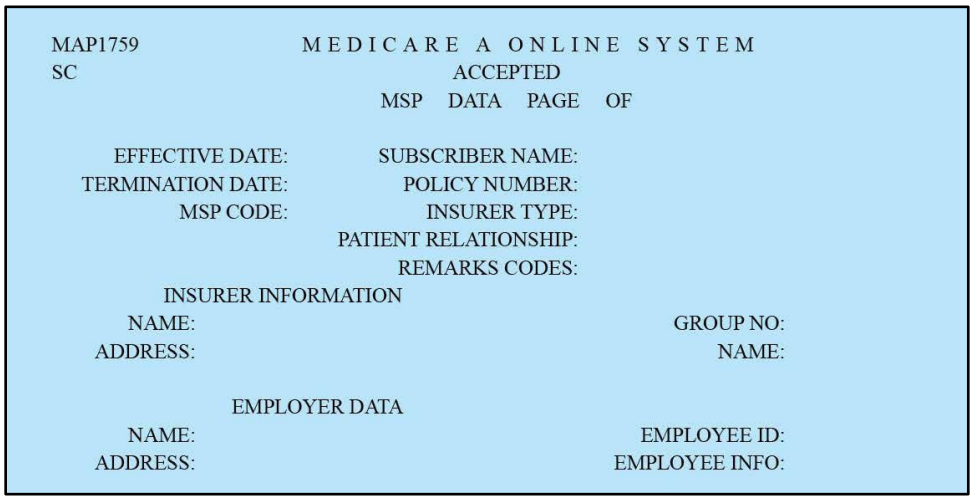
MAP175Q is a Radiation Oncology (RO) Model screen showing the Prospective Bundled Payments for Radiation Oncology Model (PBRO) auxiliary file information.




| FIELD | DESCRIPTION |
|---|---|
| MID | The Medicare ID number used to bill the claim. |
| NAME | The first six digits of the last name of the beneficiary. |
| INITIAL | The first initial of the beneficiary. |
| DOB | The beneficiary's date of birth. |
| SEX | The sex of the beneficiary. |
| PROF-HCPCS | The Professional RO Model HCPCS codes billed on the claim. |
| ACT-SOE-DT | The start date of the RO Model Episode. |
| ACT-EOE-DT | The end date of the RO Model Episode. |
| PROF-DIAG-CD | The RO Model Diagnosis Code billed on the claim. |

| FIELD | DESCRIPTION |
|---|---|
| RENDERING-NPI | The NPI of the Rendering Physician on the claim. |
| TAX-ID-NBR | The Professional Participant billed on the claim. |
| TECH-HCPCS | The Facility/Technical RO Model-specific HCPCS code billed on the claim. |
| TEMP-SOE-DT | The Temporary start of the episode. |
| TEMP-EOE-DT | The Temporary end of the episode. |
| TECH-DIAG-CD | The Technical First Diagnosis Code or Line Item Diagnosis Code billed on the claim. |
| CCN/TIN | The Facility/Technical participant billed on the claim. |

## Beneficiary/CWF Screen – MAP1759




### MSP DATA

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

### INSURER INFORMATION

| FIELD | DESCRIPTION |
|---|---|
| NAME | Name of the insurance company that may be primary over Medicare. |
| GROUP NO | The group number for the policyholder with this insurer name. |
| ADDRESS | The street, city, state and zip code for the insurer. |
| NAME | The name of the insurer group. |

**EMPLOYER DATA**

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

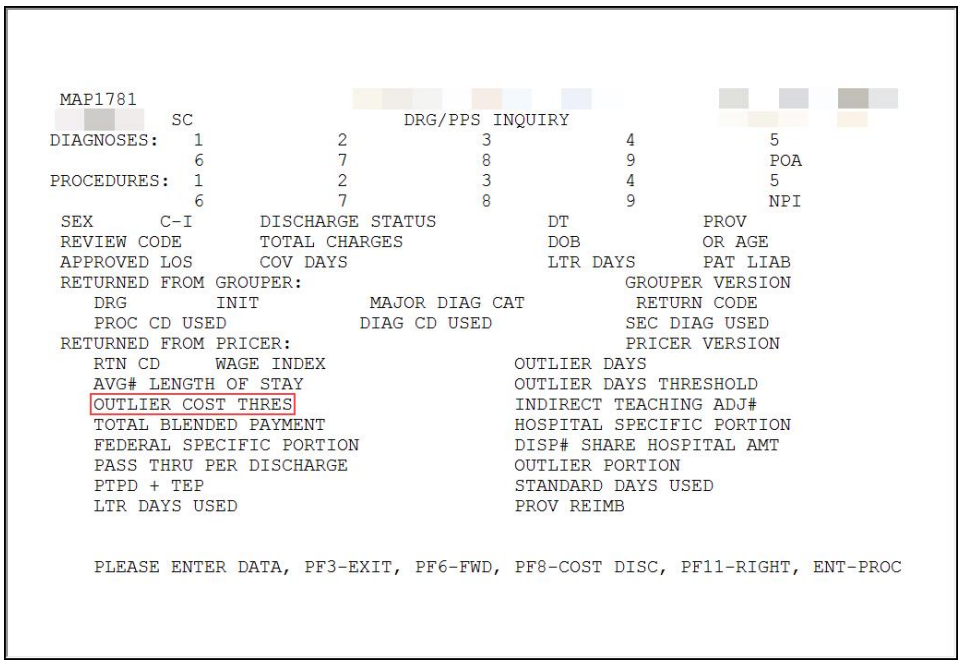
## DRG (PRICER/GROUPER) – OPTION 11

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

To begin the inquiry, enter the following data:

- Principal and up to 8 additional diagnosis codes (do not include admitting diagnosis). Include the appropriate Present on Admission (POA) indicator (Y, N, U, W, or 1) following each diagnosis code.
- End of Present On Admission (POA) Indicator (Z or X)
- Principal and up to five additional procedures codes
- NPI
- Beneficiary's sex
- Discharge status code
- Discharge date (MMDDYY)
- Total Charges
- Beneficiary's date of birth or age (MMDDYYYY)
- Approved LOS – number of days approved by QIO, normally same as covered days
- Covered days

## DRG/PPS Inquiry Screen – MAP1781




| FIELD | DESCRIPTION |
|---|---|
| DIAGNOSIS | Diagnosis Codes - This field identifies up to nine ICD-9-CM codes for conditions coexisting on a particular claim. NOTE: The first page displays occurrences 01 through 09. Pressing PF6 displays occurrences 10 through 18. Pressing PF6 again displays occurrences 19 through 25. The last two occurrences on the last page are protected (no data may be entered.) Pressing PF5 allows the previous page to display. This is a seven-position alphanumeric field, with 25 occurrences. There are also two additional positions with one being blank, and the next position is the first character of the Present On Admission (POA) Indicator (for every principal and secondary diagnosis effective with discharges on or after 01/01/08). The POA Indicator identifies whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The valid values for the POA Indicator are:<br>Y = Yes, Present at the time of inpatient admission.<br>N = No, not present at the time of inpatient admission.<br>U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission.<br>W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.<br>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.<br>' ' = Not acute care, POAs do not apply. |
| POA | This field identifies the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. This is a one-position alphanumeric field. The valid values are:<br>Z = The end of POA indicators for principal and, if applicable, other diagnoses.<br>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.<br>' ' = Not acute care, POA's do not apply. |

| FIELD | DESCRIPTION |
|---|---|
| PROCEDURES | Procedure Codes - The ICD-9-CM code(s) identifies the principal procedure (1st code) and up to 25 other procedures performed during the billing period covered by this claim. Required for inpatient claims. This is a seven-position alphanumeric field, with 25 occurrences.<br>NOTE: The first page displays occurrences 01 through 09. Pressing PF6 displays occurrences 10 through 18. Pressing<br>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. |
| 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:<br>8 = 1800-1899<br>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. |
| REVIEW CODE | Indicates the code used in calculating the standard payment. Valid values are:<br>00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers<br>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<br>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<br>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<br>04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers<br>05 = Pay transfer with cost – Pays transfer with cost outlier approved<br>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<br>07 = Pay without cost – Calculates the standard payment without cost portion<br>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<br>11 = Pay transfer special DRG no cost post acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate the cost outlier portion of the payment |
| TOTAL CHARGES | The total covered charges submitted on the claim. |
| DOB | The beneficiary's date of birth. |

| FIELD | DESCRIPTION |
|---|---|
| OR AGE | The beneficiary's age at the time of discharge. This field may be used instead of the date of birth and century indicator. |
| APPROVED LOS | The approved length of stay (LOS) is necessary for the Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases, to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay. |
| 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. |
| MAJOR DIAG CAT | Identifies the category in which the DRG resides. Valid values are:<br>01 = Diseases and Disorders of the Nervous System<br>02 = Diseases and Disorders of the Eye<br>03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat<br>04 = Diseases and Disorders of the Respiratory System<br>05 = Diseases and Disorders of the Circulatory System<br>06 = Diseases and Disorders of the Digestive System<br>07 = Diseases and Disorders of the Hepatobiliary System and Pancreas<br>08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue<br>09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast<br>10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders<br>11 = Diseases and Disorders of the Kidney and Urinary Tract<br>12 = Diseases and Disorders of the Male Reproductive System<br>13 = Diseases and Disorders of the Female Reproductive System<br>14 = Pregnancy, Childbirth, and the Puerperium<br>15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period<br>16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders<br>17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms<br>18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites)<br>19 = Mental Diseases and Disorders<br>20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders<br>21 = Injuries, Poisonings, and Toxic Effects of Drugs<br>22 = Burns<br>23 = Factors Influencing Health Status and Other Contacts with Health Services<br>24 = Multiple Significant Trauma<br>25 = Human Immunodeficiency Viral Infections |
| PROC CD USED | ICD-9-CM procedure code(s) that identifies the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims. |
| DIAG CD USED | Identifies the primary ICD-9-CM diagnosis code used by the Grouper program for calculation. |

| FIELD | DESCRIPTION |
|---|---|
| SEC DIAG USED | ICD-9-CM diagnosis code used by the Grouper program for calculation. |

## RETURNED FROM PRICER

| FIELD | DESCRIPTION |
|---|---|
| GROUPER VER | The program identification number for the Grouper program used. |
| RETURN CODE | Return Code - This field identifies the status of the claim when it has returned from the Grouper program. This is a one- position alphanumeric field. |
| WAGE INDEX | Provider's wage index factor for the state where the services were provided to determine reimbursement rates for the services rendered. |
| OUTLIER DAYS | The number of outlier days that exceed the cutoff point for the applicable DRG. |
| AVG # LENGTH OF STAY | The predetermined average length of stay for the assigned DRG. |
| OUTLIER DAYS THRESHOLD | Shows the number of days of utilization permissible for this claim's DRG code. Day outlier payment is made when the length of stay (including days for a beneficiary awaiting SNF placement) exceeds the length of stay for a specific DRG plus the CMS-mandated adjustment calculation. |
| OUTLIER COST THRESHOLD | Additional payment amount for claims with extraordinarily high charges. Payment is based on the applicable Federal rate percentage times 75% of the difference between the hospitals cost for the discharge and the threshold established for the DRG. |
| INDIRECT TEACHING ADJ# | The amount of adjustment calculated by the Pricer for teaching hospitals. |
| TOTAL BLENDED PAYMENT | The total PPS payment amount consisting of the Federal, hospital, outlier and indirect teaching reductions (such as Gramm Rudman) or additions (such as interest). |
| HOSPITAL SPECIFIC PORTION | The hospital portion of the total blended payment. |
| FEDERAL SPECIFIC PORTION | The federal portion of the total blended payment. |
| DISP# SHARE HOSPITAL AMT | The percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also SSI. |
| PASS THRU PER DISCHARGE | Identifies the pass through discharge cost. |
| 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.

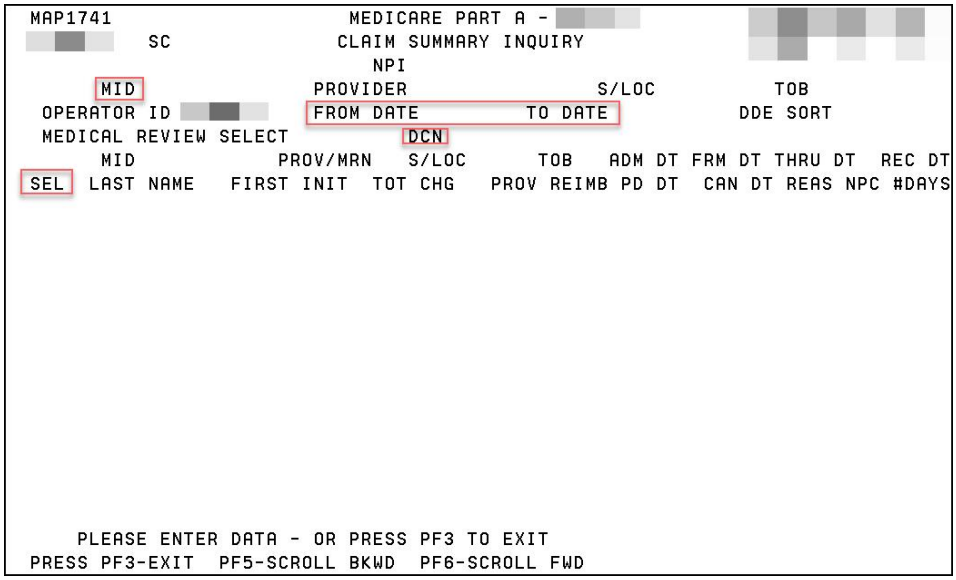
Type in your NPI and any desired selection criteria; press [ENTER]. The Claim Summary Inquiry screen will appear with a listing of claims matching the search criteria.

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”.

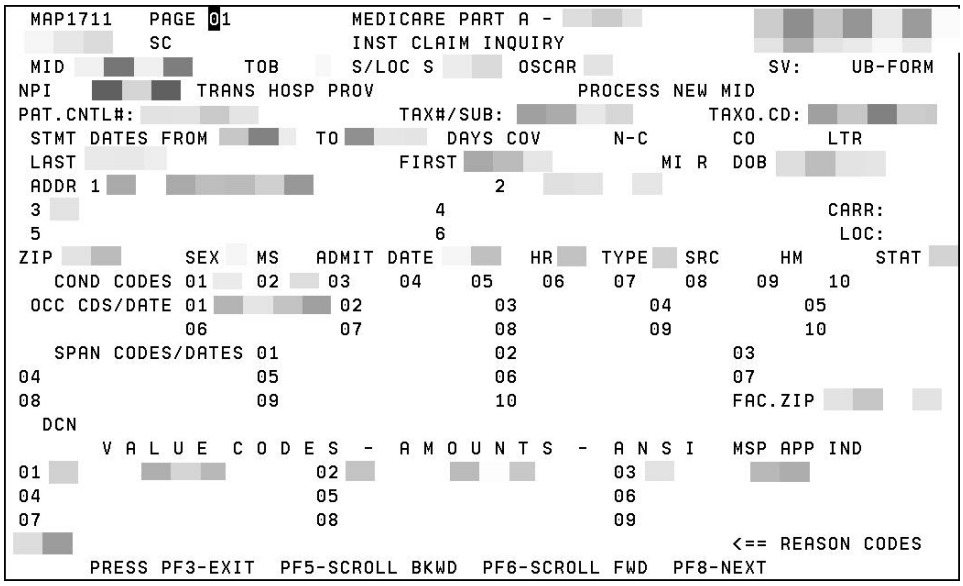
## Claim Summary Inquiry – MAP1741




| 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. |
| 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. |

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

## Claim Screen 1 – MAP1711




| FIELD | DESCRIPTION |
|---|---|
| SV | Suppress View - This field allows a claim to be suppressed. Use this field ONLY for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03). |
| MID | The beneficiary's Medicare ID number. |
| TOB | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS | Status - This field identifies the condition of the claim:<br>D = Denied<br>P = Paid<br>R = Rejected<br>S = Suspended<br>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. |
| 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.<br>A = UB-04<br>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). |

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

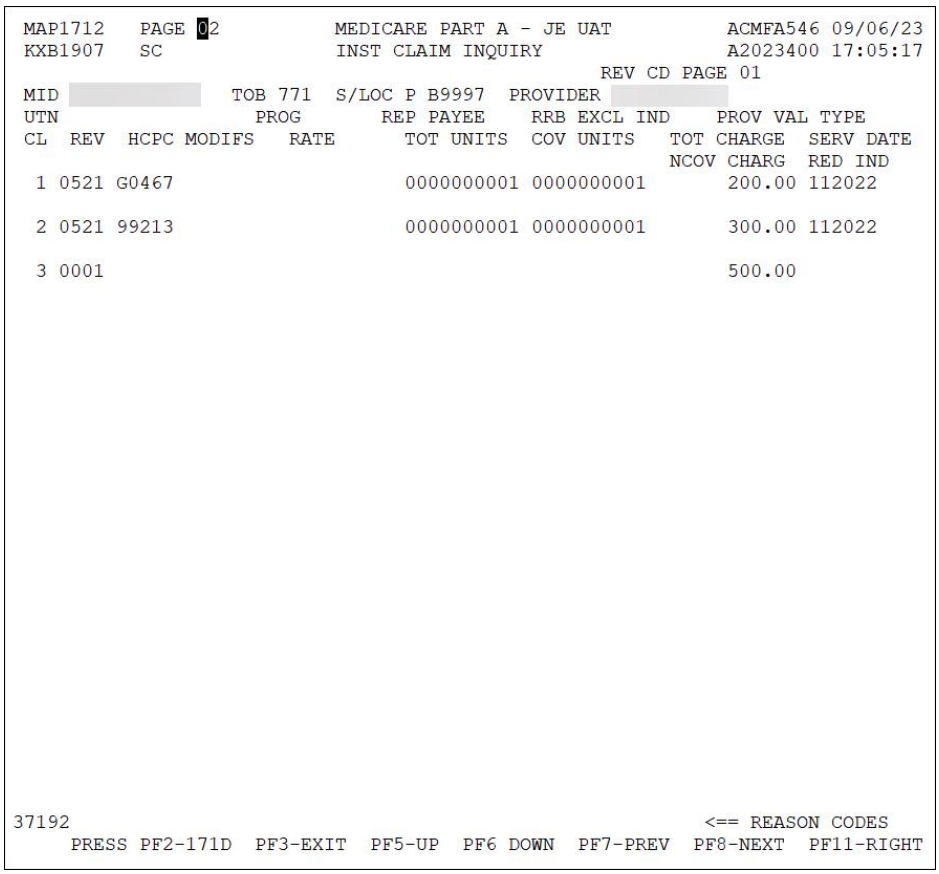
## ADMISSION DATA

| FIELD | DESCRIPTION |
|---|---|
| ADMIT DATE | Admission Date - the date of the patient's admission to this provider. |
| HR | Admission Hour. |

| FIELD | DESCRIPTION |
|---|---|
| TYPE | Admission Type - the priority of admission. The valid values are:<br>1 = Emergency<br>2 = Urgent<br>3 = Elective<br>4 = Newborn<br>5 = Trauma Center |
| SRC | Source of Admission - the way a patient was referred to the hospital for admission. The valid values are:<br>1 = physician referral<br>2 = Clinical referral<br>4 = Transfer from a hospital<br>5 = Transfer from a SNF (Skilled Nursing Facility)<br>6 = Transfer from another health care facility<br>7 = Emergency room<br>8 = Court/law enforcement<br>9 = Information not available<br>B = Transfer from another Home Health Agency<br>C = Readmission to the same Home Health Agency<br>D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer<br>E = Transfer from Ambulatory Surgical Facility<br>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. |
| 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:<br>' ' = Apportion<br>N = Do not apportion. |

## Claim Screen 2 – MAP1712

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




| 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:<br>D = Denied<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider<br>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.<br>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. |

| FIELD | DESCRIPTION |
|---|---|
| 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. |
| 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.<br>F=100% Reimbursement for multiple surgical or endoscopic procedures<br>M=Partial Reimbursement for multiple surgical or endoscopic procedures<br>P=Partial, all of the units except one were reduced<br>R=All units were reduced<br>' '= 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                      FMR
                                    1       200.00
ORIG                       ORIG REV          MR       ODC
OCE OVR 0 CWF OVR   NCD OVR   NCD DOC   NCD RESP   NCD#          OLUAC
        NON         NON        DENL  OVER ST/LC MED ------------ANSI-----------
LUAC  COV-UNT    COV-CHRG    REAS  CODE OVER  TEC ADJ GRP ------REMARKS------



