Medicare Claims Processing Manual
Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

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(Rev. 10880, 08-06-21)

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70 - Uniform Bill - Form CMS-1450
(Rev. 2874, Issued: 02-06-14, Effective: 03-07-14, Implementation: 03-07-14)

70.1 - Uniform Billing with Form CMS-1450
(Rev. 2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

This form, also known as the UB-04, is a uniform institutional provider bill suitable for use in billing multiple third party payers. Because it serves many payers, a particular payer may not need some data elements. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form. Medicare Administrative Contractors servicing both Part A and Part B lines of business (A/B MACs (A) and (HHH)) responsible for receiving institutional claims also maintain lists of codes used by Medicare. All items on Form CMS-1450 are described. The A/B MAC (A) or (HHH) must be able to capture all NUBC-approved input data described in section 75 for audit trail purposes and be able to pass coordination of benefits data to other payers with whom it has a coordination of benefits agreement.

70.2 - Disposition of Copies of Completed Forms
(Rev. 2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

The provider retains the copy designated "Institution Copy" and submits the remaining copies of the completed Form CMS-1450 to its A/B MAC (A) or (HHH), managed care plan, or other insurer. Where it knows that a managed care plan will pay the bill, it sends the bill and any necessary supporting documentation directly to the managed care plan for coverage determination, payment, and/or denial action. It sends to the A/B MAC (A) or (HHH) bills that it knows will be paid and processed by the A/B MAC (A) or (HHH).

75 - General Instructions for Completion of Form CMS-1450 for Billing
(Rev. 2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

This section contains Medicare requirements for use of codes maintained by the NUBC that are needed in completion of the Form CMS-1450 and compliant Accredited Standards Committee (ASC) X12 837 institutional claims. **Note that the internal claim record used for processing is not being expanded.** Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted. The A/B MAC (A) or (HHH) does not need to search paper files to annotate missing data unless it does not have an electronic history record. It does not need to obtain data that is not needed to process the claim.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the Form CMS-1450, this simply means that the A/B MAC (A) or (HHH) accepts claims of up to 9 pages. The following layout describes the data specifications Form CMS-1450.

FORM CMS-1450 LAYOUT SUMMARY

FL	Description	Line	Type	Size	Buffer Space
FL01	[Billing Provider Name]	1	AN	25	
FL01	[Billing Provider Street Address]	2	AN	25	
FL01	[Billing Provider City, State, Zip]	3	AN	25	
FL01	[Billing Provider Telephone, Fax, Country Code]	4	AN	25	
FL02	[Billing Provider's Designated Pay-to Name]	1	AN	25	
FL02	[Billing Provider's Designated Pay-to Address]	2	AN	25	
FL02	[Billing Provider's Designated Pay-to City, State]	3	AN	25	
FL02	[Billing Provider's Designated Pay-to ID]	4	AN	25	
FL03a	Patient Control Number		AN	24	
FL03b	Medical/Health Record Number		AN	24	
FL04	Type of Bill	1	AN	4	1
FL05	Federal Tax Number	1	AN	4	
FL05	Federal Tax Number	2	AN	10	
FL06	Statement Covers Period - From/Through	1	N/N	6/6	1/1
FL07	Unlabeled	1	AN	7	
FL07	Unlabeled	2	AN	8	
FL08	Patient Name and Identifier (ID)	1a	AN	19	
FL08	Patient Name	2b	AN	29	
FL09	Patient Address - Street	1a	AN	40	1
FL09	Patient Address - City	2b	AN	30	2
FL09	Patient Address - State	2c	AN	2	1
FL09	Patient Address - ZIP	2d	AN	9	1
FL09	Patient Address - Country Code	2e	AN	3	
FL10	Patient Birthdate	1	N	8	1

FL	Description	Line	Type	Size	Buffer Space
FL11	Patient Sex	1	AN	1	2
FL12	Admission/Start of Care Date	1	N	6	
FL13	Admission Hour	1	AN	2	1
FL14	Priority (Type) of Admission or Visit	1	AN	1	2
FL15	Point of Origin for Admission or Visit	1	AN	1	2
FL16	Discharge Hour	1	AN	2	1
FL17	Patient Discharge Status	1	AN	2	1
FL18	Condition Code		AN	2	1
FL19	Condition Code		AN	2	1
FL20	Condition Code		AN	2	1
FL21	Condition Code		AN	2	1
FL22	Condition Code		AN	2	1
FL23	Condition Code		AN	2	1
FL24	Condition Code		AN	2	1
FL25	Condition Code		AN	2	1
FL26	Condition Code		AN	2	1
FL27	Condition Code		AN	2	1
FL28	Condition Code		AN	2	1
FL29	Accident State		AN	2	1
FL30	Unlabeled	1	AN	12	
FL30	Unlabeled	2	AN	13	
FL31	Occurrence Code/Date	a	AN/N	2/6	1/1
FL31	Occurrence Code/Date	b	AN/N	2/6	1/1
FL32	Occurrence Code/Date	a	AN/N	2/6	1/1
FL32	Occurrence Code/Date	b	AN/N	2/6	1/1
FL33	Occurrence Code/Date	a	AN/N	2/6	1/1
FL33	Occurrence Code/Date	b	AN/N	2/6	1/1