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

| FIELD | 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. |

| 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:<br>D = Denied<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider<br>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:<br>Y = The claim has been denied |
| CL MR IND | Complex Manual Medical Review Indicator – This field identifies if all services on the claim received complex manual medical review. The valid values are:<br>' ' = The services did not receive manual medical review (default value).<br>Y = Medical records received. This service received complex manual medical review.<br>N = Medical records were not received. This service received routine manual medical review. |
| TPE-TO-TPE | Tape-to-Tape Flag - This field identifies the tape-to-tape flag (if applicable). |
| WAIV IND | Waiver Indicator - This field identifies whether the provider has their presumptive waiver status. The valid values are:<br>Y = The provider does have their waiver status.<br>N = The provider does not have their waiver status |
| MR REV URC | Medical Review Utilization Review Committee Reversal - This field indicates whether an SNF URC Claim has been reversed. The valid values are:<br>P = Partial reversal<br>F = Full reversal, the system reverses all charges and days |
| DEMAND | Medical Review Demand Reversal - This field identifies if a SNF demand claim has been reversed. The valid values are:<br>P = Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal.<br>F = Full reversal, the system reverses all charges and days. |
| REJ CD | Reject Code - The reason code for which the claim is being denied. |
| MR HOSP RED | Medical Review Hospice Reduced - This field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. The valid values are:<br>' ' = Not reduced<br>Y = Reduced |

| FIELD | DESCRIPTION |
|---|---|
| RCN IND | Reconsideration Indicator - This field used only for home health claims. The valid values are:<br>A = Finalized count affirmed<br>B = Finalized no adjustment count (pay per waiver)<br>R = Finalized count reversal (adjustment)<br>U = Reconsideration |
| 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:<br>' ' = Not referred<br>Y = Referred |
| ORIG UAC | Original User Action Code - the original user action code. |
| MED REV RSNS | Medical Review Reasons - a specific error condition relative to medical review. |
| FIELD | DESCRIPTION |
| OCE MED REV RSNS | This field identifies the edit returned from the OPPS version of OCE. The valid values are:<br>11 = Non-covered service submitted for review (condition code 20).<br>12 = Questionable covered service.<br>30 = Insufficient services on day of partial hospitalization.<br>31 = Partial hospitalization on same day as electroconvulsive therapy or type T procedure.<br>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.<br>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. |
| ORIG REV CD | Original Revenue Code. |
| MR | Complex Manual Medical Review Indicator – This field identifies if all services on the claim received complex manual medical review. The valid values are:<br>' ' = The services did not receive manual medical review (default value).<br>Y = Medical records received. This service received complex manual medical review.<br>N = Medical records were not received. This service received routine manual medical review. |
| OCE OVR | OCE Override - This field overrides the way the OCE module controls the line item. |
| CWF OVR | CWF Home Health Override. |
| NCD OVR | National Coverage Determinations Override Indicator - This field identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. The valid values are:<br>' ' = The NCD edits are not bypassed, (default value)<br>Y = The line has been reviewed for medical necessity and bypasses the NCD edits.<br>D = The line has no covered charges and bypasses the NCD edits. |

| FIELD | DESCRIPTION |
|---|---|
| NCD DOC | National Coverage Determination Documentation Indicator – identifies whether the documentation was received for the medically necessary service. The valid values are:<br>Y = The documentation supporting the medical necessity was received.<br>N = The documentation supporting the medical necessity was not received, (default value.) |
| NCD RESP | National Coverage Determination Response Code –The valid values are: ' ' = Set to space for all lines on resubmitted RTP'D claims<br>0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria.<br>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.<br>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.<br>3 = The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list 2 codes). The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to non-coverage by statute.<br>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.<br>5 = Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the FI will RTP the claim. |
| NCD # | National Coverage Determination Number. |
| OLUAC | Original Line User Action Code. |
| LUAC | Line User Action Code. |
| NON COV-UNT | Non-Covered Units - Units of service is a quantitative measure of service rendered by revenue category. |
| NON COV-CHRG | Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line. |
| DENIAL REAS | Denial Reason - the cause of denial for the revenue code line. |
| OVER CODE | ANSI Override Code - the override code that allows the operator to manually override the system generated ANSI codes. |
| ST/LC OVER | Status Location Override - the override of the reason code file status when a line item has been suspended. |
| 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:<br>M = Medial denial and waiver was applied<br>S = Medical denial and waiver was not applied<br>T = Technical denial and waiver was applied<br>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 PART A - JE UAT          ACMFA546 09/06/23
 KXB1907   SC              INST CLAIM INQUIRY                A2023400 17:17:27
 DCN                          MID                 RECEIPT DATE 120622  TOB 771
 STATUS P  LOCATION B9997     TRAN DT 120922    STMT COV DT 112022   TO 112022
   1    REP PAYEE       SERV      SERV    UTN                PGM       CAH
  REV  HCPC MODIFIERS   DATE      RATE         TOT-UNT    COV-UNT   TOT-CHRG
 0521 G0467            112022                      1          1       200.00
                                                          COV-CHRG       200.00
  ANES CF       ANES BV                    FQHCADD              PC/TC IND
 HCPC TYPE       DEDUCTIBLES        COINSURANCE           ESRD-RED/   VALCD-05/
            BLOOD        CASH    WAGE-ADJ     REDUCED  PSYCH/HBCF      OTHER
 PAT->                             36.03
 MSP->                                    ANSI ->               PAY/HCPC
 MSP ->                                OUTLIER ->               APC CD 00000
            PAYER-1     PAYER-2      OTAF  DENIAL      OCE FLAGS
 MSP ->                                    IND  1  2  3  4  5  6  7  8  9  10
  ID ->                                         A 10  1  0  0  0  5  0 01   0
        REIMB        RESP        PAID
 PAT ->                    36.03                      LABOR      NON-LABOR
PROV ->      141.25
 MED ->      141.25                PRICER        PAY                    ASC
         ADJUSTMENT  ANSI        AMT    RTC    METHOD    IDE/NDC/UPC   GRP %
 CONTR-       19.84  CO 45      180.16  01      10
37192                                                  <== REASON CODES
 PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF10-LEFT PF11-RIGHT
```

## Line-Item Detail – MAP171A

| FIELD | DESCRIPTION |
|---|---|
| DCN | Document Control Number assigned by DDE. |
| MID | The beneficiary's Medicare ID number. |
| RECEIPT DATE | The date the claim was received. |
| TOB | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>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. |
| TOT-CHRG | The total amount of charges for the revenue line. |

| FIELD | DESCRIPTION |
|---|---|
| COV-CHRG | The total amount of covered charges for the revenue line. |
| ANES CF | Anesthesia Conversion Factor – the anesthesia conversion factor. |
| ANES BV | Anesthesia Base Unit Value - the anesthesia base unit value |
| FQHCADD | This field identifies the line level FQHC (Federally Qualified Health Center) additional payment amount for a new patient or initial Medicare visit. |
| PC/TC IND | Professional Component/Technical Component - the PC/TC indicator PC/TC HPSA Payment Policy<br>Pay the Health Professional Shortage Area (HPSA) bonus.<br>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.<br>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.<br>Professional component only, pay the HPSA bonus.<br>Technical component only, do not pay the HPSA bonus.<br>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.<br>Incident codes, do not pay the HPSA bonus.<br>Laboratory physician interpretation codes, pay the HPSA bonus.<br>Physical therapy service, do not pay the HPSA bonus.<br>Physician interpretation codes, pay the HPSA bonus.<br>Concept of PC/TC does not apply, do not pay the HPSA bonus |
| CAH INCEN IN | CAH Incentive Indicator, identifies whether a claim line is eligible for a specific type of bonus.<br>1=HPSA<br>2=PSA<br>3=HPSA AND PSA<br>4=HSIP<br>5=HPSA and HSIP<br>6=PCIP<br>7=HPSA and PCIP<br>' '=Not applicable |
| HCPC TYPE | HCPC Type –identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. The value values are:<br>M = Originated from MPFS database files<br>' ' = Did not originate from the MPFS database files |
| COINSURANCE | Identifies the Variable Coinsurance Percentage used for Drug HCPCs. |
| BLOOD DEDUCTIBLES | Identifies the amount of the patient's Medicare blood deductible applied to the line item. The blood deductible is applied at the line level on revenue codes 380, 381, and 382. |
| CASH DEDUCTIBLES | The amount of the patient's Medicare cash deductible applied to the line item. |
| WAGE-ADJ COINSURANCE | The amount of coinsurance applicable to the line, based on the particular service rendered. The service is defined by the revenue and HCPCS code submitted. For services subject to outpatient PPS (OPPS) in hospitals (TOBs '12X', '13X', and '14X') and in community mental health centers (TOB '76X'), the applicable coinsurance is wage adjusted. This field will have either a zero (for services which no coinsurance is applicable), or a regular coinsurance amount (calculated on either charges or a fee schedule) unless the service is subject to OPPS. If the service is subject to OPPS, the national coinsurance amount will be wage adjusted, based on the MSA where the provider is located or assigned as the result of a reclassification. |

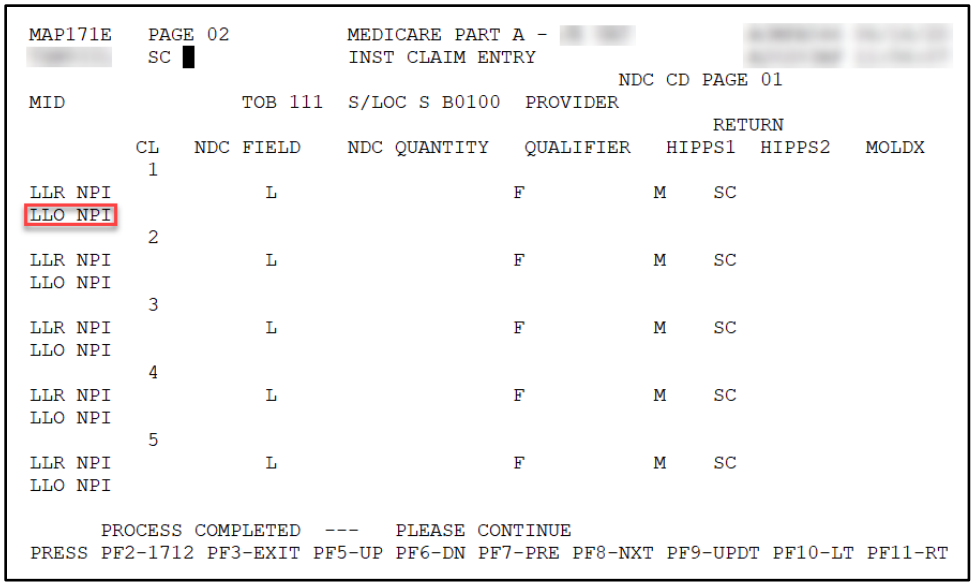
| FIELD | DESCRIPTION |
|---|---|
| REDUCED COINSURANCE | The amount of the reduced coinsurance applicable to the line for a particular service (HCPCS) rendered on which the provider has elected to reduce the coinsurance amount for all services subject to OPPS. |
| ESRD-RED/ PSYCH/HBCF | ESRD Reduction Amount / Psychiatric Reduction Amount / Hemophilia Blood Clotting Factor Amount<br>ESRD Reduction Amount - This value refers to the ESRD Network Reduction amount.<br>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).<br>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. |
| VALCD 05/OTHER | Value Code 05 – Do not use on CAH method II or CRNA pass-through claims. |
| MSP BLOOD DEDUCTIBLES | The blood deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. |
| MSP CASH DEDUCTIBLES | The cash deduction amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. |
| MSP COINSURANCE | The coinsurance amount calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. |
| ANSI ESRD-RED/PSYCH/HBCF | The 2 position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice. |
| ANSI VALCD-05/OTHER | The 2 position ANSI group code and 3 position ANSI reason (adjustment) code. The ANSI data for the value codes are sent to the financial system for reporting on the remittance advice. |
| MSP PAYER 1 | The amount entered by the user or apportioned by FISS as payment from the primary payer. |
| MSP PAYER 2 | Identifies the amount entered by the user (if available) or apportioned by FISS as payment from the secondary payer. |
| OTAF | Obligated To Accept Payment In Full - This field identifies the line item apportioned amount entered by the user (if available) or apportioned amount calculated by FISS, of the obligated to accept as payment in full, when value code 44 is present. |
| DENIAL IND | Denial Indicator - This field identifies the MSPPAY module that an insurer primary to Medicare has denied this line item. The valid values are:<br>" = Not denied<br>D = Denied |
| OCE FLAGS | OCE Flags- This field identifies 10 flags, two alphanumeric positions each.<br>Flag 1 – Status Indicator<br>Flag 2 – Payment Indicator<br>Flag 3 – Discounting Formula Number<br>Flag 4 – Line Item Denial or Rejection<br>Flag 5 – Packaging<br>Flag 6 – Payment Adjustment<br>Flag 7 – Payment Method<br>Flag 8 – Line Item Action<br>Flag 9 – Composite Adjustment<br>Flag 10 – Payment Adjustment<br>Refer to the Noridian Quick Reference Billing Guide for code definitions. |
| PAY/HCPC APC CD | Payment Ambulatory Patient Classification Code or HCPC Ambulatory Patient Classification Code - This field displays the number that identifies the APC group. |
| PAYER 1 | MSP Payer 1 ID - This field displays the one-position alphanumeric code identifying the specific payer. If Medicare is primary, this field is blank. |
| PAYER 2 | MSP Payer 2 ID - This field displays the one-position alphanumeric code identifying the specific payer. If Medicare is primary, this field is blank. |

| FIELD | DESCRIPTION |
|---|---|
| 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. |
| 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.<br>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.<br>1=Paid standard OPPS amount (status indicators K, S, T, V, X or P)<br>2=Services not paid under OPPS (status indicator A)<br>3=Not paid (status indicators W, Y, or E) or not paid under OPPS (status indicators B, C, or Z)<br>4=Acquisition cost paid (status indicator L or F)<br>5=Additional payment for drug or biological (status indicator G)<br>6-Additional payment for device (status indicator H)<br>7=Additional payment for new drug or new biological (status indicator J)<br>8=Paid partial hospitalization per diem (status indicator P)<br>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. |
| IDE | Investigational Device Exemption authorization number assigned by the FDA. It is only used for revenue code 0624. |
| NDC | Reserved for future use. |
| UPC | Reserved for future use. |
| ASC GRP | ASC Group - This field identifies the ASC Group code for the indicated revenue code |
| % | ACS Percentage - This field identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code. |

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

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

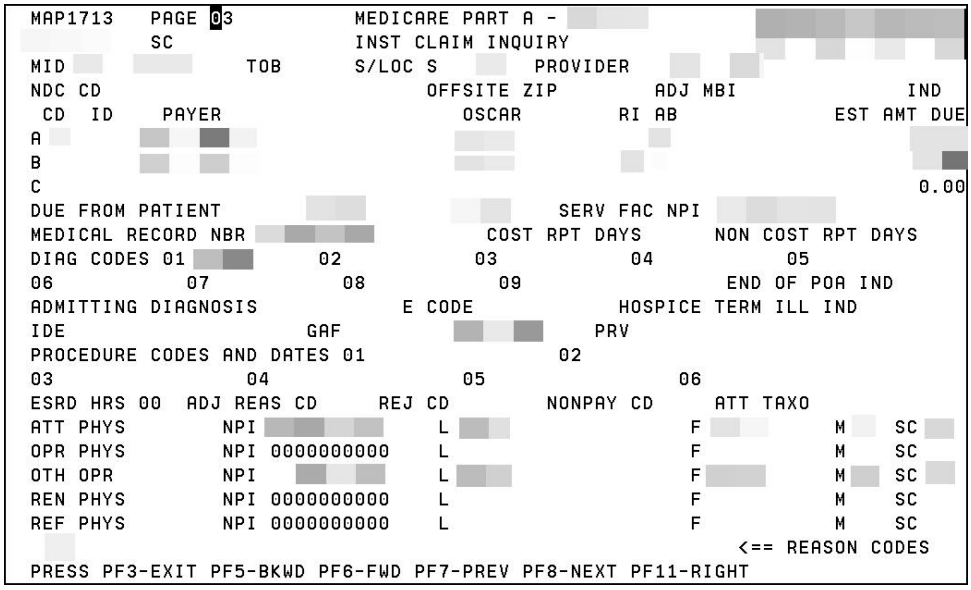
## National Drug Code Information – MAP171E




| FIELD | DESCRIPTION |
|---|---|
| MID | The beneficiary's Medicare ID number. |
| 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:<br>D = Denied<br>P = Paid<br>R = Rejected<br>S = Suspended<br>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. |

| FIELD | DESCRIPTION |
|---|---|
| QUALIFIER | NDC Qualifier – The valid values are:<br>F2 = International Unit<br>FR = Gram<br>ML = Milliliter<br>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. |
| MOLDX | Molecular Diagnostic Services – Enter the DEX Z-Code™ identifier |

## Claim Screen 3 – MAP1713




| FIELD | DESCRIPTION |
|---|---|
| MID | The beneficiary's Medicare ID number. |
| TOB | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider |
| LOC | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| PROVIDER | If there is a one-to-one relationship between the NPI and provider number, the provider number will appear. |
| OFFSITE ZIPCD | Identifies offsite Clinic/Outpatient department zip codes. It determines the claim line HPSA/PSA bonus eligibility. |

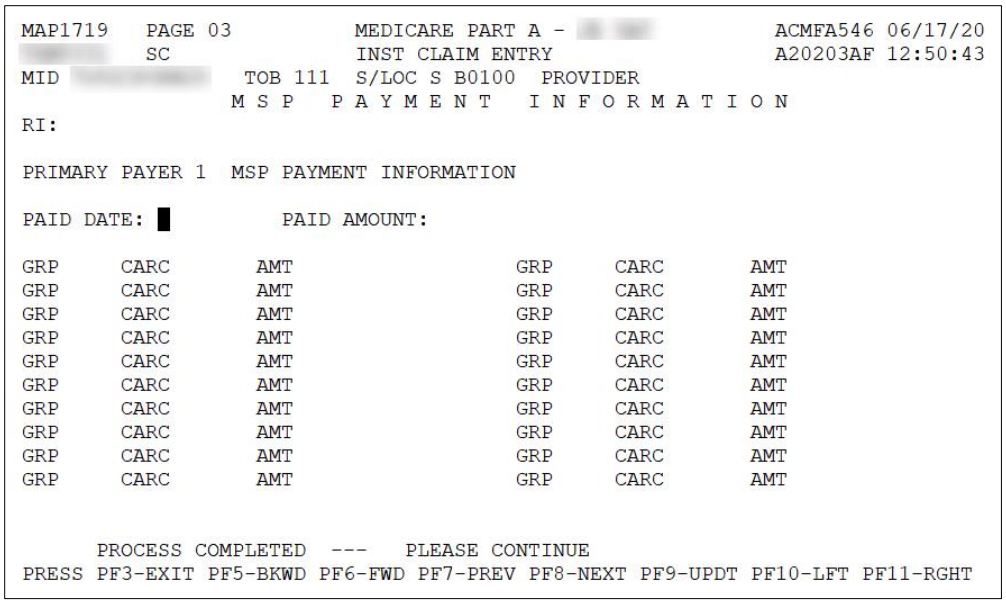
| FIELD | DESCRIPTION |
|---|---|
| CD | Payer Code – Valid values are:<br>1 = Medicaid secondary<br>2 = Blue Cross secondary<br>3 = Other secondary<br>4 = None<br>A = Working Aged (value code 12)<br>B = ESRD beneficiary in 18-month coordination period with (value code 13)<br>C = Conditional Payment<br>D = Auto no-fault (value code 14)<br>E = Workers Compensation (value code 15)<br>F = Public Health of Federal Agency (value code 16)<br>G = Disabled (value code 43)<br>H = Black Lung (value code 41)<br>I = Veterans Administration (value code 42)<br>L = Liability (value code 47)<br>Z = Medicare |
| ID | Payer ID - not used at this time. |
| PAYER | Payer name identifying each payer organization from which the provider might expect some payment. |
| OSCAR | The provider number of the facility that is billing for the services provided. |
| RI | Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are:<br>R = Restricted or modified release<br>N = No release |
| AB | Assignment of Benefits – identifies whether or not the provider has a signed form authorizing the third-party payer to pay the provider. The valid values are:<br>Y = Yes benefits assigned<br>N = No benefits assigned |
| EST AMT DUE | Estimated Amount Due - This field identifies the amount estimated by the provider to be still due from the indicated payer (estimated responsibility less prior payments). |
| DUE FROM PATIENT | Due from Patient - Entry only in Prior Payments portion of this field. |
| MEDICAL RECORD NBR | Identifies the number assigned to the patient's medical/health record by the provider. |
| COST RPT DAYS | Cost Report Days - This field identifies the number of days claimable as Medicare patient days for inpatient and SNF types of bills. The system calculates this field and generates the applicable data. |
| NON COST RPT DAYS | Non-Cost Report Days - This field identifies the number of days not claimable as Medicare patient days. |

| FIELD | DESCRIPTION |
|---|---|
| DIAGNOSIS CODES | The ICD-9-CM code(s) describing the principal diagnosis (first code) and additional conditions (codes two through nine) that co-exist at the time of admission or develop subsequently. Each diagnosis code is a six-position alphanumeric field, with two additional positions with the 7th being blank, and the 8th position is the first character of the Present On Admission (POA) Indicator for every principal and secondary diagnosis effective with discharges. The POA Indicator identifies whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The valid values for the POA Indicator are:<br>Y = Yes, Present at the time of inpatient admission.<br>N = No, not present at the time of inpatient admission.<br>U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission.<br>W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.<br>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.<br>' ' = Not acute care, POA's do not apply |
| END OF POA INDICATOR | End of POA Indicator – the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. The valid values are:<br>Z = The end of POA indicators for principal and, if applicable, other diagnoses.<br>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.<br>' ' = Not acute care, POA's do not apply |
| ADMITTING DIAGNOSIS | The ICD-9-CM code describing the inpatient condition at the time of the admission. |
| E-CODE | The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. |
| HOSPICE TERM ILL IND | Identifies whether a hospice patient has a terminal illness. It is only used for hospice claims. |
| IDE | Investigational Device Exemption Number (IDE) – the IDE authorization number assigned by the FDA. |
| PROCEDURE CODES AND DATES | Identifies the principal procedure (first code) and other procedures (codes two through six) performed, and dates on which they occurred. This field is required for inpatient claims where a surgical procedure is performed. |
| ESRD HOURS | End Stage Renal Disease Hours - the number of hours of certain dialysis treatments such as peritoneal. |
| ADJUSTMENT REASON CODE | Identifier for the type of adjustment being performed. Enter “16” in the SC field in the upper left corner of the screen to access a listing of codes. |
| REJECT CODE | The reason code for which the claim is being non-medically denied. |
| NON PAY CODE | The reason for Medicare's decision not to make payment. |
| ATT PHYS | Attending Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician. |
| NPI | Attending physician’s NPI number. |
| LN | Attending physician’s last name. |
| FN | Attending physician’s first name. |
| MI | Attending physician’s middle initial. |
| SC | Specialty Code - This field identifies the specialty code. |
| OPER PHYS | Operating Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician. |

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

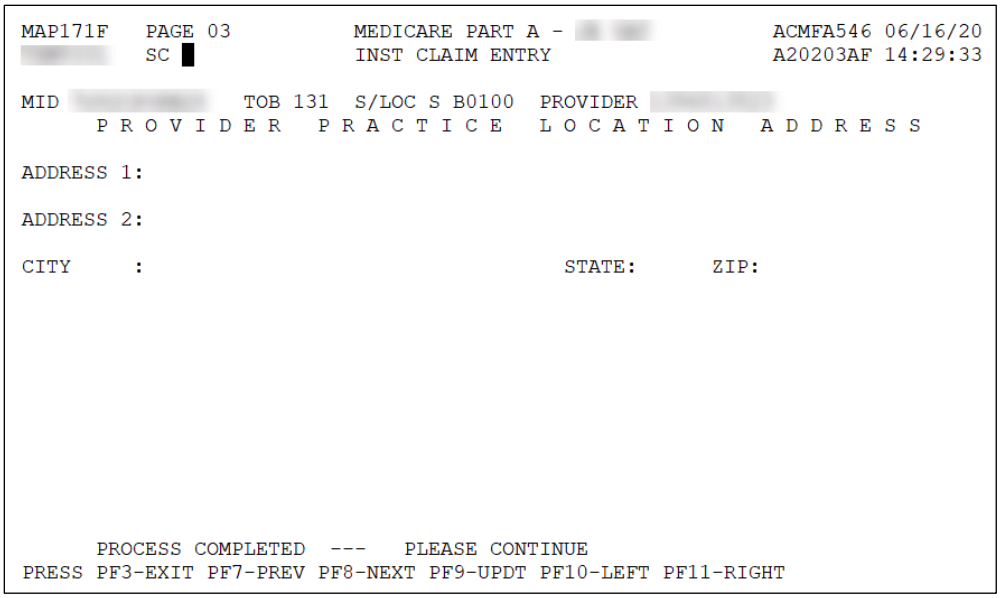
## Claim Screen 3 – MAP1719

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




| FIELD | DESCRIPTION |
|---|---|
| RI | Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are:<br>R = Restricted or modified release<br>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. |
| CARC | ANSI CARC codes. This is a four-position alphanumeric field, with 20 occurrences. |
| AMT | The dollar amount associated with the group/CARC combination. This field is an eleven-position numeric field in 999999999.99 format, with 20 occurrences. |

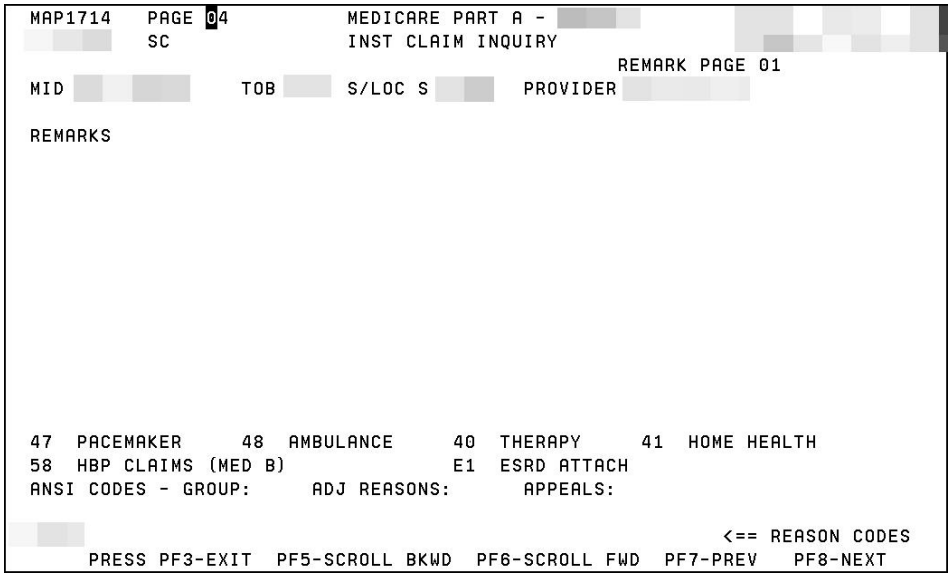
## Claim Screen 3 – MAP171F




| FIELD | DESCRIPTION |
|---|---|
| MID | The Health Insurance Claim (HIC) Number or Medicare Beneficiary Identifier (MBI) assigned to the beneficiary by CMS. This is a twelve-position alphanumeric field. |
| TOB | The type of bill. This is the type of facility, bill classification, and frequency of the claim in a particular period of care. This is a three-position alphanumeric field. |
| S | The status of the claim (e.g., good, suspended, inactive). The location field is subsequent. This is a one-position alphanumeric field. |
| LOC | the location of where the claim resides in the system. This is a five-position alphanumeric field. |
| ADDRESS 1 | The Service Facility address 1. This is a 55-position alphanumeric field. |
| ADDRESS 2 | The Service Facility Address 2. This is a 55-position alphanumeric field. |
| CITY | The Service Facility City. This is a 30-position alphanumeric field. |
| STATE | The Service Facility State. This is a two-position alphanumeric field. |
| ZIP | The Service Facility Zip. This is a 15-position alphanumeric field. |

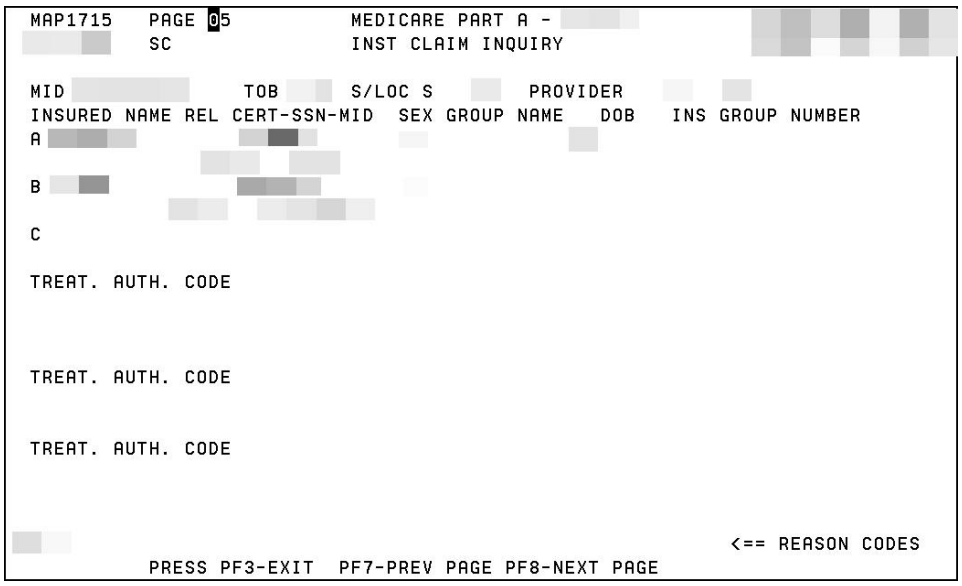
## Claim Screen 4 – MAP1714 – Remarks

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




| FIELD | DESCRIPTION |
|---|---|
| MID | The beneficiary's Medicare ID number. |
| TOB | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>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. |
| 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. |
| 48 AMBULANCE | Ambulance Attachment – not used. |
| 40 THERAPY | Therapy Attachment – not used. |
| 41 HOME HEALTH | Home Health Attachment – not used. |
| 58 HBP CLAIMS | Hospital-based Physician Attachment – not used. |
| ANSI CODES-GROUP | General category of payment adjustment. Used for claims submitted in an ANSI automated format only. |
| ADJ REASONS | Claim adjustment standard reason code identifying the detailed reason the adjustment was made. This is a three-position alphanumeric field. See Claims Entry Screen 3 for explanation. |
| APPEALS | ANSI Appeals Codes - This field identifies codes for inpatient or outpatient. |

## Claim Screen 5 – MAP1715




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

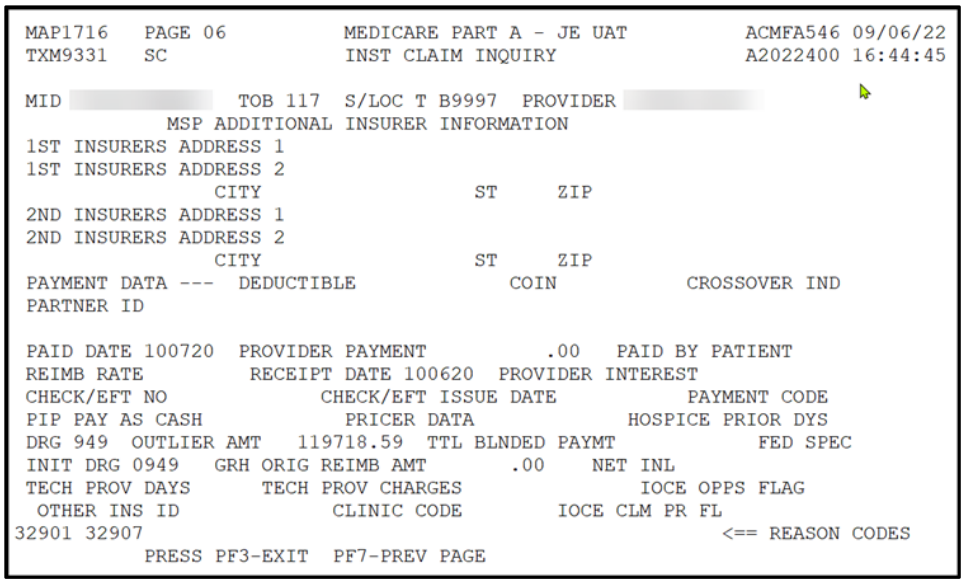
## Valid Patient Relationship to Insurer Values

| HIPAA CODE | CWF CODE | RELATIONSHIP |
|---|---|---|
| 1 | 4 | Spouse |
| 4 | 19 | Grandparent |

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

## Claim Screen 6 – MAP1716

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



| FIELD | DESCRIPTION |
|---|---|
| MID | The beneficiary's Medicare ID number. |
| TOB | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>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. |

## MSP ADDITIONAL INSURANCE INFORMATION

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

## PAYMENT DATA

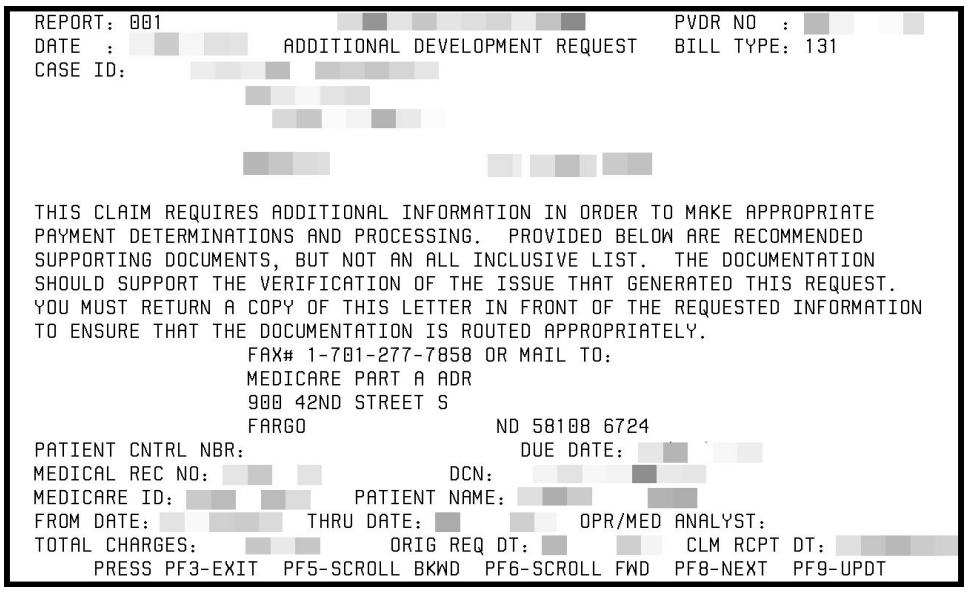
| FIELD | DESCRIPTION |
|---|---|
| DEDUCTIBLE | The amount of deductible for which the beneficiary/patient is liable. |
| COIN | The amount of coinsurance for which the beneficiary/patient is responsible. |
| CROSSOVER IND | This field identifies the Medicare payer on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. The valid values are:<br>1 = Primary<br>2 = Secondary<br>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:<br>' ' = Crossed Over<br>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. |

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

## Additional Development Requests (ADRs)

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

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




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

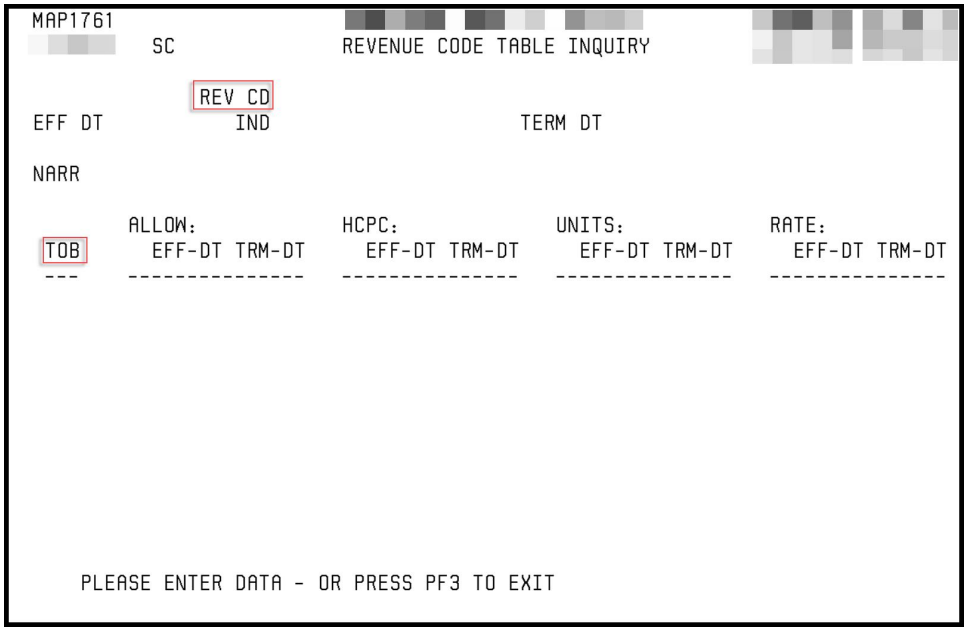
| FIELD | DESCRIPTION |
|---|---|
| REASONS | Displays a list of up to 10 ADR reason codes that identify the specific information being requested. |
| REASON CODE NARRATIVES FOR MID/DCN | The definitions for each ADR reason code for the specific Medicare ID/DCN combination listed. |

## 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




| 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:<br>F = From date<br>R = Receipt date<br>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:<br>Y = Yes<br>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:<br>Y = HCPC required for all providers<br>N = HCPC not required<br>V = Validation of HCPC is required<br>F = HCPC required only for claims from free-standing ESRD facility<br>H = HCPC required only for claims from hospital-based ESRD facility |

| FIELD | DESCRIPTION |
|---|---|
| UNITS | Identifies if the revenue code requires units to be present for a specific Type of Bill. Valid values are:<br>Y = Yes<br>N = No |
| RATE | Identifies if the revenue codes require a rate to be present for a specific Type of Bill. Valid values are:<br>Y = Yes<br>N = No |

## HCPC CODES – OPTION 14

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

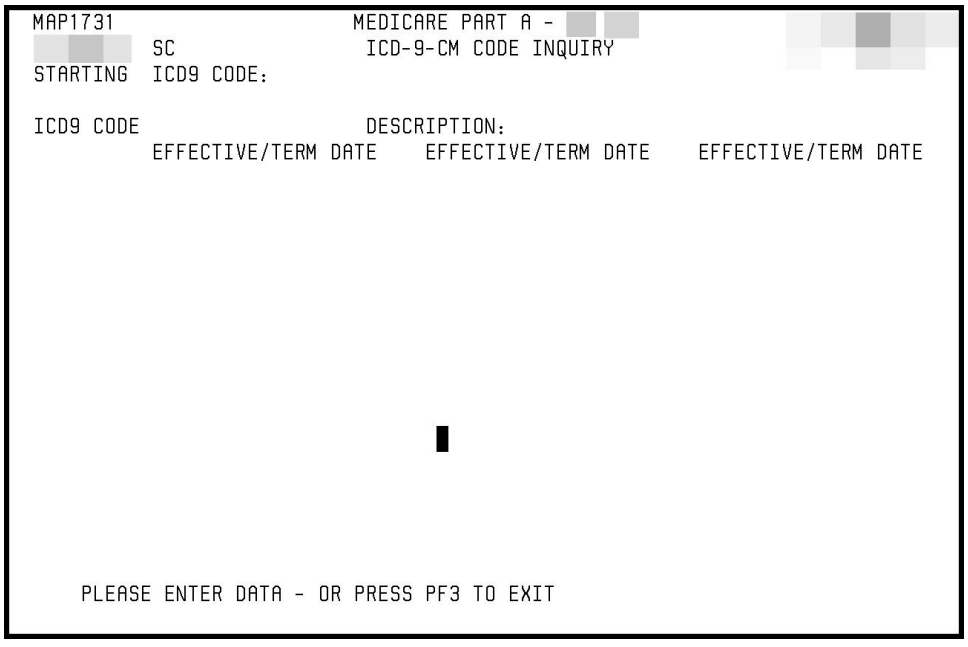
## DX/PROC CODES – OPTION 15

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

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

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

## ICD-9-CM Code Inquiry – MAP1731



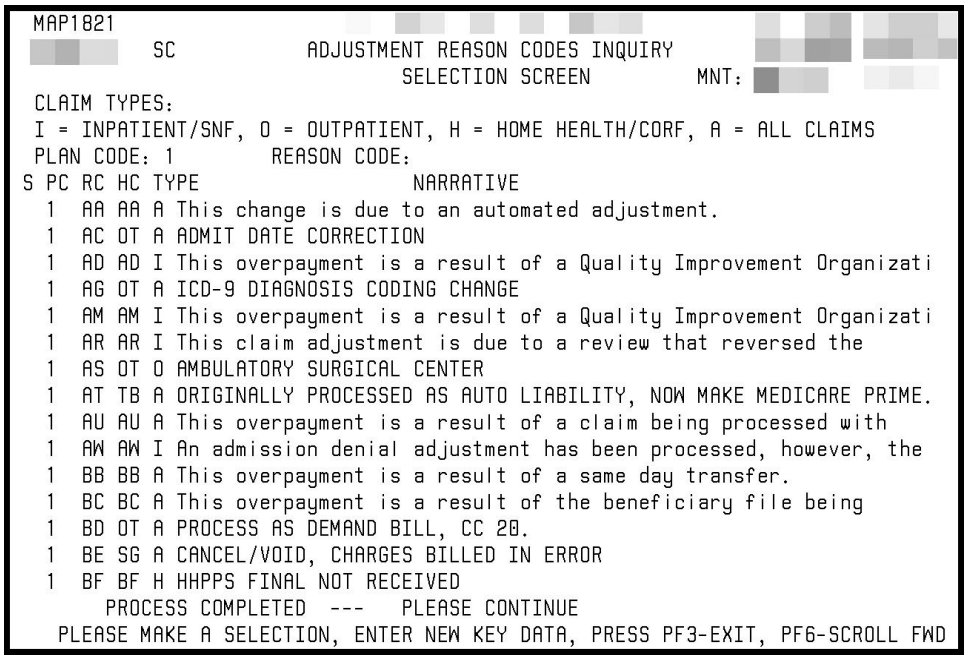

| FIELD | DESCRIPTION |
|---|---|
| ICD-9 CODE | The specific ICD-9 code to be viewed. |
| DESCRIPTION | A description of ICD-9 code. |
| EFFECTIVE/ TERM DATE | The effective date of the program and the program ending date (both in MMDDYY format). |

# ADJUSTMENT REASON CODES – OPTION 16

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

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

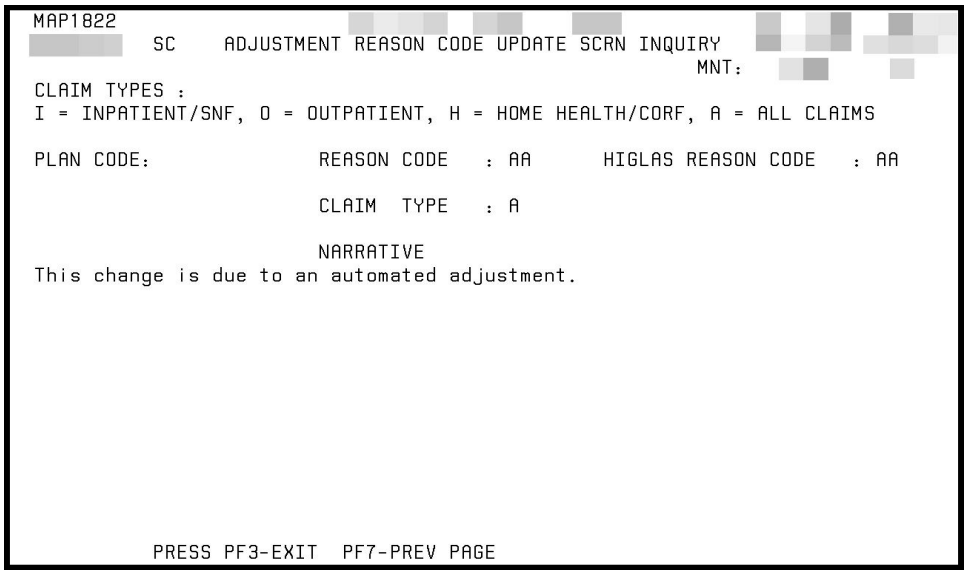
## Adjustment Reason Codes Inquiry Selection Screen – MAP1821