FL	Description	Line	Type	Size	Buffer Space
FL34	Occurrence Code/Date	a	AN/N	2/6	1/1
FL34	Occurrence Code/Date	b	AN/N	2/6	1/1
FL35	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	1/1/1
FL35	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	1/1/1
FL36	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6	1/1/1
FL36	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6	1/1/1
FL37	Unlabeled	a	AN	8	
FL37	Unlabeled	b	AN	8	
FL38	Responsible Party Name/Address	1	AN	40	2
FL38	Responsible Party Name/Address	2	AN	40	2
FL38	Responsible Party Name/Address	3	AN	40	2
FL38	Responsible Party Name/Address	4	AN	40	2
FL38	Responsible Party Name/Address	5	AN	40	2
FL39	Value Code	a	AN	2	1
FL39	Value Code Amount	a	N	9	1
FL39	Value Code	b	AN	2	1
FL39	Value Code Amount	b	N	9	1
FL39	Value Code	c	AN	2	1
FL39	Value Code Amount	c	N	9	1
FL39	Value Code	d	AN	2	1
FL39	Value Code Amount	d	N	9	1
FL40	Value Code	a	AN	2	1
FL40	Value Code Amount	a	N	9	1
FL40	Value Code	b	AN	2	1
FL40	Value Code Amount	b	N	9	1
FL40	Value Code	c	AN	2	1
FL40	Value Code Amount	c	N	9	1
FL40	Value Code	d	AN	2	1
FL40	Value Code Amount	d	N	9	1
FL41	Value Code	a	AN	2	1
FL41	Value Code Amount	a	N	9	1
FL41	Value Code	b	AN	2	1
FL41	Value Code Amount	b	N	9	1

FL	Description	Line	Type	Size	Buffer Space
FL41	Value Code	c	AN	2	1
FL41	Value Code Amount	c	N	9	1
FL41	Value Code	d	AN	2	1
FL41	Value Code Amount	d	N	9	1
FL42	Revenue Codes	1-23	N	4	
FL43	Revenue Code Description/IDE Number/Medicaid Drug rebate	1-23	AN	24	
FL44	HCPCS/Accommodation Rates/HIPPS Rate Codes	1-23	N	14	
FL45	Service Dates	1-23	N	6	
FL46	Service Units	1-23	N	7	
FL47	Total Charges	1-23	N	9	
FL48	Non-Covered Charges	1-23	N	9	
FL49	Unlabeled	1-23	AN	2	
FL50	Payer Identification - Primary	A	AN	23	
FL50	Payer Identification - Secondary	B	AN	23	
FL50	Payer Identification - Tertiary	C	AN	23	
FL51	Health Plan Identification Number	A	AN	15	
FL51	Health Plan Identification Number	B	AN	15	
FL51	Health Plan Identification Number	C	AN	15	
FL52	Release of Information - Primary	A	AN	1	1
FL52	Release of Information - Secondary	B	AN	1	1
FL52	Release of Information - Tertiary	C	AN	1	1
FL53	Assignment of Benefits - Primary	A	AN	1	1
FL53	Assignment of Benefits - Secondary	B	AN	1	1
FL53	Assignment of Benefits - Tertiary	C	AN	1	1
FL54	Prior Payments - Primary	A	N	10	1
FL54	Prior Payments - Secondary	B	N	10	1