```
 MAP1821
          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 HHPPS FINAL NOT RECEIVED
       PROCESS COMPLETED  ---   PLEASE CONTINUE
   PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

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

## Adjustment Reason Code Update Screen inquiry – MAP1822



```
 MAP1822
          SC    ADJUSTMENT REASON CODE UPDATE SCRN 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. |
| TYPE | Displays the type of claim associated with this reason code. Valid values are:<br>A = All Claims<br>H = Home Health/CORF<br>I = Inpatient/SNF<br>O = Outpatient |
| NARRATIVE | The narrative provides a short description for the adjustment reason code. |

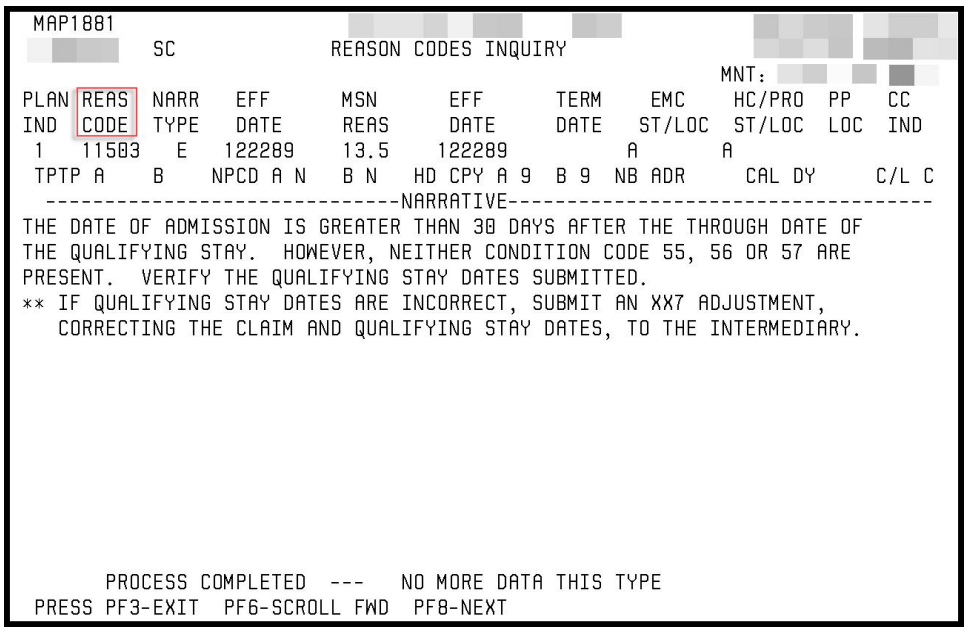
## REASON CODES – OPTION 17

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

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

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

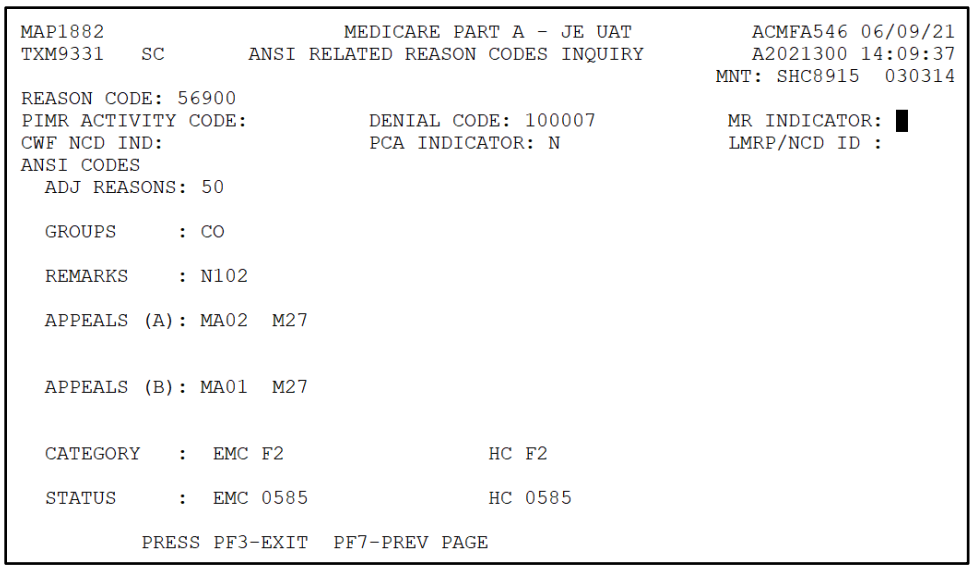
## Reason Codes Inquiry – MAP1881




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



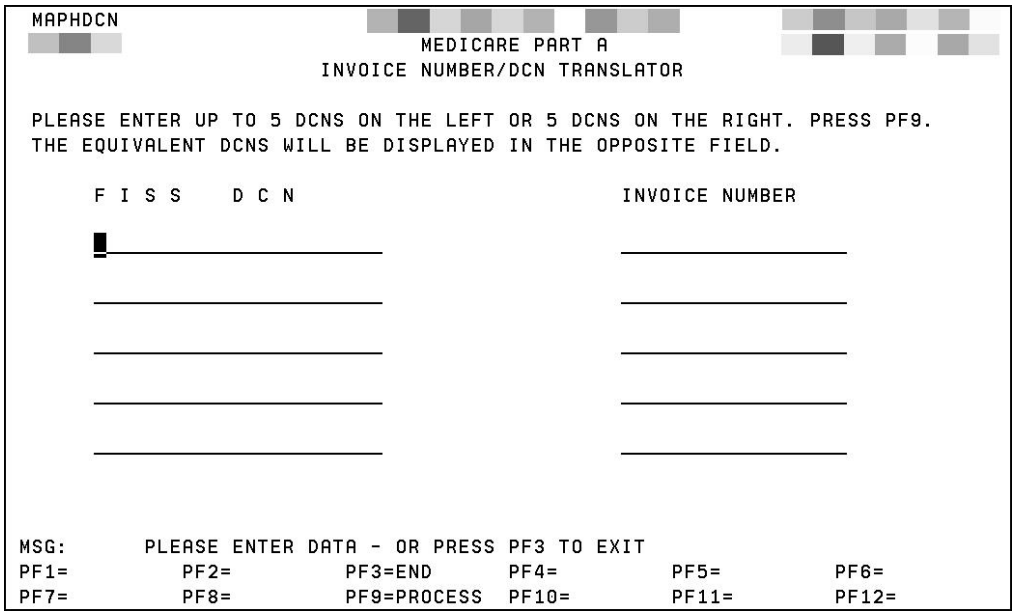

| FIELD | DESCRIPTION |
|---|---|
| REASON CODE | FISS reason code related to the following ANSI codes relate. |
| PIMR ACTIVITY CODE | Program Integrity Management Reporting (PIMR) Activity Code – identifies the PIMR activity code. The valid values are:<br>AI = Automated CCI Edit<br>AL = Automated Locally Developed Edit<br>AN = Automated National Edit<br>CP = Prepay Complex Probe Review<br>DB = TPL or Demand Bill Claim Review<br>MR = Manual Routine Review<br>PS = Prepay Complex Provider Specific Review<br>RO = Reopening<br>SS = Prepay Complex Service Specific Review |
| DENIAL CODE | Program Integrity Management Reporting (PIMR) Denial Reason Code –the PIMR Denial reason. The valid values are:<br>NOPIMR = Default<br>100001 = Documentation Does Not Support Service<br>100002 = Investigation/Experimental<br>100003 = Item/Services Excluded From Medicare Coverage<br>100004 = Requested Information Not Received<br>100005 = Services Not Billed Under The Appropriate Revenue Or Procedure Code (Includes Denials Due To Unbundling In This Category<br>100006 = Services Not Documented In Record<br>100007 = Services Not Medically Reasonable And Necessary<br>100008 = Skilled Nursing Facility Demand Bills<br>100009 = Daily Nursing Visits Are Not Intermittent/ Part Time |
| DENIAL CODE CONT'D | 100010 = Specific Visits Did Not Include Personal Care Service<br>100011 = Home Health Demand Bills<br>100012 = Ability To Leave Home Unrestricted<br>100013 = Physician's Order Not Timely<br>100014 = Service Not Ordered/Not Included In Treatment Plan<br>100015 = Services Not Included In Plan Of Care<br>100016 = No Physician Certification (E.G. Home Health)<br>100017 = Incomplete Physician Order<br>100018 = No Individual Treatment Plan<br>100019 = Other |

| FIELD | DESCRIPTION |
|---|---|
| M/R IND | Complex Manual Medical Review – This field identifies whether or not the service received complex manual medical review. The valid values are:<br>‘ ' = The services did not receive manual medical review (default value).<br>Y = Medical records received. This service received complex manual medical review.<br>N = Medical records were not received. This service received routine manual medical review. |
| CWF NCD IND | Common Working File National Coverage Determination Indicator. The values displayed are:<br>Y = Yes<br>N = No<br>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:<br>' ' = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files.<br>Y = The Medical Policy Parameter is PCA-related and is included in the PCA transfer files.<br>N = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files. |
| LMRP/NCD ID | Local Medical Review Policy (LMRP) and/or National Coverage Determination (NCD) identification number –the LMRP/NCD identification numbers assigned to the FMR reason code for reporting on the beneficiaries Medicare Summary Notice. |
| ADJ REASONS | Adjustment Reason Codes - the ANSI reason code related to the FISS reason code. |
| GROUPS | The ANSI Group Codes. |
| REMARKS | ANSI Remarks - identifies the reason for non-payment. |
| APPEALS (A) | ANSI Appeal-A Codes - used for inpatient only. |
| APPEALS (B) | ANSI Appeal-B Codes - used for outpatient only. |
| EMC CATEGORY | Electronic Media Claim Category Code – the EMC category of the claim that is returned on a 277 claim response. |
| HC CATEGORY | Hard Copy Claim Category Code – the Hard Copy category of the claim that is returned on a 277 claim response. |
| EMC STATUS | Electronic Media Claim Status Code – the EMC status of the claim that is returned on a 277 claim response. |
| HC STATUS | Hard Copy Claim Status – the Hard Copy status of the claim that is returned on a 277 claim response. |

## INVOICE NO/DCN TRANS – OPTION 88

This Invoice Number and DCN translator inquiry accepts entry of either the claim’s DCN or the invoice number. Upon entry of either field, the corresponding element will be returned as a cross reference. Providers can now use the invoice number to look up the DCN, which can be entered in option 12, claims inquiry, to return the claim information, including the MID and dates of service.

## Invoice No/DCN Trans – MAPHDCN

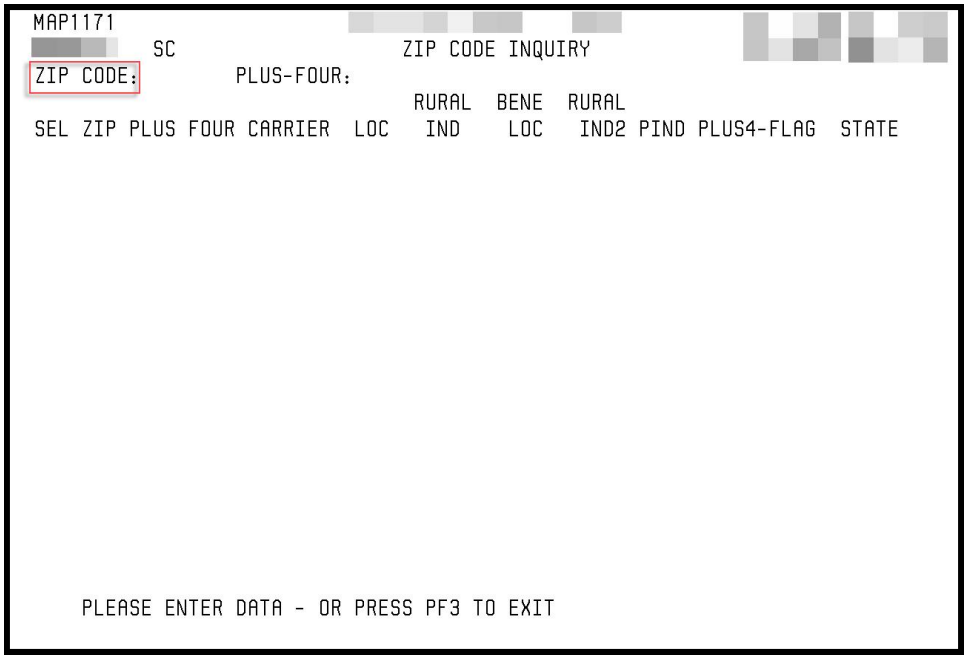



## ZIP CODE FILE – OPTION 19

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

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

## ZIP Code Inquiry – MAP1171




| FIELD | DESCRIPTION |
|---|---|
| SEL | Identifies a selection option, which is used to access MAP1172 (ZIP9 Information). Enter an S. |

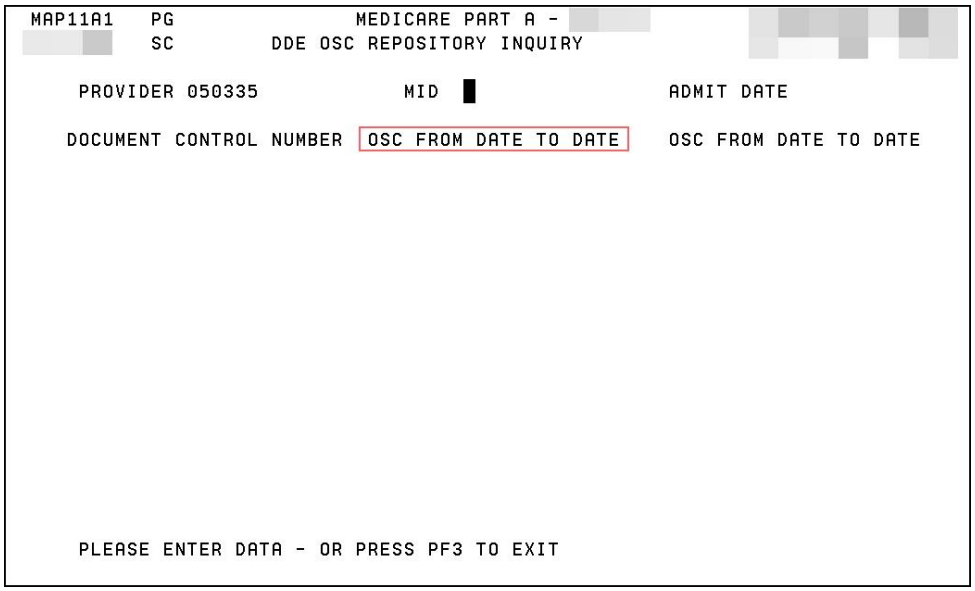
| FIELD | DESCRIPTION |
|---|---|
| ZIP | Identifies the zip code on the zip code file. |
| PLUS FOUR | The four-digit zip code extension. |
| CARRIER | Identifies the carrier number assigned. |
| LOC | Locality Code – The locality identification number for the area (or county) where the provider is located. |
| RURAL IND | Rural Indicator – This field identifies the rural indicator. The valid values are:<br>U = Urban<br>R = Rural<br>B = Rural Bonus |
| BENE LOC | Beneficiary Lab CB Locality – This field is used in the Laboratory Competitive Bidding Demonstration. The valid values are:<br>Z1 = CBA 1<br>Z2 = CBA 2<br>Z9 = Not a demo locality |
| RURAL IND2 | Rural Indicator 2–The rural indicator 2. The valid values are:<br>U = Urban<br>R = Rural<br>B = Rural Bonus |
| PLUS4-FLAG | Plus4-Flag – The plus 4 flag indicator. The valid values are:<br>0 = No +4 Extension<br>1 = +4 Extension |
| STATE | State associated with the zip code. |

## OSC REPOSITORY INQUIRY – OPTION 1A

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

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

## OSC Repository Screen – MAP11A1/MAP11B1




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

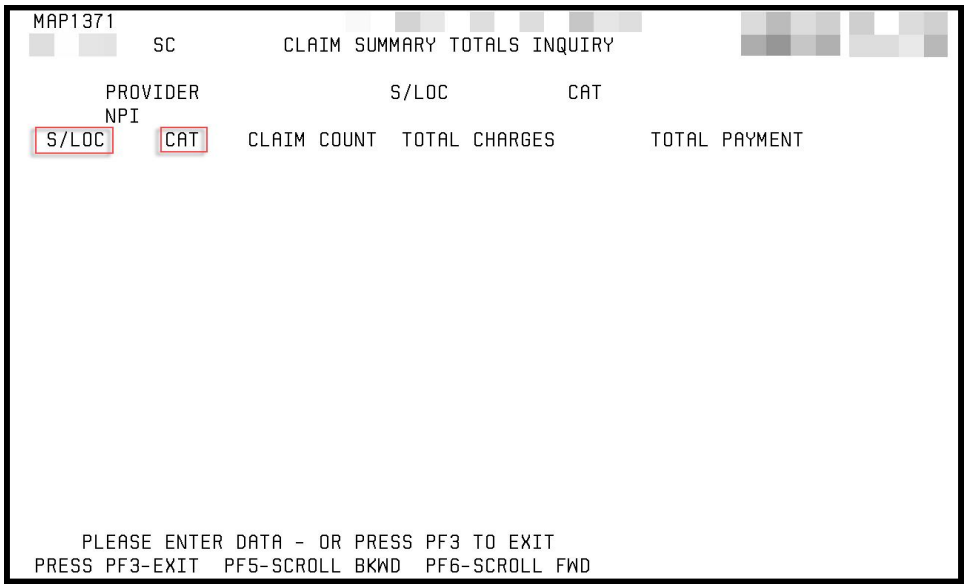
## CLAIM COUNT SUMMARY – OPTION 56

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

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

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

## Claim Summary Totals Inquiry – MAP1371




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

| FIELD | DESCRIPTION |
|---|---|
| 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

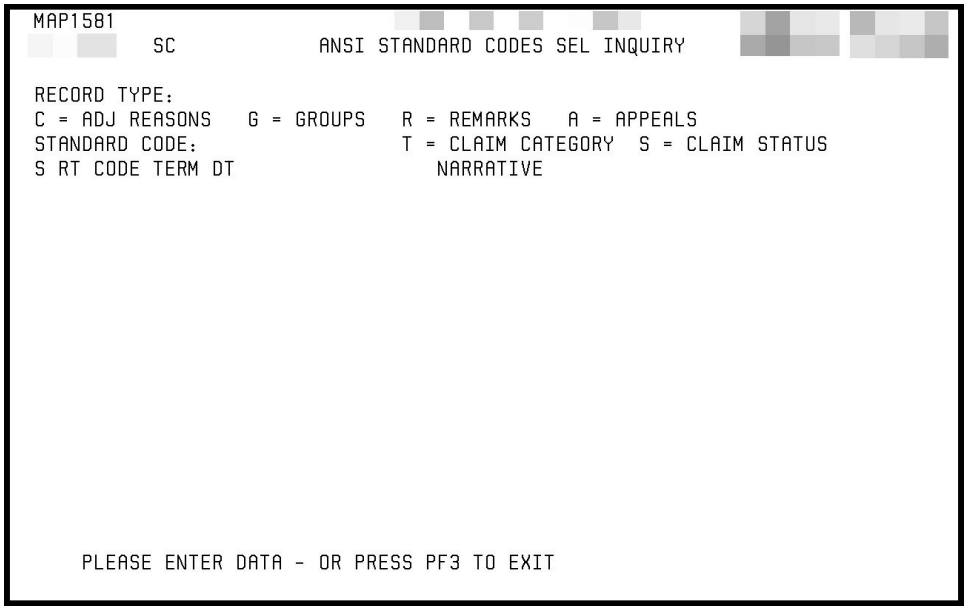
Noridian currently does not process home health claims. To access home health claim information, sign into the DDE applications available through the Medicare contractor who processes those claims.

## 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

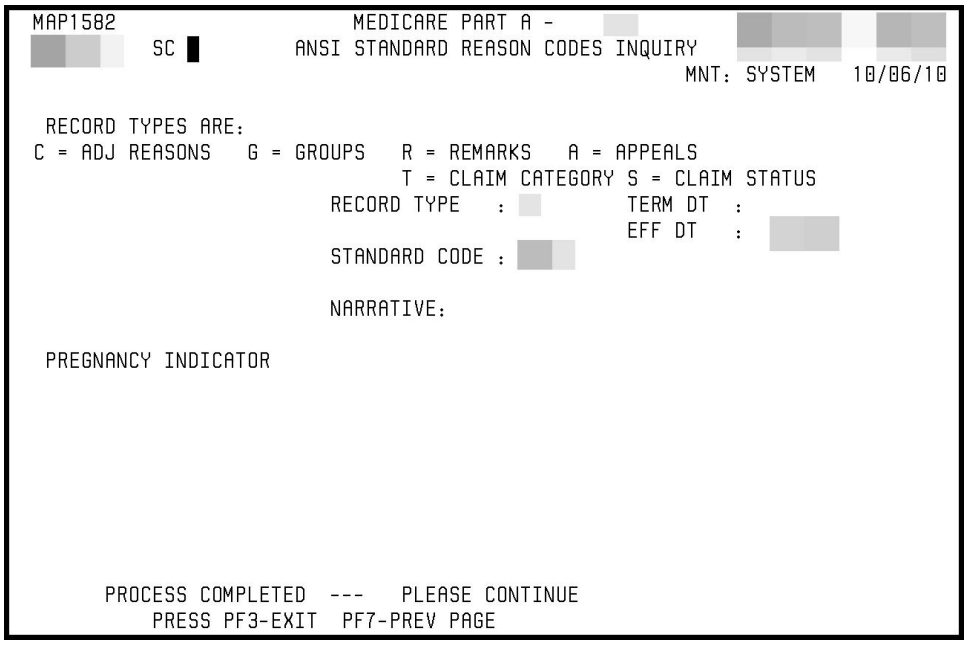



| FIELD | DESCRIPTION |
|---|---|
| RECORD TYPE | Identifies the record type for the standard code:<br>A = Appeals<br>C = Adjustment reasons<br>G = Groups<br>R = Reference remarks<br>S = Claim status<br>T = Claim category |

| 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. |
| S | Used to select a specific code when a list is displayed. |
| RT | Identifies the record type selected. |
| CODE | Identifies the standard code you selected. |
| TERM DT | Term Date - This field identifies the date the ANSI Standard Code is deactivated. This is a six-digit field in MMDDYY format. |
| NARRATIVE | Description of the standard code. |

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

## ANSI Reason Code Narrative – MAP1582



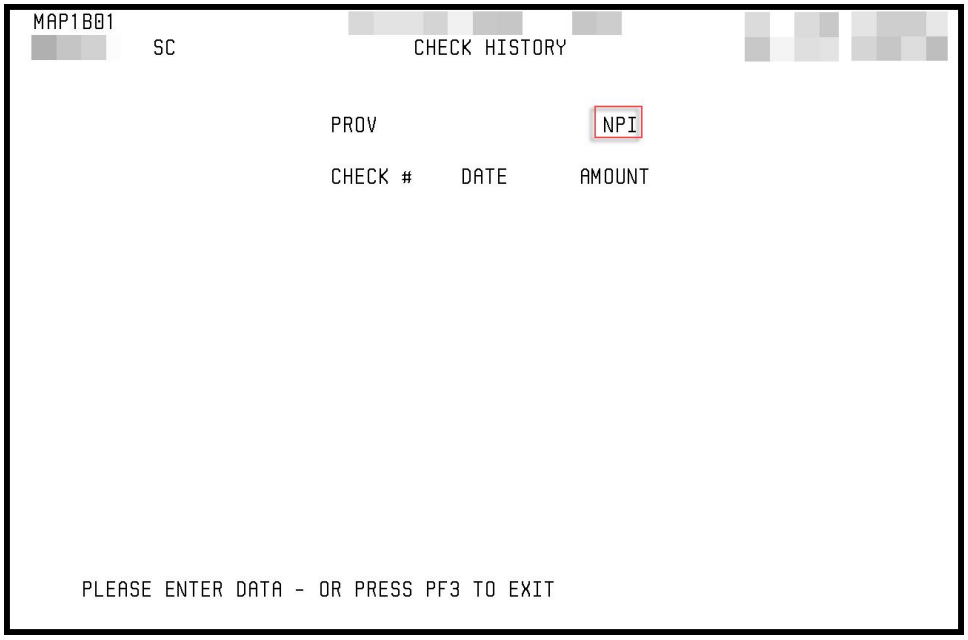

| FIELD | DESCRIPTION |
|---|---|
| RECORD TYPE | Identifies the record type for the standard code:<br>A = Appeals<br>C = Adjustment reasons G = Groups<br>R = Reference remarks S = Claim status<br>T = Claim category |
| TERM DT | Identifies the date the ANSI Standard Code is deactivated; ANSI codes that do not have a termination date has a default value of 'blank'. |
| STANDARD CODE | The standard code within the above record type that is being inquired upon or updated. If record code is present and no standard code is shown, all standard codes for the record type displays. If both record type and standard codes are present, the specific standard code displays. If neither the record type nor the standard code is shown, all ANSI codes are displayed in record type/standard code sequence. |
| NARRATIVE | Description of the standard code. |

## CHECK HISTORY – OPTION FI

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

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

## Check History – MAP1B01




| FIELD | DESCRIPTION |
|---|---|
| PROV | The Medicare assigned provider number. |
| NPI | The National Provider Indicator number. |
| CHECK # | The last three payments issued to the provider by Medicare. Leading zeros indicate a check. 'EFT' indicates electronic fund transfer. |
| DATE | The date when the payments were issued (YYYYMMDD). |
| AMOUNT | The dollar amount of the last three payments issued to the provider. |

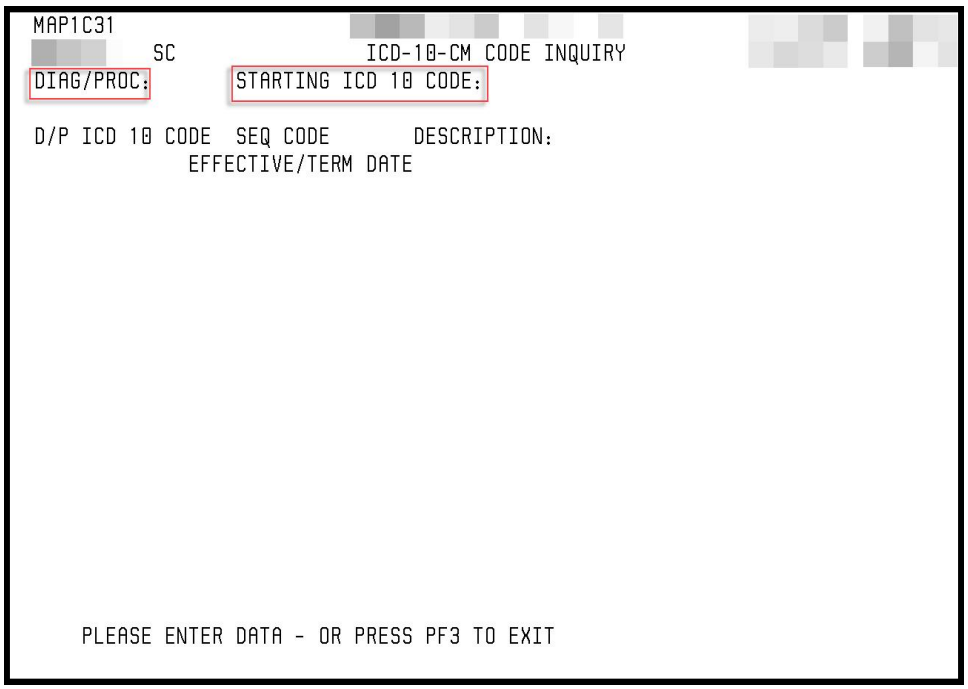
## DX/PROC CODES ICD-10 – OPTION 1B

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

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

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

## ICD-10 Code Inquiry Screen – MAP1C31



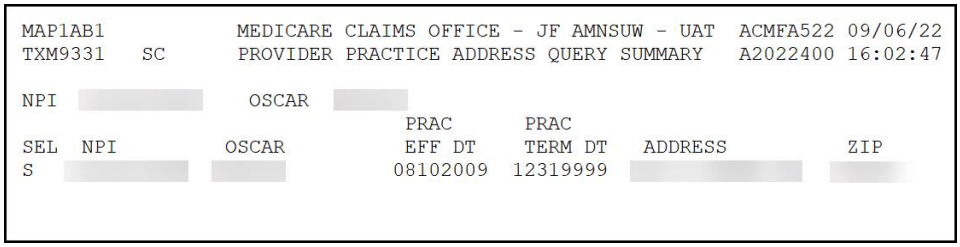

| FIELD | DESCRIPTION |
|---|---|
| DIAG/PROC | Diag\Proc - This field identifies whether this is an ICD-10 diagnosis or procedure:<br>D=Diagnosis code<br>P=Procedure code |
| STARTING ICD 10 CODE | Starting ICD-10 Code - The ICD-10 code is used to identify a specific diagnosis(s) or inpatient surgical 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:<br>D=Diagnosis code<br>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.

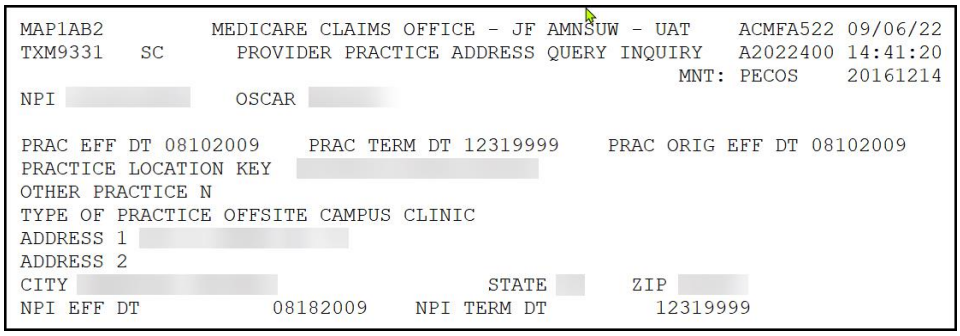
### Provider Practice Address Query Summary Screen – MAP1AB1




| FIELD | DESCRIPTION |
|---|---|
| NPI | The National Provider Indicator number |
| OSCAR | The Provider Transaction Access Number (PTAN) |
| PRAC EFF DT | Practice Effective Date |
| PRAC TERM DT | Practice Termination Date |
| ADDRESS | Street address of the practice location |
| ZIP | Nine digit ZIP code of the practice location |

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

## Provider Practice Address Query Inquiry Screen – MAP1AB2




| FIELD | DESCRIPTION |
|---|---|
| NPI | The National Provider Indicator number |
| OSCAR | The Provider Transaction Access Number (PTAN) |
| MNT: PECOS | The date the file was created in PECOS. Anything prior to 2017 will display December 19, 2016 |
| PRAC EFF DT | Practice Effective Date |
| PRAC TERM DT | Practice Termination Date |
| PRAC ORIG EFF DT | Practice Original Effective Date |
| PRACTICE LOCATION KEY | The ID of the application approval. The first 8 digits are in the YYYYMMDD format |
| TYPE OF PRACTICE | The practice type |
| ADDRESS 1 AND 2 | Street address of the practice location |
| ZIP | Nine-digit ZIP code of the practice location |

## NEW HCPC CODES – OPTION 1E

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

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

## New HCPC Information Inquiry – MAP1E01

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

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

 070119       F 0




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


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

The example above uses HCPC Q5115.

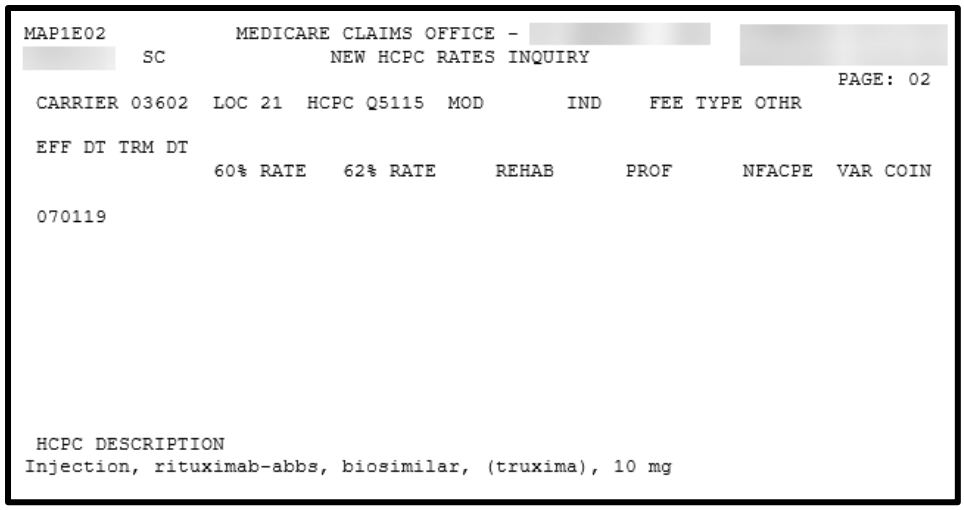
| FIELD | DESCRIPTION |
|---|---|
| CARRIER | The Medicare Intermediary identification number. The Carrier Number will be system filled. |
| LOCALITY CODE | The area (or county) where the provider is located. This field accepts as a valid value only the six locality codes entered on the Provider File and “01.” If a HCPC does not exist for the specific locality, the system will default to a “01,” except for 90743 with a locality of “00.” |
| HCPC | Type the five-digit HCPC code to view. |
| MOD | This field identifies Multiple fees for one HCPC code based on the presence or absence of a modifier in this field. The default value is blank unless a valid modifier is entered for the HCPC. |
| IND | HCPC Indicator-this field is not used in DDE. |
| EFF DT | This field identifies the National Drug Code effective date. |
| TRM DT | This field identifies the National Drug Code termination date. |
| PROVIDER | This field identifies the identification number of the Alias Provider. |
| DRUG CODE | This field identifies whether the HCPC is a drug.<br>E = The HCPC is a drug<br>‘ ’ = 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:<br>D = Discharge Date<br>F = From Date<br>R = Receipt Date |

| FIELD | DESCRIPTION |
|---|---|
| OVR | The override code instructs system in applying the services to the beneficiary deductible and coinsurance. Valid values are:<br>0 = Apply deductible and coinsurance<br>1 = Do not apply deductible<br>2 = Do not apply coinsurance<br>3 = Do not apply deductible or coinsurance<br>4 = No need for total charges (used for multiple HCPC for single revenue code centers)<br>5 = RHC or CORF psychiatric<br>M = EGHP (may only be used on the 0001 Total line for MSP)<br>N = Non-EGHP (may only be used on the 0001 Total line for MSP)<br>Y = IRS/SSA data match project; MSP cost avoided |
| FEE | Displays the fee indicator received in the Physician Fee Schedule file. Valid values include: B = Bundled procedure<br>R = Rehab/Audiology Function Test/CORF Services ' ' = Default value |
| OPH | Outpatient Hospital Indicator - This field identifies the outpatient hospital indicator that is received from CMS in the physician fee schedule abstract test file. This is a one-position alphanumeric field, with six occurrences. The valid values are:<br>' ' = Default value<br>0 = Fee is applicable<br>1 = Fee is not applicable |
| CAT | Category Code - This field identifies the CMS category of the DME equipment. This is a one-position alphanumeric field. The valid values are:<br>1 = Inexpensive or other routinely purchased DME<br>2 = DME items requiring frequent maintenance and substantial servicing<br>3 = Certain customized DME items<br>4 = Prosthetic and orthotic devices<br>5 = Capped rental DME items<br>6 = Oxygen and oxygen equipment |
| PCTC | Professional Component/Technical Component - This field identifies the PC/TC indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) services Supplemental Fee Schedule. The valid values are:<br>PC/TC HPSA Payment Policy<br>0 = Pay the Health Professional Shortage Area (HPSA) bonus.<br>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.<br>2 = Professional component only, pay the HPSA bonus.<br>3 = Technical component only, do not pay the HPSA bonus.<br>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.<br>5 = Incident codes, do not pay the HPSA bonus.<br>6 = Laboratory physician interpretation codes, pay the HPSA bonus.<br>7 = Physical therapy service, do not pay the HPSA bonus.<br>8 = Physician interpretation codes, pay the HPSA bonus.<br>9 = Concept of PC/TC does not apply; do not pay the HPSA bonus. |
| ANES BASE VAL | Identifies the Anesthesia Base Unit Value. The valid values are 1-199. |

| FIELD | DESCRIPTION |
|---|---|
| TYP | Identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. This is a one-position alphanumeric field. The value values are:<br>M = Originated from MPFS database files<br>‘ ' = Did not originate from the MPFS database files<br>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. |
| MSI DESCRIPTOR | MSI - This field identifies the Multiple Service Indicator. |
| ALLOWABLE REVENUE CODES | The allowable revenue code(s) that this particular HCPC code may use in billing. This is a four-position alphanumeric field and can have up to ten occurrences. The fourth digit of the revenue code may be stored with an 'X' indicating that it is a variable. For example, by storing the revenue code '029X', the system allows this HCPC code with any revenue code that begins with '029'. By leaving this field blank, the system allows a HCPC code on any revenue code. |
| HCPC DESCRIPTION | The narrative description of the HCPC code. |

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

## New HCPC Rates Inquiry – MAP1E02




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

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

## OUD DEMO 99 – OPTION 1F

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

## Opioid Use Disorder DEMO 99 Inquiry – MAP1E91