FL	Description	Line	Type	Size	Buffer Space
FL54	Prior Payments - Tertiary	C	N	10	1
FL55	Estimated Amount Due - Primary	A	N	10	1
FL55	Estimated Amount Due - Secondary	B	N	10	1
FL55	Estimated Amount Due - Tertiary	C	N	10	1
FL56	National Provider Identifier (NPI) - Billing Provider	1	AN	15	
FL57	Other Provider ID	A	AN	15	
FL57	Other Provider ID	B	AN	15	
FL57	Other Provider ID	C	AN	15	
FL58	Insured’s Name - Primary	A	AN	25	1
FL58	Insured's Name - Secondary	B	AN	25	1
FL58	Insured's Name -Tertiary	C	AN	25	1
FL59	Patient’s Relationship - Primary	A	AN	2	1
FL59	Patient's Relationship - Secondary	B	AN	2	1
FL59	Patient's Relationship - Tertiary	C	AN	2	1
FL60	Insured's Unique ID - Primary	A	AN	20	
FL60	Insured's Unique ID - Secondary	B	AN	20	
FL60	Insured's Unique ID - Tertiary	C	AN	20	
FL61	Insurance Group Name - Primary	A	AN	14	1
FL61	Insurance Group Name - Secondary	B	AN	14	1
FL61	Insurance Group Name -Tertiary	C	AN	14	1
FL62	Insurance Group Number - Primary	A	AN	17	1
FL62	Insurance Group Number - Secondary	B	AN	17	1
FL62	Insurance Group Number - Tertiary	C	AN	17	1
FL63	Treatment Authorization Code - Primary	A	AN	30	1
FL63	Treatment Authorization Code - Secondary	B	AN	30	1
FL63	Treatment Authorization Code - Tertiary	C	AN	30	1
FL64	Document Control Number (DCN)	A	AN	26	
FL64	DCN	B	AN	26	
FL64	DCN	C	AN	26	

FL	Description	Line	Type	Size	Buffer Space
FL65	Employer Name (of the insured) - Primary	A	AN	25	
FL65	Employer Name (of the insured) - Secondary	B	AN	25	
FL65	Employer Name (of the insured) - Tertiary	C	AN	25	
FL66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)		AN	1	
FL67	Principal Diagnosis Code and Present on Admission (POA) Indicator		AN	8	
FL67A	Other Diagnosis and POA Indicator		AN	8	
FL67B	Other Diagnosis and POA Indicator		AN	8	
FL67C	Other Diagnosis and POA Indicator		AN	8	
FL67D	Other Diagnosis and POA Indicator		AN	8	
FL67E	Other Diagnosis and POA Indicator		AN	8	
FL67F	Other Diagnosis and POA Indicator		AN	8	
FL67G	Other Diagnosis and POA Indicator		AN	8	
FL67H	Other Diagnosis and POA Indicator		AN	8	
FL67I	Other Diagnosis and POA Indicator		AN	8	
FL67J	Other Diagnosis and POA Indicator		AN	8	
FL67K	Other Diagnosis and POA Indicator		AN	8	
FL67L	Other Diagnosis and POA Indicator		AN	8	
FL67M	Other Diagnosis and POA Indicator		AN	8	
FL67N	Other Diagnosis and POA Indicator		AN	8	
FL67O	Other Diagnosis and POA Indicator		AN	8	
FL67P	Other Diagnosis and POA Indicator		AN	8	
FL67Q	Other Diagnosis and POA Indicator		AN	8	
FL68	Unlabeled	1	AN	8	
FL68	Unlabeled	2	AN	9	
L69	Admitting Diagnosis Code		AN	7	
FL70a	Patient Reason for Visit Code		AN	7	
FL70b	Patient Reason for Visit Code		AN	7	
FL70c	Patient Reason for Visit Code		AN	7	

FL	Description	Line	Type	Size	Buffer Space
FL71	Prospective Payment System (PPS) Code		AN	3	2
FL72a	External Cause of Injury (ECI) Code and POA Indicator		AN	8	
FL72b	ECI Code and POA Indicator		AN	8	
FL72c	ECI Code and POA Indicator		AN	8	
FL73	Unlabeled		AN	9	
FL74	Principal Procedure Code/Date		N/N	7/6	1/1
FL74a	Other Procedure Code/Date		N/N	7/6	1/1
FL74b	Other Procedure Code/Date		N/N	7/6	1/1
FL74c	Other Procedure Code/Date		N/N	7/6	1/1
FL74d	Other Procedure Code/Date		N/N	7/6	1/1
FL74e	Other Procedure Code/Date		N/N	7/6	1/1
FL75	Unlabeled	1	AN	3	1
FL75	Unlabeled	2	AN	4	1
FL75	Unlabeled	3	AN	4	1
FL75	Unlabeled	4	AN	4	1
FL76	Attending Provider - IDs	1	AN	11/2/9	
FL76	Attending Provider - Last Name/First Name	2	AN	16/12	
FL77	Operating Physician - IDs	1	AN	11/2/9	
FL77	Operating Physician - Last Name/First Name	2	AN	16/12	
FL78	Other Provider - IDs	1	AN	2/11/2/9	
FL78	Other Provider - Last Name/First Name	2	AN	16/12	
FL79	Other Provider - IDs	1	AN	2/11/2/9	
FL79	Other Provider - Last/First	2	AN	16/12	
FL80	Remarks	1	AN	21	
FL80	Remarks	2	AN	26	
FL80	Remarks	3	AN	26	
FL80	Remarks	4	AN	26	