```
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                   G2215-G2216            G1028
YEAR              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 |

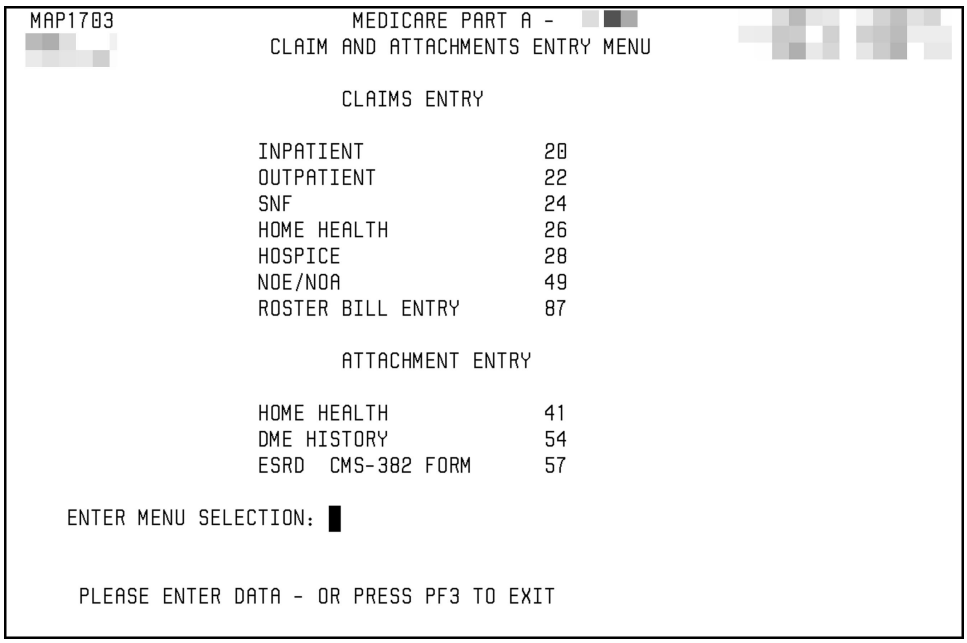
| FIELD | DESCRIPTION |
|---|---|
| CAP LIMIT USED | Current number of claims billing HCPC G2172 for that Provider in that CAP Year |
| CAP LIMIT MAX | Maximum number of claims billing HCPC G2172 that can be billed for that Provider in that CAP Year |
| G2172 AMT PAID | Total Amount Paid for HCPC G2172 |
| 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 |
| G2086-G2088 COST SHR AMT | Total Cost Sharing Amount for HCPCS G2086-G2088 |
| G2086-G2088 CLMS | Total Claims Paid for HCPCS G2086-G2088 |
| G2215-G2216 COST SHR AMT | Total Cost Sharing Amount for HCPCS G2215-G2216 |
| G2215-G2216 CLMS | Total Claims Paid for HCPCS G2215-G2216 |

# CHAPTER FOUR – CLAIMS ENTRY

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

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

## Claim and Attachment Entry Menu – MAP1703




## Claims Entry – Options 20, 22, and 24

The UB-04 Claim Entry consists of six (6) separate screens/pages:

- Page 01 - Patient information (corresponds to form locators 1-41)
- Page 02 - Revenue/HCPCS codes and charges (corresponds to form locators 42-49)
- Page 03 - Payer information, diagnoses/procedure codes (corresponds to form locators 50-57 and 67-83)
- Page 04 - Remarks and attachments (corresponds to form locators 84-86)
- Page 05 - Other payer and MSP information (corresponds to form locators 58-66)
- Page 06 - MSP information, crossover, and other inquiry (does not corresponds to any form locator)

### General Information

Enter the NPI on claims page 3.

The system defaults to the 111 type of bill for inpatient claims, 131 for outpatient claims, and 211 for SNF claims. If you are entering a different type of bill, type over the default with the correct type of bill.

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

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

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

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

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

Unless otherwise specified, dates are entered in MMDDYY format.

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

### Transmitting Data

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

If any information is missing or entered incorrectly, the DDE system will display reason codes at the bottom of the claim screen so that you can correct the errors. The claim will not transmit until it is free of front-end edit errors.

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

### Correcting Reason Codes

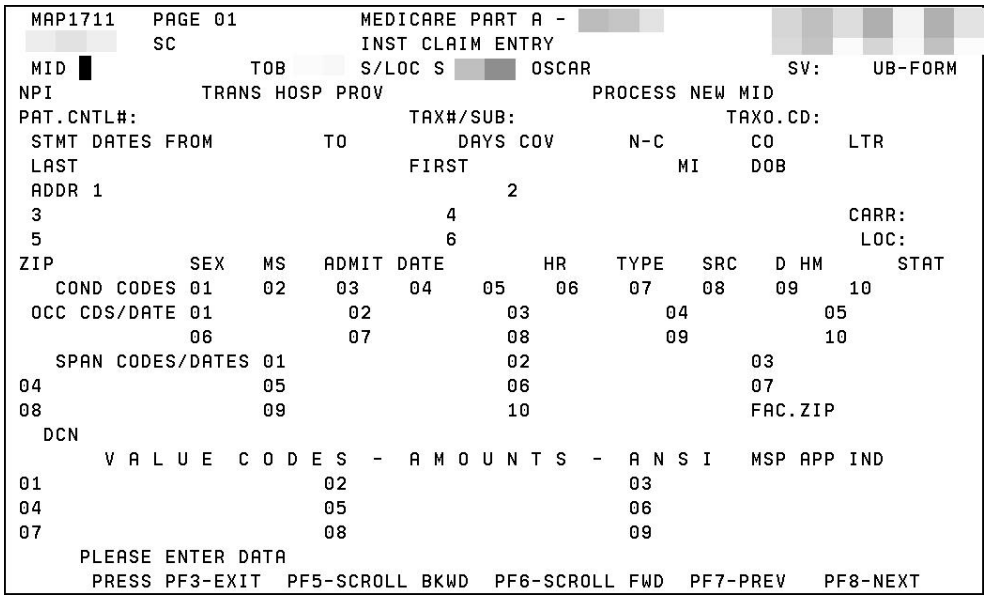
When a reason code appears in the lower left corner of the screen, press [F1] to see an explanation of the reason code. After reviewing the explanation, press [F3] to return to your claim and make the necessary corrections. If more than one reason code appears, continue this process until all reason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

If more than one reason code is present, pressing the [F1] key will always bring up the explanation of the first reason code unless the cursor is positioned over one of the other reason codes, or unless a new reason code is typed over the first one on the reason code narrative screen. Working through the reason codes in the order they are listed is the most efficient method. Eliminating the reason codes at the beginning of the list may result in the reason codes at the end of the list being corrected as well.

### Cancel Method

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

## Claims Entry Screen 1 – MAP1711




| FIELD<br>R = Required<br>S = Situational<br>A = System filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| SV - S | (Not Applicable) | Suppress View - This field allows a claim to be suppressed. Use this field ONLY for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03). |
| MID - R | 60 | The beneficiary's Medicare ID number. |
| TOB - R | 4 | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS - A | (Not Applicable) | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider |
| LOC - A | (Not Applicable) | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| OSCAR - R | 51 | The provider number of the facility that is billing for the services provided. If your access identification number is assigned to multiple provider numbers, check this field to be sure the correct number appears. |
| UB-FORM | (Not Applicable) | UB Form - This field identifies the type of claim form.<br>A = UB-04 |
| NPI - R | 56 | The National Provider Identifier number. |
| TRANS HOSP PROV - A | (Not Applicable) | The identification number of the institution which rendered services to the beneficiary /patient. It is system generated for external operators that are directly associated with one provider. |
| PROCESS NEW MID - S | 60 | Process New Medicare ID Number. Use this field ONLY in for claims appearing in the Return to Provider file (see Claims Correction, Main Menu option 03). |

## PATIENT STAY INFORMATION

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

## PATIENT INFORMATION

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

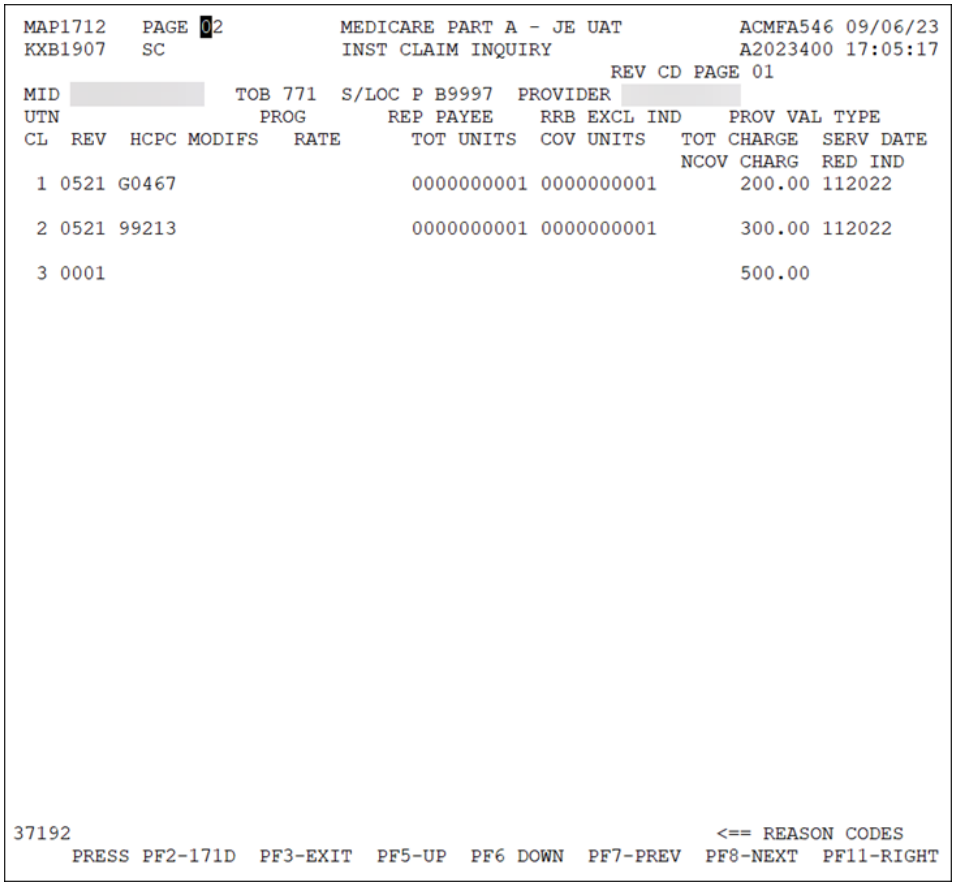
| FIELD<br>R = Required<br>S = Situational<br>A = System filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MS | (Not Applicable) | Marital Status - the patient's marital status at the time services were rendered. Not Required. The valid values are:<br>S = Single<br>M = Married<br>X = Legally separated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

## ADMISSION DATA

| FIELD<br>R = Required<br>S = Situational<br>A = System filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| ADMIT DATE - R - Inpatient | 12 | Admission Date - the date of the patient's admission to this provider. |
| HR | 13 | Admission Hour. |
| TYPE - R - Inpatient | 14 | Admission Type - the priority of admission. The valid values are:<br>1 = Emergency<br>2 = Urgent<br>3 = Elective<br>4 = Newborn<br>5 = Trauma Center |
| SRC - R | 15 | Source of Admission - the way a patient was referred to the hospital for admission. The valid values are:<br>1 = physician referral<br>2 = Clinical referral<br>4 = Transfer from a hospital<br>5 = Transfer from a SNF (Skilled Nursing Facility)<br>6 = Transfer from another health care facility<br>7 = Emergency room<br>8 = Court/law enforcement<br>9 = Information not available<br>B = Transfer from another Home Health Agency<br>C = Readmission to the same Home Health Agency<br>D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer<br>E = Transfer from Ambulatory Surgical Facility<br>F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program |
| D HM | 16 | Discharge Hour and Minutes. |
| STAT - R | 17 | Patient Status - the code indicating the patient's status at the ending service date in the period. |
| COND CODES - S | 18-28 | Condition Codes - the codes used to identify conditions relating to the claim that may affect payer processing. |
| OCC CDS/DATE - S | 31-34 | Occurrence Codes and Dates - identifies a significant event relating to payment of this claim. |

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

## Claims Entry Screen 2 – MAP1712



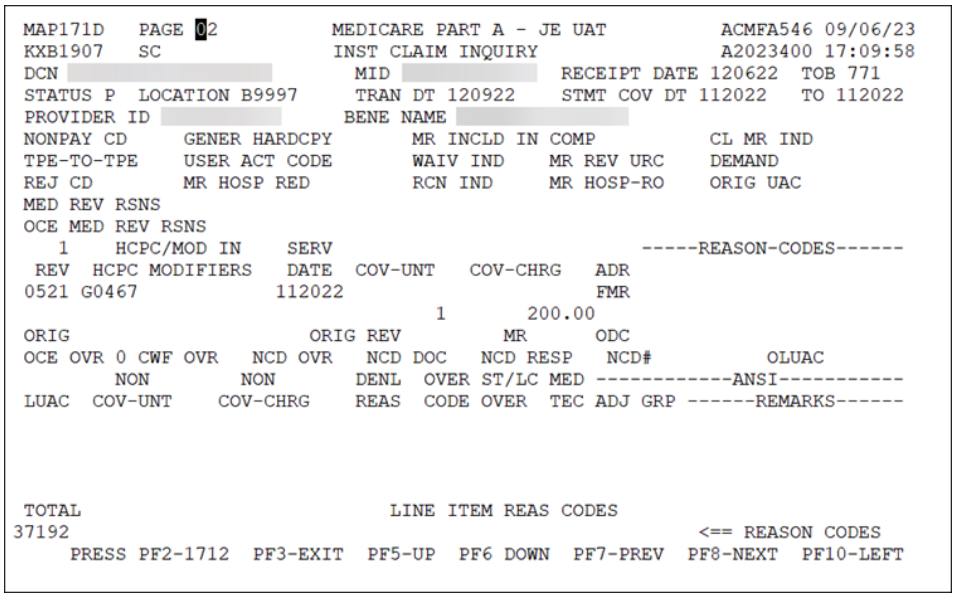

If additional revenue lines are needed, press [F6] to go to additional entry screens.

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MID - A | 60 | The beneficiary's Medicare ID number. |
| TOB - A | 4 | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS - A | (Not Applicable) | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider |
| LOC - A | (Not Applicable) | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| PROVIDER - A | 51 | If there is a one-to-one relationship between the NPI and provider number, the provider number will appear. |
| CL - R | (Not Applicable) | Claim Line Number - This field identifies the line number of the revenue code. |
| REV - R | 42 | Revenue Code - This field identifies the code for a specific accommodation or service that was billed on the claim. NOTE: When correcting a claim under the Claims Correction or Adjustment Menus, to delete a Revenue Code line, place a 'D' in the first position of the affected line, position the cursor on the page number field, press [ENTER]. To add a Revenue Code line, pass the 0001 line, add the Revenue Code, position the cursor on the page number field, press [ENTER]. |
| HCPC - S | 44 | Health Care Common Procedure Coding - identifies certain medical procedures or equipment for special pricing. The field also is used to report HIPPS codes for Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) claims. |
| MODIFS - S | 44 | Common Procedure Coding System Modifier - This field identifies the HCPCS modifier codes. If more than two modifiers are needed, additional modifiers can be entered on the line item detail screen. |
| RATE - S | 44 | Rate - a per unit cost for a particular revenue code line item. |
| TOT UNT – R | 44 | Total Units - Units of service is a quantitative measure of service rendered by revenue category. |
| COV UNT - S | 44 | Covered Units - Units of service is a quantitative measure of service rendered by revenue category. |
| TOT CHARGES | 47 | Total Charges - identifies the total amount of charges for a particular revenue line identifying a specific service for the current period. |
| NCOV CHARGES | 47 | Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line. |
| SERV DT | 45 | Line Item Date of Service. |

## Claims Entry Screen 2A Line-Item Detail – MAP171D

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

## Line-Item Detail – MAP171D




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

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MR INCLD IN COMP - A | (Not Applicable) | Composite Medical Review Included In The Composite Rate - For ESRD bills, this field identifies if the claim has been denied because the service should have been included in the Comp Rate. The valid value is:<br>Y = The claim has been denied |
| CL MR IND - A | (Not Applicable) | Complex Manual Medical Review Indicator – This field identifies if all services on the claim received complex manual medical review. The valid values are:<br>' ' = The services did not receive manual medical review (default value).<br>Y = Medical records received. This service received complex manual medical review.<br>N = Medical records were not received. This service received routine manual medical review. |
| TPE-TO-TPE - A | (Not Applicable) | Tape-to-Tape Flag - This field identifies the tape-to-tape flag (if applicable). |
| WAIV IND - A | (Not Applicable) | Waiver Indicator - This field identifies whether the provider has a presumptive waiver status. The valid values are:<br>Y = The provider does have a waiver status.<br>N = The provider does not have a waiver status |
| MR REV URC - A | (Not Applicable) | Medical Review Utilization Review Committee Reversal - This field indicates whether an SNF URC Claim has been reversed. The valid values are:<br>P = Partial reversal<br>F = Full reversal, the system reverses all charges and days |
| DEMAND - A | (Not Applicable) | Medical Review Demand Reversal - This field identifies if a SNF demand claim has been reversed. The valid values are:<br>P = Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal.<br>F = Full reversal, the system reverses all charges and days. |
| REJ CD - A | (Not Applicable) | Reject Code - The reason code for which the claim is being denied. |
| MR HOSP RED - A | (Not Applicable) | Medical Review Hospice Reduced - This field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. The valid values are:<br>' ' = Not reduced<br>Y = Reduced |
| RCN IND - A | (Not Applicable) | Reconsideration Indicator - This field used only for home health claims. The valid values are:<br>A = Finalized count affirmed<br>B = Finalized no adjustment count (pay per waiver)<br>R = Finalized count reversal (adjustment)<br>U = Reconsideration |
| MR HOSP-RO - A | (Not Applicable) | Medical Review Regional Office Referred - This field identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. The valid values are:<br>' ' = Not referred<br>Y = Referred |
| ORIG UAC - A | (Not Applicable) | Original User Action Code - the original user action code. |
| MED REV RSNS - A | (Not Applicable) | Medical Review Reasons - a specific error condition relative to medical review. |

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| OCE MED REV RSNS - A | (Not Applicable) | This field identifies the edit returned from the OPPS version of OCE. The valid values are:<br>11 = Non-covered service submitted for review (condition code 20).<br>12 = Questionable covered service.<br>30 = Insufficient services on day of partial hospitalization.<br>31 = Partial hospitalization on same day as electro convulsive therapy or type T procedure.<br>32 = Partial hospitalization claim spans three or less days with insufficient services, or electro convulsive therapy or significant procedure on at least one of the days.<br>33 = Partial hospitalization claim spans more than three days with insufficient number of days having mental health services. |
| REV - A | 42 | Revenue Code - the code for a specific accommodation or service. |
| HCPC - A | 44 | HCPCS/CPT code describing service provided. |
| MODIFIERS - S | 44 | The HCPCS modifier codes. |
| SERV DATE - A | 45 | The line item date of service. |
| COV-UNT - A | 46 | The covered units billed by revenue code. |
| COV-CHRG - A | 47 | The total amount of covered charges for the revenue line. |
| ADR REASON CODES - A | (Not Applicable) | Additional Development Reason - the ADR reason codes uses to create the appropriate reason code narrative on ADR letters. |
| FMR REASON CODES - A | (Not Applicable) | Focused Medical Review Suspense Codes - This field identifies when a claim is edited in the system, based on a Medical Policy parameter. |
| ODC REASON CODES - A | (Not Applicable) | Original Denial Reason Codes. |
| ORIG - A | 44 | Original HCPC and Modifiers Billed. |
| ORIG REV - A | 42 | Original Revenue Code. |
| MR - A | (Not Applicable) | Complex Manual Medical Review Indicator – This field identifies if all services on the claim received complex manual medical review. The valid values are:<br>' ' = The services did not receive manual medical review (default value).<br>Y = Medical records received. This service received complex manual medical review.<br>N = Medical records were not received. This service received routine manual medical review. |
| OCE OVR - A | (Not Applicable) | OCE Override - This field overrides the way the OCE module controls the line item. |
| CWF OVR - A | (Not Applicable) | CWF Home Health Override. |
| NCD OVR - A | (Not Applicable) | National Coverage Determinations Override Indicator - This field identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. The valid values are:<br>' ' = The NCD edits are not bypassed, (default value)<br>Y = The line has been reviewed for medical necessity and bypasses the NCD edits.<br>D = The line has no covered charges and bypass's the NCD edits. |

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| NCD DOC - A | (Not Applicable) | National Coverage Determination Documentation Indicator – identifies whether the documentation was received for the medically necessary service. The valid values are:<br>Y = The documentation supporting the medical necessity was received.<br>N = The documentation supporting the medical necessity was not received, (default value.) |
| NCD RESP - A | (Not Applicable) | National Coverage Determination Response Code –The valid values are:<br>' ' = Set to space for all lines on resubmitted RTP'D claims<br>0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria.<br>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.<br>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.<br>3 = The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list 2 codes). The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to non- coverage by statute.<br>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.<br>5 = Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the FI will RTP the claim. |
| NCD # - A | (Not Applicable) | National Coverage Determination Number. |
| OLUAC - A | (Not Applicable) | Original Line User Action Code. |
| LUAC - A | (Not Applicable) | Line User Action Code. |
| NON COV-UNT - A | (Not Applicable) | Non-Covered Units - Units of service is a quantitative measure of service rendered by revenue category. |
| NON COV-CHRG - A | 48 | Non-Covered Charges - identifies the total amount of non-covered charges for a particular revenue line. |
| DENIAL REAS - A | (Not Applicable) | Denial Reason - the cause of denial for the revenue code line. |
| OVER CODE - A | (Not Applicable) | ANSI Override Code - the override code that allows the operator to manually override the system generated ANSI codes. |
| ST/LC OVER - A | (Not Applicable) | Status Location Override - the override of the reason code file status when a line item has been suspended. |
| MED TEC - A | (Not Applicable) | Medical Technical Denial Indicator - This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. The valid values are:<br>M = Medial denial and waiver was applied<br>S = Medical denial and waiver was not applied<br>T = Technical denial and waiver was applied<br>U = Technical denial and waiver was not applied |

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| ANSI ADJ - A | (Not Applicable) | ANSI Adjustment Reason Code. |
| ANSI GRP - A | (Not Applicable) | ANSI Group Code. |
| ANSI REMARKS - A | (Not Applicable) | ANSI Remarks Code. |
| TOTAL - A | (Not Applicable) | The total of all revenue code non-covered units and charges present on MAP171D. |
| LINE ITEM REASON CODES - A | (Not Applicable) | Line Item Reason Code - This field identifies the reason code that is assigned out of the system for suspending the line item. |

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

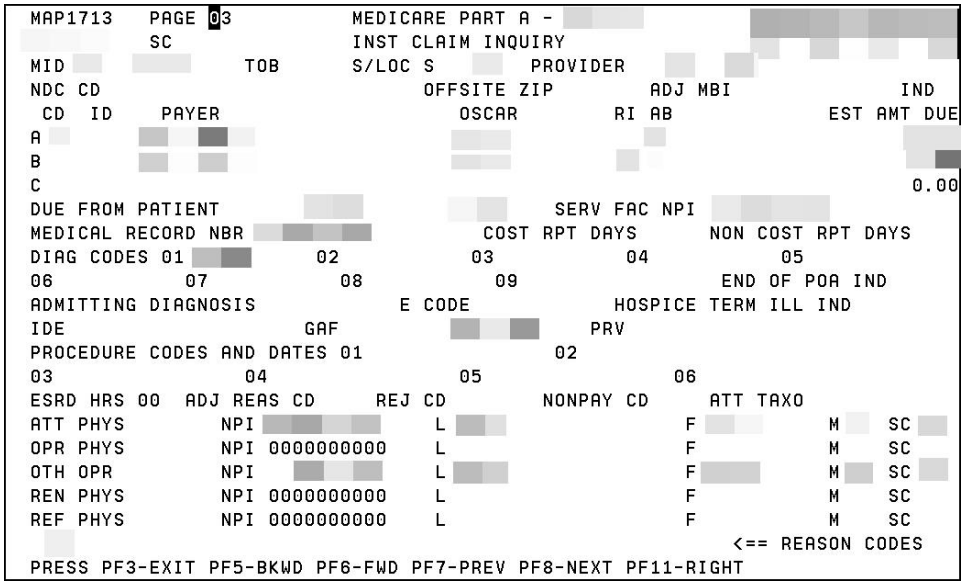
Hospitals subject to OPPS must include NDC information for drugs coded with HCPCS code C9399, and all hospital outpatient departments who serve patients who are dually eligible for Medicare and Medicare need to include the NDC, corresponding amounts and qualifiers on crossover claims. This information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

## National Drug Code Information – MAP171E

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

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

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MID - A | 60 | The beneficiary's Medicare ID number. |
| TOB - A | 4 | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS - A | (Not Applicable) | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider |
| LOC - A | (Not Applicable) | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| PROVIDER - A | 51 | If there is a one-to-one relationship between the NPI and provider number, the provider number will appear. |
| CL - A | (Not Applicable) | Code line number. |
| NDC FIELD - R | (Not Applicable) | National Drug Code- 11 digit number. Only one NDC will cross to the secondary payer; providers will need to supply any additional NDCs directly to the secondary payer. |
| NDC QUANTITY - R | (Not Applicable) | The quantity amount of the drug represented by the NDC code, based on HCPCS description and the amount distributed to the patient. Enter the decimal point if necessary. If there is not a dollar amount, enter a zero before the decimal. |
| QUALIFIER - R | (Not Applicable) | NDC Qualifier – The valid values are:<br>F2 = International Unit<br>FR = Gram<br>ML = Milliliter<br>UN = Units |
| MOLDX - S | (Not Applicable) | Molecular Diagnostic Services – Enter the DEX Z-Code™ identifier |
| LLR NPI | (Not Applicable) | Line Level Rendering Physician NPI |
| LLO NPI | (Not Applicable) | Line Level Ordering Physician NPI |

## Claims Entry Screen 3 – MAP1713




As discussed previously, Medicare Secondary Payer claims cannot be accepted through the DDE system. Lines A, B and C under the CD, ID, Payer, Oscar, RI, AB, and EST AMT DUE fields correspond to the primary, secondary, or tertiary payer ranking. If Medicare is not the primary payer (line A), the claim must be submitted electronically or on paper.