FL	Description	Line	Type	Size	Buffer Space
FL81	Code-Code - QUALIFIER/CODE/VALUE	a	AN/AN/ AN	2/10/12	
FL81	Code-Code - QUALIFIER/CODE/VALUE	b	AN/AN/ AN	2/10/12	
FL81	Code-Code - QUALIFIER/CODE/VALUE	c	AN/AN/ AN	2/10/12	
FL81	Code-Code - QUALIFIER/CODE/VALUE	d	AN/AN/ AN	2/10/12	

75.1 - Form Locators 1-15

(Rev. 3709, Issued: 02-03-17; Effective: 04-04-17; Implementation: 04-04-17)

Form Locator (FL) 1 - Billing Provider Name, Address, and Telephone Number

Required. The minimum entry is the provider name, city, State, and nine-digit ZIP Code. Phone and/or Fax numbers are desirable.

FL 2 - Billing Provider's Designated Pay-to Name, address, and Secondary Identification Fields

Not Required. If submitted, the data will be ignored.

FL 3a - Patient Control Number

Required. The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.

FL 3b - Medical/Health Record Number

Situational. The number assigned to the patient's medical/health record by the provider (not FL3a).

FL 4 - Type of Bill

Required. This four-digit alphanumeric code gives three specific pieces of information after a leading zero. CMS will ignore the leading zero. CMS will continue to process three specific pieces of information. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Code Structure

2nd Digit-Type of Facility (CMS will process this as the 1st digit)

3rd Digit-Bill Classification (Except Clinics and Special Facilities) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Clinics Only) (CMS will process this as the 2nd digit)

3rd Digit-Classification (Special Facilities Only) (CMS will process this as the 2nd digit)
4th Digit-Frequency - Definition (CMS will process this as the 3rd digit)

FL 5 - Federal Tax Number

Required. The format is NN-NNNNNNN.

FL 6 - Statement Covers Period (From-Through)

Required. The provider enters the beginning and ending dates of the period included on this bill in numeric fields (MMDDYY).

FL 7

Not Used.

FL 8 - Patient's Name and Identifier

Required. The provider enters the patient's last name, first name, and, if any, middle initial, along with patient identifier (if different than the subscriber/insured's identifier).

FL 9 - Patient's Address

Required. The provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP Code.

FL 10 - Patient's Birth Date

Required. The provider enters the month, day, and year of birth (MMDDCCYY) of patient. If full birth date is unknown, indicate zeros for all eight digits.

FL 11 - Patient's Sex

Required. The provider enters an "M" (male) or an "F" (female). The patient's sex is recorded at admission, outpatient service, or start of care.

FL 12 - Admission/Start of Care Date

Required For Inpatient and Home Health. The hospital enters the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.

FL 13 - Admission Hour

Not Required. If submitted, the data will be ignored.
FL 14 - Priority (Type) of Admission or Visit

Required.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

FL 15 - Point of Origin for Admission or Visit

Required except for Bill Type 014X. The provider enters the code indicating the source of the referral for this admission or visit.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

75.2 - Form Locators 16-30
(Rev. 1973, Issued: 05-21-10, Effective: 09-01-10, Implementation: 09-01-10)

FL 16 - Discharge Hour

Not Required.

FL 17 - Patient Discharge Status

Required. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's discharge status as of the "Through" date of the billing period (FL 6).

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

FLs 18 - 28 - Condition Codes

Situational. The provider enters the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

FL 29 - Accident State

Not used. Data entered will be ignored.

FL 30 - (Untitled)

Not used. Data entered will be ignored.

75.3 - Form Locators 31-41

(Rev. 2922, Issued: 04-03-14, Effective: 04-18-14, Implementation: 04-18-14)

FLs 31, 32, 33, and 34 - Occurrence Codes and Dates

Situational. Required when there is a condition code that applies to this claim.

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION
Due to the varied nature of Occurrence and Occurrence Span Codes, provisions have been made to allow the use of both type codes within each. The Occurrence Span Code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as 10 Occurrence Codes to be utilized. With respect to Occurrence Codes, complete field 31a - 34a (line level) before the "b" fields. Occurrence and Occurrence Span codes are mutually exclusive. An example of Occurrence Code use: A Medicare beneficiary was confined in hospital from January 1, 2005 to January 10, 2005, however, his Medicare Part A benefits were exhausted as of January 8, 2005, and he was not entitled to Part B benefits. Therefore, Form Locator 31 should contain code A3 and the date 010805.