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

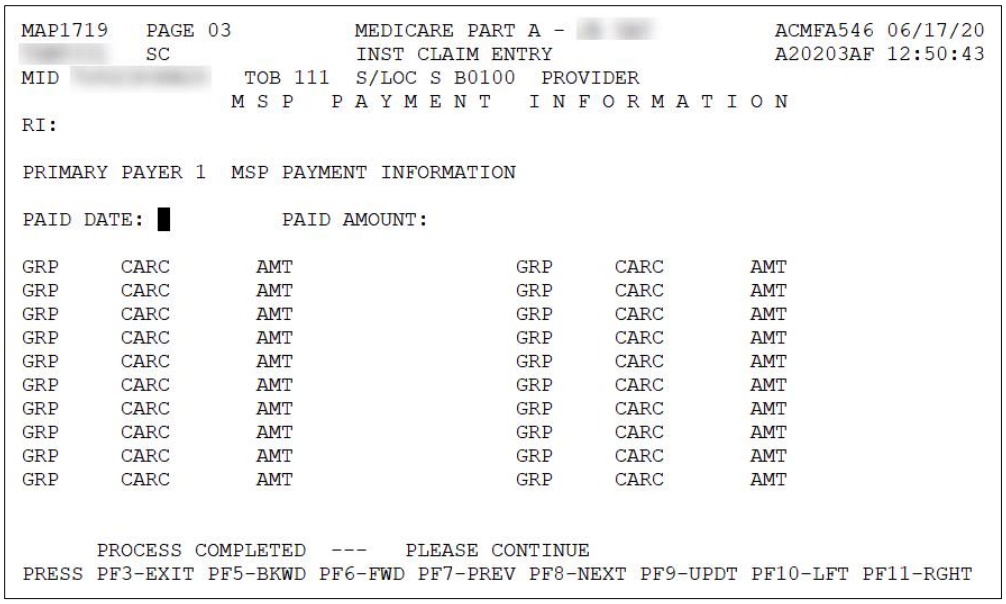
| FIELD | DESCRIPTION |
|---|---|
| CD | Payer Code – Valid values are:<br>1 = Medicaid secondary<br>2 = Blue Cross secondary<br>3 = Other secondary<br>4 = None<br>A = Working Aged (value code 12)<br>B = ESRD beneficiary in 18-month coordination period with (value code 13)<br>C = Conditional Payment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

| FIELD | DESCRIPTION |
|---|---|
| DIAGNOSIS CODES | The ICD-9-CM code(s) describing the principal diagnosis (first code) and additional conditions (codes two through nine) that co-exist at the time of admission or develop subsequently. Each diagnosis code is a six-position alphanumeric field, with two additional positions with the 7th being blank, and the 8th position is the first character of the Present On Admission (POA) Indicator for every principal and secondary diagnosis effective with discharges. The POA Indicator identifies whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The valid values for the POA Indicator are:<br>Y = Yes, Present at the time of inpatient admission.<br>N = No, not present at the time of inpatient admission.<br>U = Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission.<br>W = Clinically undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.<br>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.<br>' ' = Not acute care, POA's do not apply |
| END OF POA INDICATOR | End of POA Indicator – the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. The valid values are:<br>Z = The end of POA indicators for principal and, if applicable, other diagnoses.<br>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.<br>' ' = Not acute care, POA's do not apply |
| ADMITTING DIAGNOSIS | The ICD-9-CM code describing the inpatient condition at the time of the admission. |
| E-CODE | The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. |
| HOSPICE TERM ILL IND | Identifies whether or not a hospice patient has a terminal illness. It is only used for hospice claims. |
| IDE | Investigational Device Exemption Number (IDE) – the IDE authorization number assigned by the FDA. |
| PROCEDURE CODES AND DATES | Identifies the principal procedure (first code) and other procedures (codes two through six) performed, and dates on which they occurred. This field is required for inpatient claims where a surgical procedure is performed. |
| ESRD HOURS | End Stage Renal Disease Hours - the number of hours of certain dialysis treatments such as peritoneal. |
| ADJUSTMENT REASON CODE | Identifier for the type of adjustment being performed. Enter “16” in the SC field in the upper left corner of the screen to access a listing of codes. |
| REJECT CODE | The reason code for which the claim is being non-medically denied. |
| NON PAY CODE | The reason for Medicare's decision not to make payment. |
| ATT PHYS | Attending Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician. |
| NPI | Attending physician’s NPI number. |
| LN | Attending physician’s last name. |
| FN | Attending physician’s first name. |
| MI | Attending physician’s middle initial. |
| SC | Specialty Code - This field identifies the specialty code. |
| OPER PHYS | Operating Physician/UPIN Code - identifies the physician identification number or the UPIN number and the name of the licensed physician. |

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

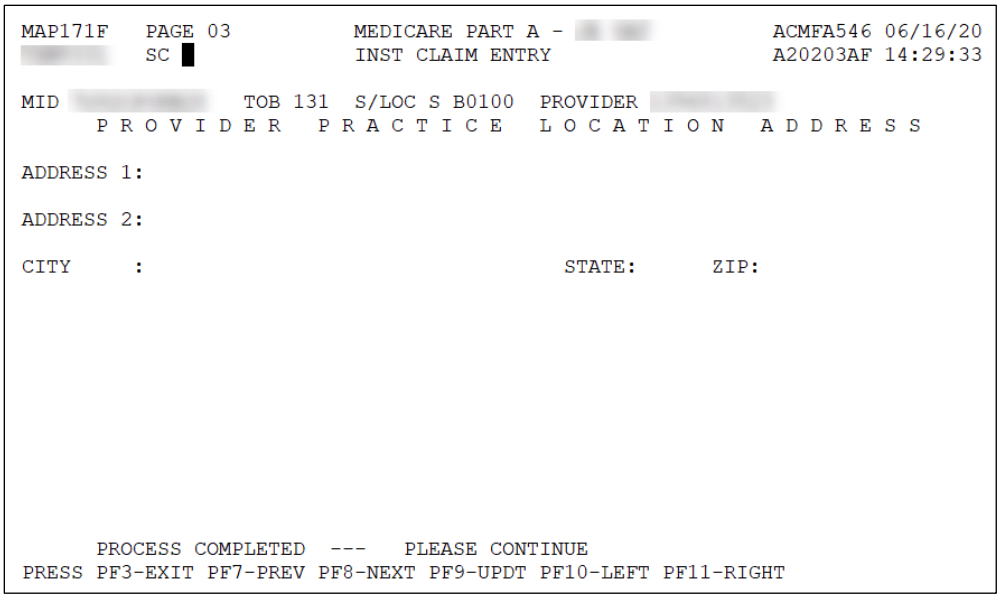
## Claims Entry Screen 3 – MAP1719

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



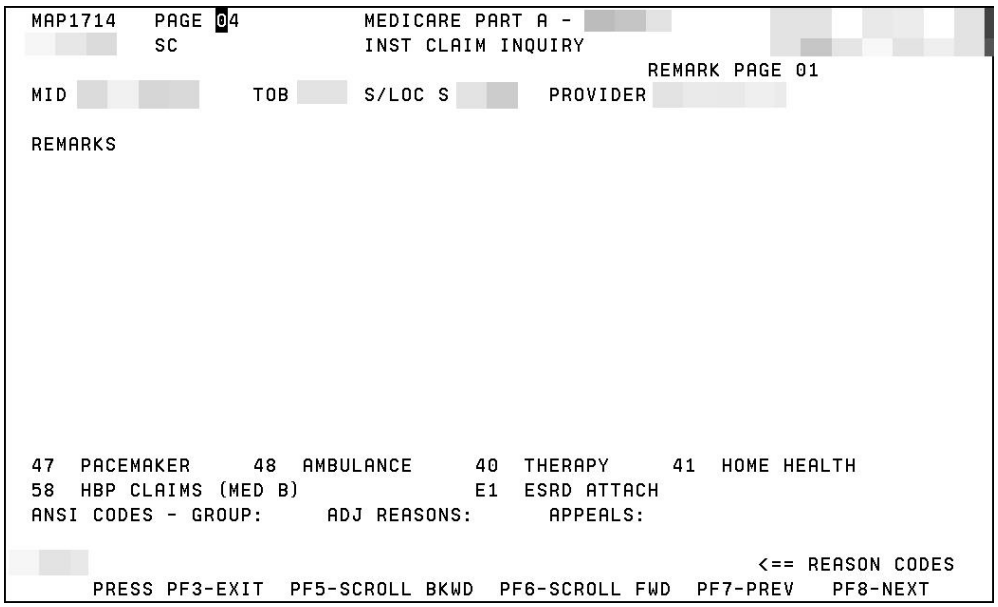

| FIELD | DESCRIPTION |
|---|---|
| RI | Release of Information - identifies whether or not the provider has a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. The valid values are:<br>R = Restricted or modified release<br>N = No release |
| 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. |
| CARC | ANSI CARC codes. This is a four-position alphanumeric field, with 20 occurrences. |
| AMT | The dollar amount associated with the group/CARC combination. This field is an eleven-position numeric field in 999999999.99 format, with 20 occurrences. |

## Claims Entry Screen 3 – MAP171F




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

## Claims Entry Screen 4 – MAP1714

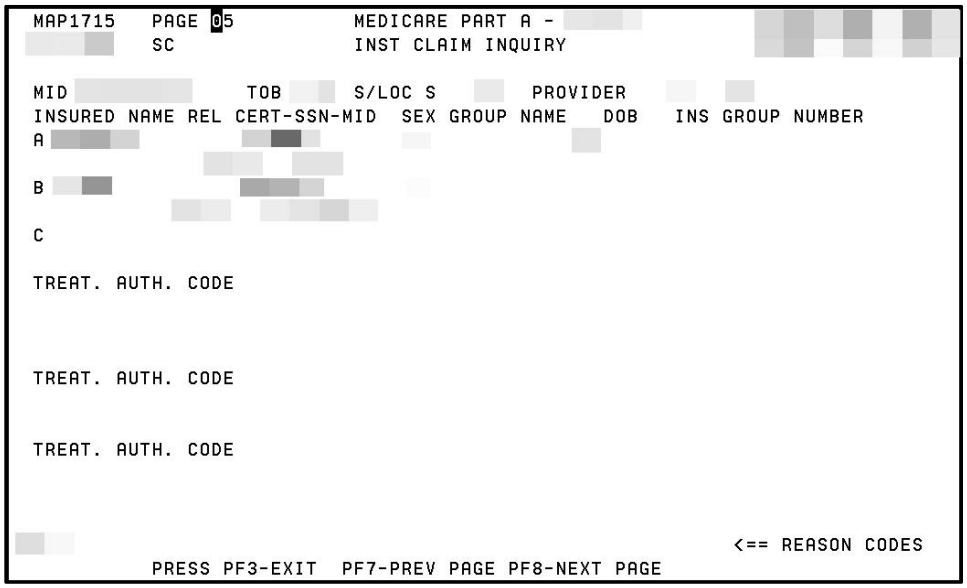



Remarks can be entered by provider staff (and by Noridian staff) and are used to add clarifying information. They become part of the permanent claim record. It is not necessary to use complete sentences, but the information should be easily understandable, and any abbreviations should be commonly used.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

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MID | 60 | The beneficiary's Medicare ID number. |
| TOB - A | 4 | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS - A | (Not Applicable) | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider |
| LOC - A | (Not Applicable) | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| PROVIDER - A | 51 | If there is a one-to-one relationship between the NPI and provider number, the provider number will appear. |
| REMARKS - A | (Not Applicable) | Information submitted by providers or contractor staff to provide permanent comments regarding special considerations that affect adjudicating the claim. Common abbreviations are acceptable. End each entry with your initials and the date. Addition space is available by pressing [F6]. |
| ZIP - A | (Not Applicable) | Identifies the zip code. |
| 48 AMBULANCE | (Not Applicable) | Ambulance Attachment – not used. |

| FIELD<br>R = Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| 40 THERAPY | (Not Applicable) | Therapy Attachment – not used. |
| 41 HOME HEALTH | (Not Applicable) | Home Health Attachment – not used. |
| 58 HBP CLAIMS | (Not Applicable) | Hospital-based Physician Attachment – not used. |
| ANSI CODES-GROUP - A | (Not Applicable) | General category of payment adjustment. Used for claims submitted in an ANSI automated format only. |
| ADJ REASONS - A | (Not Applicable) | Claim adjustment standard reason code identifying the detailed reason the adjustment was made. This is a three- position alphanumeric field. See Claims Entry Screen 3 for explanation. |
| APPEALS – A | (Not Applicable) | ANSI Appeals Codes - This field identifies codes for inpatient or outpatient. |

## Claims Entry Screen 5 – MAP1715




The information on this screen gives beneficiary and subscriber information for the primary, secondary, or tertiary payers. If Medicare is not the primary payer, the claim cannot be submitted through DDE.

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

| FIELD<br>R= Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| STATUS - A | (Not Applicable) | Status - This field identifies the condition of the claim:<br>D = Denied<br>I = Inactive<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider |
| LOC - A | (Not Applicable) | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| PROVIDER - A | 51 | If there is a one-to-one relationship between the NPI and provider number, the provider number will appear. |
| INSURED NAME - R | 58 | The individual in whose name the insurance is carried, as qualified by the payer organization. If Medicare is primary, enter the beneficiary's last name, first name, and middle initial on Line A. Name must be the same as one the patient's Medicare card or other Medicare notice.<br>Line A = primary payer<br>Line B = secondary payer<br>Line C = tertiary payer |
| REL - R | 59 | Patient Relationship to Insurer – Enter the HIPAA relationship codes (these cross-reference to CWF codes); If Medicare is primary, the valid values are:<br>HIPAA Code = 18<br>CWF Code = 1<br>Relationship = Self |
| CERT-SSN- MID - R | 60 | Identifies the insurer assigned beneficiary number.<br>Line A = primary payer<br>Line B = secondary payer<br>Line C = tertiary payer |
| SEX - R | 11 | The sex of the beneficiary.<br>Line A = primary payer<br>Line B = secondary payer<br>Line C = tertiary payer |
| GROUP NAME - S | 61 | Name of the group or plan through which the insurance is provided to the insured.<br>Line A = primary payer<br>Line B = secondary payer<br>Line C = tertiary payer |
| DOB - S | (Not Applicable) | The insured's date of birth.<br>Line A = primary payer<br>Line B = secondary payer<br>Line C = tertiary payer |
| INS GROUP NUM.- S | 62 | The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.<br>Line A = primary payer<br>Line B = secondary payer<br>Line C = tertiary payer |
| TREAT AUTH CODE | (Not Applicable) | HHPPS Treatment Authorization Code – used for home health claims. |

## Claims Entry Screen 6 – MAP1716

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

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

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

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

| FIELD<br>R= Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MID - A | 60 | The beneficiary's Medicare ID number. |
| TOB - A | 4 | Type of Bill - This field identifies the type of facility, bill classification, and frequency of the claim in a particular period of care. |
| STATUS - A | (Not Applicable) | Status - This field identifies the condition of the claim:<br>D = Denied<br>P = Paid<br>R = Rejected<br>S = Suspended<br>T = Returned to Provider<br>I = Inactive |
| LOC - A | (Not Applicable) | Location - This field identifies where the claim resides in the system. Refer to the Noridian Quick Reference Guide for code descriptions. |
| PROVIDER - A | 51 | If there is a one-to-one relationship between the NPI and provider number, the provider number will appear. |

## MSP ADDITIONAL INSURER INFORMATION

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

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

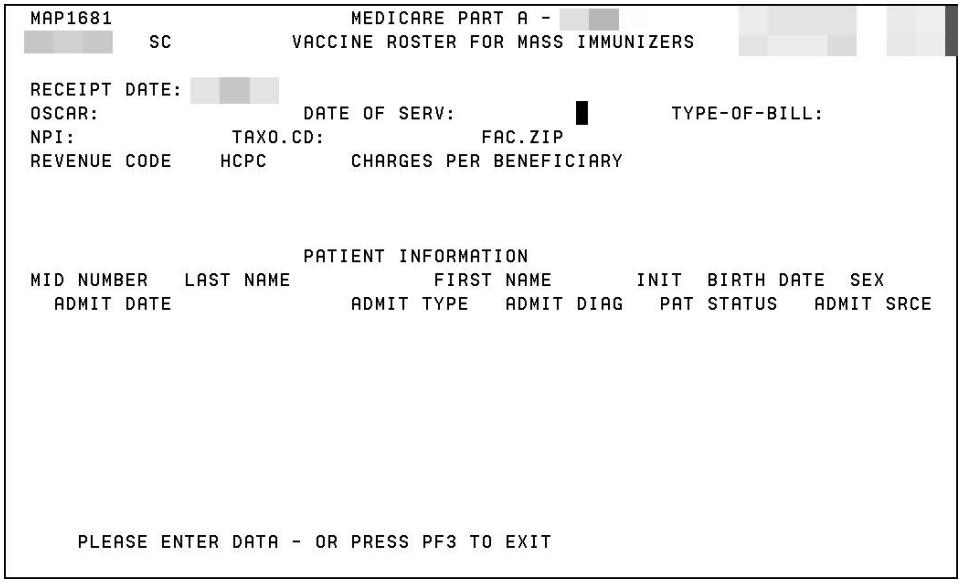
## PAYMENT DATA

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

| FIELD<br>R= Required<br>S = Situational<br>A = System Filled | DESCRIPTION |
|---|---|
| PAYMENT CODE - A | The payment method of the check or electronic funds transfer. The valid values are:<br>ACH = Automated Clearing House or Electronic Funds Transfer<br>CH = Check<br>NON = Non-payment Data |
| DRG - A | Diagnosis Related Group Code – the Diagnosis Related Group code assigned by the CMS grouper program using length of stay, covered days, sex, age, diagnosis and procedure codes, discharge date, and total charges. |
| INIT DRG - A | Initial Diagnosis Related Group Code. |
| OUTLIER AMT - A | Capital Outlier Payment – This field identifies the outlier portion of the PPS payment for capital and the PPS dollar threshold for a cost outlier |
| TTL BLENDED PAYMENT – A | This field is not used by FISS. |
| FED SPEC - A | This field is not used by FISS. |
| GRH ORIG REIMB AMT - A | Gramm Rudman Original Reimbursement Amount – the amount reduced from the provider's reimbursement as mandated by Gramm/Rudman/Hollings legislation. |
| NET INL | Internal use. |
| TECH PROV DAYS - A | The days present on the benefit savings record or the days reflected in the occurrence span '77' if the benefit savings record is not present. |
| TECH PROV CHARGES - A | The charges present on the benefit savings record. |
| IOCE OPPS FLAG | Identifies OPPS claims. |
| OTHER INS ID | This field not used by FISS. |
| CLINIC CODE | This field not used by FISS. |
| IOCE CLM PR FL | IOCE Claim Processed Flag<br>0 - Claim is processed.<br>1 - Claim could not be processed (edits 23, 24, 46*, TOB 83x or other invalid bill type).<br>2 - Claim could not be processed (claim has no line items).<br>3 - Claim could not be processed (edit 10 - condition code 21 is present).<br>4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted.<br>9 - Fatal error; OCE cannot run - the environment cannot be set up as needed. |

## Roster Billing – Option 87 – MAP1681

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




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

## PATIENT INFORMATION

| FIELD<br>R= Required<br>S = Situational<br>A = System Filled | UB-04 X-REF | DESCRIPTION |
|---|---|---|
| MID - R | 60 | The beneficiary's Medicare ID number. |
| LAST NAME - R | 8 | Last Name - the patient's last name at the time services were rendered. |
| FIRST NAME - R | 8 | First Name - the patient's first name. |
| INIT | 8 | Middle Initial - the patient's middle initial. |
| BIRTH DATE - R | 10 | Date of Birth - the patient's date of birth. |
| SEX - R | 11 | Sex - This field identifies the patient's sex as recorded at the time services were rendered. The valid values are:<br>M = Male<br>F = Female<br>U = Unknown |
| ADMIT DATE - R | 12 | Admission Date – the date of the patient's admission to this provider. Field available only for bill types 12X and 22X.<br>S = Single<br>M = Married<br>X = Legally separated<br>D = Divorced<br>W = Widowed<br>U = Unknown |
| ADMIT TYPE - R | 14 | Admission Type - the priority of admission. The valid values are:<br>1 = Emergency<br>2 = Urgent<br>3 = Elective<br>4 = Newborn<br>5 = Trauma Center<br>Field available only for types of bill 12X and 22X. |
| ADMIT DIAG - R | 69 | Enter the ICD-9-CM V- diagnostic code for Influenza vaccines.<br>Field available only for types of bill 12X and 22X. |
| PAT STATUS - R | 17 | Patient Status - the code indicating the patient's status at the ending service date in the period. Field available only for types of bill 12X and 22X. |
| ADMIT SOURCE - R | 15 | Source of Admission - the way a patient was referred to the hospital for admission. The valid values are:<br>1 = Physician referral<br>2 = Clinical referral<br>4 = Transfer from a hospital<br>5 = Transfer from a SNF (Skilled Nursing Facility)<br>6 = Transfer from another health care facility<br>7 = Emergency room<br>8 = Court/law enforcement<br>9 = Information not available<br>B = Transfer from another Home Health Agency<br>C = Readmission to the same Home Health Agency<br>D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer<br>E = Transfer from Ambulatory Surgical Facility<br>F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program Field available only for types of bill 12X and 22X. |

## ESRD CMS-382 Form – MAP1391

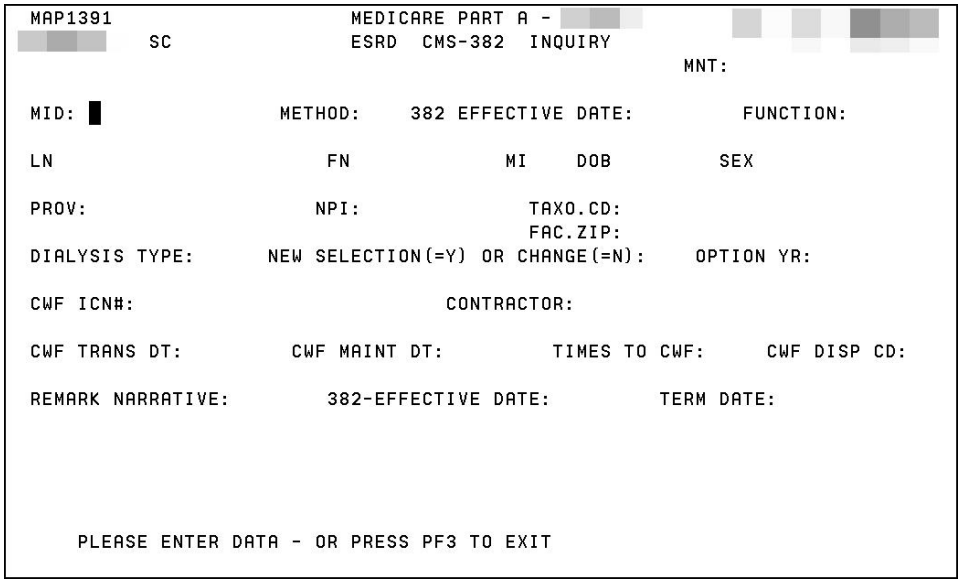
Per CMS CR 7064, providers no longer need to submit the ESRD CMS-382 form for Method I or Method II; however, the DDE functionality remains. Providers are encouraged to review the following CMS resources for current ESRD guidance.

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

Choose one of the following functions:

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

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

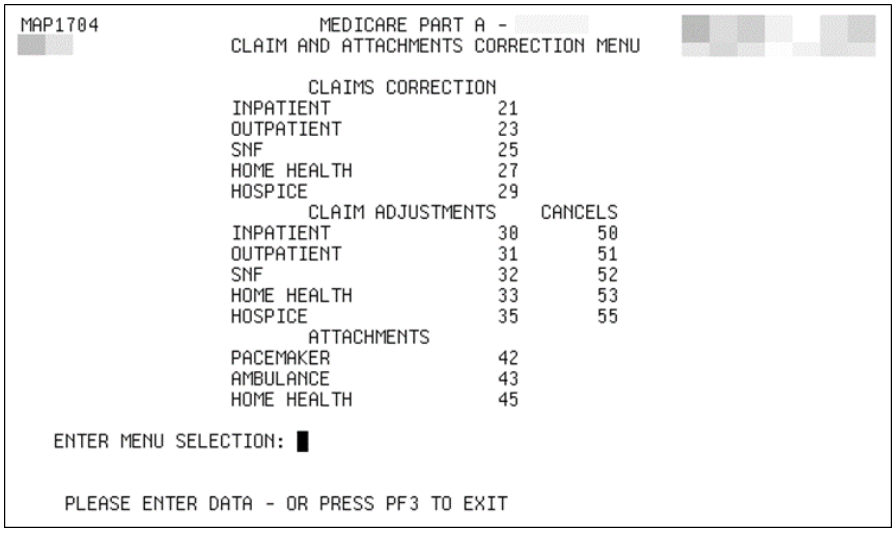



| FIELD | DESCRIPTION |
|---|---|
| OP | The last operator who created or revised (F9'd) this file. |
| DT | The date this code was last saved (F9'd). |
| MID | The beneficiary's Medicare ID number. |
| METHOD | The method of home dialysis selected by the beneficiary. The valid values are:<br>1 = Method I - The beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits claims for services they render.<br>2 = Method II - The beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and the beneficiary is responsible for submitting their own claims to the carrier for reimbursement. |
| 382 EFFECTIVE DATE | The date the Beneficiary's ESRD Method Selection becomes effective on the (CMS-382) form. |
| FUNCTION | The specific function to be conducted on the CMS-382 option. The valid values are:<br>E = Entry<br>I = Inquiry<br>U = Update |
| LN | Last Name - the patient's last name at the time services were rendered |
| FN | First Name - the patient's first name |

| FIELD | DESCRIPTION |
|---|---|
| MI | Middle Initial - the patient's middle initial |
| DOB | Date of Birth - the patient's date of birth |
| SEX | Sex - This field identifies the patient's sex as recorded at the time services were rendered. The valid values are:<br>F = Female<br>M = Male<br>U = Unknown |
| PROV | The provider number of the facility that is billing for the services provided. |
| NPI | The National Provider Identifier number |
| TAXO CD | The Health Care Provider Taxonomy Code |
| FAC ZIP | The provider or subpart zip code. |
| DIALYSIS TYPE | The type of dialysis services the beneficiary has selected on the ERSD Beneficiary Selection Form CMS-382) in form locator 9. The valid values are:<br>1 = Hemodialysis<br>2 = Continuous ambulatory peritoneal dialysis (CAPD)<br>3 = Continuous cycling peritoneal dialysis<br>4 = Peritoneal dialysis |
| NEW SELECTION OR CHANGE | This field indicates an exception to other ERSD data. The valid values are:<br>Y = Entered on initial selection or for exceptions such as when the option year is equal to the year of the select date.<br>N = Entered for a change in selection, i.e., option year is one year greater than the year of select date. |
| OPTION YR | The year that a beneficiary selection or change is effective. A selection change becomes effective on January 1st of the year following the year in which the ESRD beneficiary signed the selection form. |
| CWF ICN # | When an ESRD maintenance transaction is transmitted to CWF, FISS assigns an internal control number (ICN) and inserts this number on the ESRD Remarks screen. |
| CONTRACTOR | The carrier or intermediary responsible for a particular ESRD maintenance file. |
| CWF TTRANS DATE | The date an ESRD maintenance transaction was transmitted to CWF. |
| CWF MAINT DATE | The date that a CWF response was applied to a particular ESRD record. |
| TIMES TO CWF | The number of times a particular ESRD maintenance transaction has been transmitted to CWF. |
| CWF DISP CODE | The specific disposition code that has been received from CWF for a particular ESRD maintenance transaction. |
| REMARK NARRATIVE | Data that was entered in the method field. System generated. The valid values are:<br>M1 = Method 1<br>M2 = Method 2 |
| 382-EFFECTIVE DATE | The effective date of the Method Selection. This date is system calculated and is based on whether the selection or change is equal to one of the following values:<br>Y = The 382 effective date is equal to the 382 effective date.<br>N = The 382 effective date is January 1 of the following year. |
| TERM DATE | The projected termination date for a particular beneficiary relative to dialysis coverage under the Medicare Program. |

# CHAPTER FIVE – CLAIMS CORRECTIONS – MAP1704

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




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

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

Options available from this menu are:

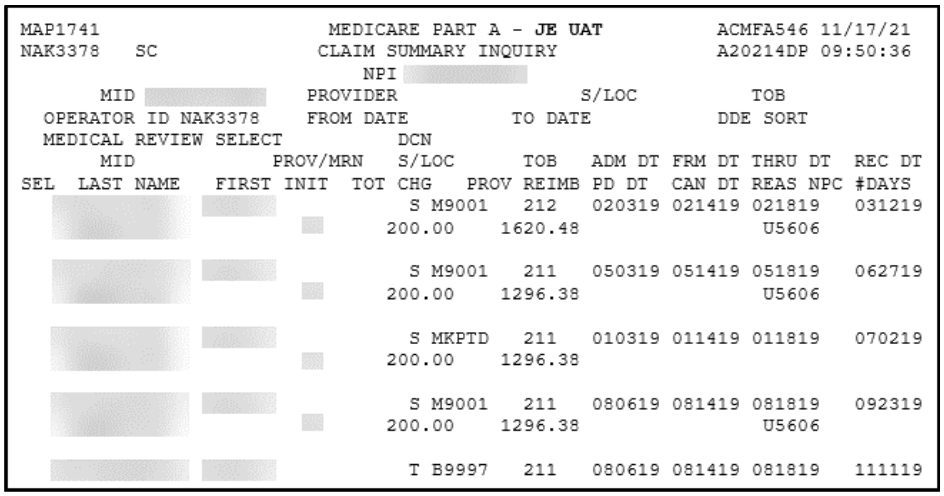
- Claims Correction
  - Inpatient – 21
  - Outpatient – 23
  - SNF – 25
- Claim Adjustment
  - Inpatient – 30
  - Outpatient – 31
  - SNF – 32
- Cancel
  - Inpatient – 50
  - Outpatient – 51
  - SNF – 52

Attachments options shown on the menu are not used.

## General Information

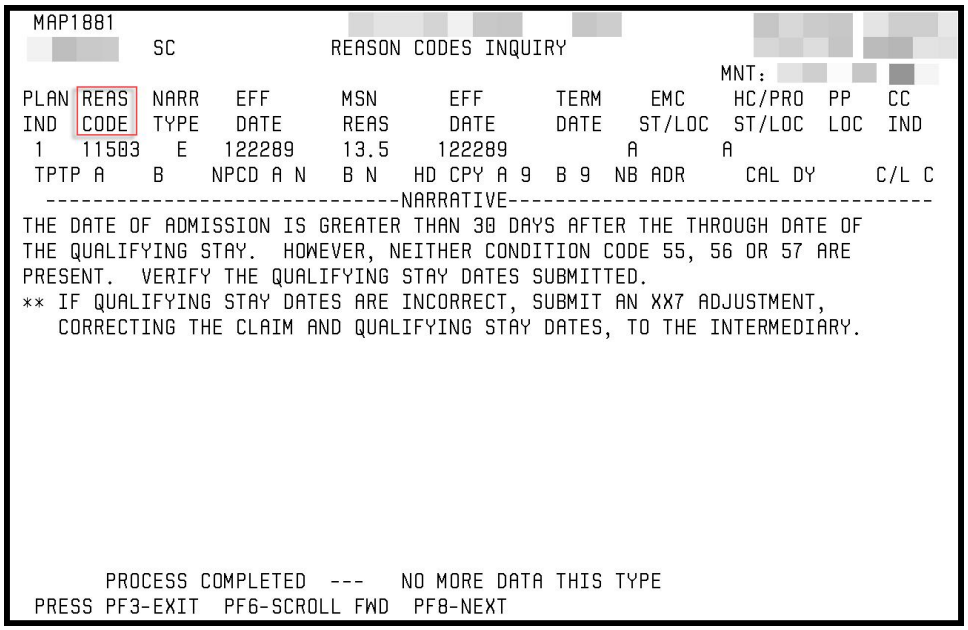
When you select an option from the Claims and Attachment Corrections menu, the same Claims Summary Inquiry screen you would see under the Claims Inquiry menu; however, you must access it through the Corrections menu in order to make changes to claims. The system will assign edits and auto-fill certain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

## Claim Summary Inquiry – MAP1741




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

## Reason Code Inquiry – MAP1881




### Correcting Revenue Code Lines

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

- To delete an entire Revenue Code line:
  - [TAB] to the line and type "D" in the first position
  - Press [HOME] to go to the Page Number field, press [ENTER]. The line will be deleted.
  - Next, add up the individual line items and correct the total charge amount on Revenue Code line 0001.

- To add a Revenue Code line:
  - [TAB] to the line below the 0001 total charge line.
  - Type the new Revenue Code information.
  - Press [HOME] to go to the Page Number field, press [ENTER]. The system will re-sort the Revenue Codes into numerical order.
  - Correct the total charge amount of line 0001.
- Changing total and non-covered charge amounts:
  - [TAB] to get to the beginning of the total charge field on a line item.
  - Press [END] to delete the old dollar amount. It is very important not to use the spacebar to delete field information. Always use [END] when clearing a field.
  - Type the new dollar amount
  - Press [ENTER]. The system will align the numbers and insert the decimal point.
  - Correct the 0001 total charge line, if necessary.
- Any time changes are needed to a line item, delete and rekey the line items to ensure the system holds the changes.

## Claims Correction – RTP Claims

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

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

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

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

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

- "M" displays claims in Medical Record order.

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

To review RTP'd claims, select the appropriate menu option and press [ENTER]. The NPI and provider number fields will default to the main NPI/provider number assigned to your Operator access ID, and the outpatient type of bill will default to 13X. Check these fields and make any necessary changes. If you want to re-sort the claim sequence, type the appropriate value in the DDE sort field and press [ENTER] again.

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

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

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

## Claim Suppression

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

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

## Adjustments

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

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

medically denied can be adjusted. The medically denied lines also must be handled through the redetermination process.

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

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

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

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

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

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

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

## Cancels

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

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

To cancel a claim, select the appropriate option code and press [ENTER]. This will bring up the Claim Summary Inquiry screen. The outpatient type of bill will default to 13X; check this field and make any necessary changes. Enter your NPI, the Medicare ID number and dates of service. Press [ENTER]. This will bring up a listing of the claims that meet the selection criteria. Select the claim you want to cancel by placing "S" in the SEL field at the beginning of the row. When the claim detail appears, the type of bill will show an 8 in the final position (xxx8).

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

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

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

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

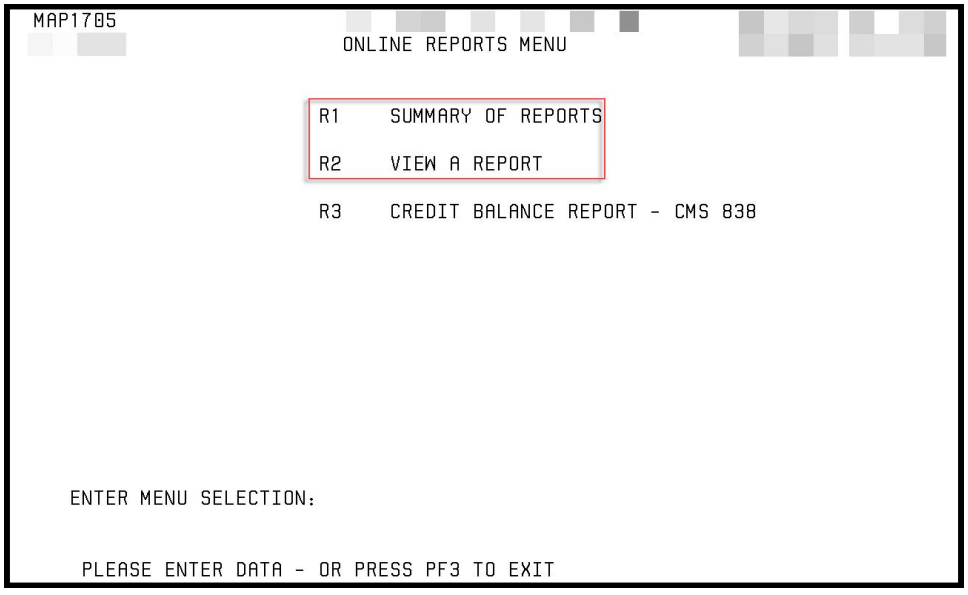
# CHAPTER SIX – REPORTS

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

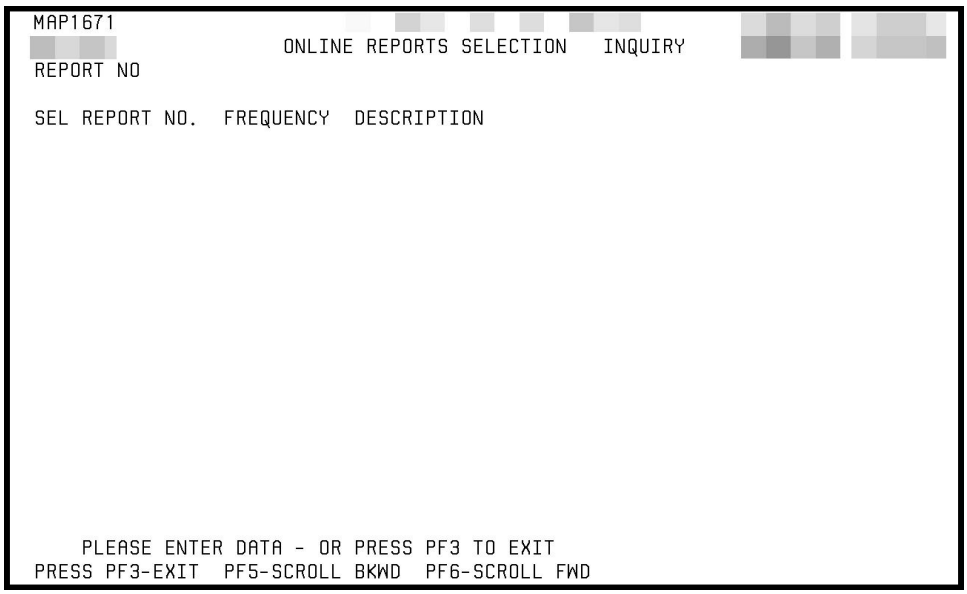
- 020 Return To Provider Summary – daily and monthly, lists RTP errors by type of bill. These claims are in status/location TB9997.
- 028 Provider Submission Reports – daily and monthly, summary of submitted claims by type of bill.
- 201 Pending, Processed, and Returned Claims – daily, weekly and monthly, lists claims that are pending, claims returned to the provider for correction and claims processed but not necessarily shown as paid on a remittance advice.
- 316 Detailed Provider Submission Report – daily and weekly, lists errors on initial bills by reason code and by type of bill.

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

## Online Reports Menu – MAP1705



## Online Reports Selection – MAP1671

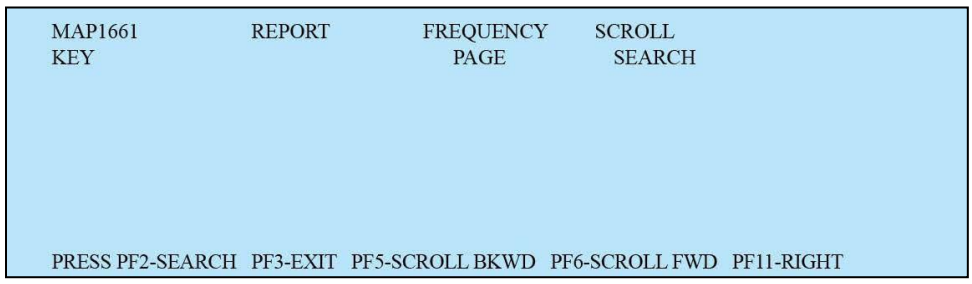



Press [ENTER] to call up a list of available reports. You may select a particular report by putting an "S" in the SEL field in front of the report and pressing [ENTER].

| FIELD | DESCRIPTION |
|---|---|
| SEL | Enter an 'S' in this field to select the report number. |
| REPORT NO | The number of the report. |
| FREQUENCY | The frequency of the report. The valid values are:<br>D = Daily<br>M = Monthly<br>W = Weekly |
| DESCRIPTION | The name or title of the report |

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

## Report View Inquiry – MAP1661




| FIELD | DESCRIPTION |
|---|---|
| REPORT NO | The number of the report. |
| FREQUENCY | The frequency the report is generated. |
| SCROLL | Used to scroll to the left or right sides of the report. |
| KEY | Provider number used for sorting the selected reports. |

| FIELD | DESCRIPTION |
|---|---|
| PAGE | The page number of the report being viewed. |
| SEARCH | This field searches for a specific field name or value. |

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

## Eligibility

1. How do I find out how much has been applied to the annual Part B therapy cap?
    a. Due to recent changes by CMS to improve data accuracy across systems, this information is best obtained through a HIPAA Eligibility Transaction System (HETS)-based tool such as the Noridian Medicare Portal (NMP) or the Interactive Voice Response (IVR) toll-free line. The amount, applied year-to-date, represents submitted claims; it cannot include charges for services provided but not yet billed.
2. How do I find out if a beneficiary is enrolled in a Medicare Advantage (MA) plan?
    a. This information is best obtained through a HETS-based tool such as the NMP or the IVR.
3. How do I find out if the beneficiary is enrolled in a Hospice or Home Health period that could cause my claim to reject?
    a. This information is best obtained through a HETS-based tool such as the NMP or the IVR.
4. How can I find out if a beneficiary is eligible for a preventive test that is subject to a frequency limit?
    a. Preventive services and the dates the beneficiary is eligible for coverage are best obtained through a HETS-based tool such as the NMP or the IVR.
5. How can I find out if the patient is eligible for a new benefit period or how many days are available in the current benefit period?
    a. This information is best obtained through a HETS-based tool such as the NMP or the IVR. Keep in mind that this information is based on filed claims and does not reflect days used in stays not yet filed. It is very important that you ask the patient about hospital and SNF admissions within the previous 60 days so you will be aware of stays that have not been reported yet.

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

## Claims

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

corrected properly or without adding requested information to the Remarks section. The claim cannot be corrected and will have to be submitted as a new claim. Before you do that, be sure to check the Remarks section of the inactivated claim to find out what information needs to be added.

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

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

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

## Adjustment/Cancel/RTP

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