The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alpha-numeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved. Occurrence and occurrence span codes are mutually exclusive. When FLs 36 A and B are fully used with occurrence span codes, FLs 34a and 34b and 35a and 35b may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field. Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

FLs 35 and 36 - Occurrence Span Code and Dates

Required For Inpatient.

The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

Special Billing Procedures When more than Ten Occurrence Span Codes (OSCs) Apply to a Single Stay

The Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) Prospective Payment Systems (PPSs) requires a single claim to be billed for an entire stay. Interim claims may be submitted to continually adjust all prior submitted claims for the stay until the beneficiary is discharged. In some instances, significantly long stays having numerous OSCs may exceed the amount of OSCs allowed to be billed on a claim.

When a provider paid under the LTCH, IPF or IRF PPSs encounters a situation in which ten or more OSCs are to be billed on the claim, the provider must bill for the entire stay up to the Through date of the 10th OSC for the stay (the Through date for the Statement Covers Period equals the Through date of the tenth OSC). As the stay continues, the provider must only bill the 11th through the 20th OSC for the stay, if applicable. Once the twentieth OSC is applied to the claim, the provider must only bill the 21st through the 30th OSC for the stay, if applicable. The Shared System Maintainers (SSMs) retain the history of all OSCs billed for the stay to ensure proper processing (i.e., as if no OSC limitation exists on the claim).

For a detailed billing example that outlines possible billing scenarios, please go to http://www.cms.hhs.gov/Transmittals/01_Overview.asp and refer to CR 6777 located on the 2010 Transmittals page.

FL 37 - (Untitled)

Not used. Data entered will be ignored.

FL 38 - Responsible Party Name and Address

Not Required. For claims that involve payers of higher priority than Medicare.

FLs 39, 40, and 41 - Value Codes and Amounts

Required. Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alpha-numeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

75.4 - Form Locator 42

(Rev. 1973, Issued: 05-21-10, Effective: 09-01-10, Implementation: 09-01-10)

FL 42 - Revenue Code

Required. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the "zero" level to the extent possible.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

75.5 - Form Locators 43-65

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and

the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

FL 43 - Revenue Description/IDE Number/Medicaid Drug Rebate

Not Required. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of durable medical equipment (DME) or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in Healthcare Common Procedure Coding System (HCPCS) coding.

When required to submit drug rebate data for Medicaid rebates, submit N4 followed by the 11-digit National Drug Code (NDC) in positions 01-13 (e.g., N499999999999). Report the NDC quantity qualifier followed by the quantity beginning in position 14. The Description Field on Form CMS-1450 is 24 characters in length. An example of the methodology is illustrated below.

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

FL 44 - HCPCS/Rates/HIPPS Rate Codes

Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.

HCPCS used for Medicare claims are available from Medicare contractors.

Health Insurance Prospective Payment System (HIPPS) Rate Codes

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a case mix group and assigns the correct RUG code. The AIs were developed by CMS.

The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Rate Codes used for Medicare claims are available from Medicare contractors. *As of October 1, 2019, SNF PDPM changes are effective (see §§120ff. in Chapter 6 of this manual).*

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HIPPS Modifiers/Assessment Type Indicators used for Medicare claims are available from Medicare contractors. *As of October 1, 2019, SNF PDPM changes are effective (see §§120ff. in Chapter 6 of this manual).*

HCPCS Modifiers (Level I and Level II)

Form CMS-1450 accommodates up to four modifiers, two characters each. See AMA publication CPT 20xx (xx= to current year) Current Procedural Terminology Appendix A - HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

HCPCS modifiers used for Medicare claims are available from Medicare contractors.

FL 45 - Service Date

Required Outpatient. CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line

item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 077X (effective April 1, 2010), 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.

FL 46 - Units of Service

Required. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.

The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.

FL 47 - Total Charges - Not Applicable for Electronic Billers

Required. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The A/B MAC (A or HHH) determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, the A/B MAC (A or HHH) adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component

must be billed to the *Part B MAC* to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.

FL 48 - Noncovered Charges

Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49 - (Untitled)

Not used. Data entered will be ignored.

Note: the "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A (Required), B (Situational), and C (Situational) - Payer Identification

If Medicare is the primary payer, the provider must enter "Medicare" on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID

Report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.

FLs 52A, B, and C - Release of Information Certification Indicator

Required. A "Y" code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An "I" code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

NOTE: The back of Form CMS-1450 contains a certification that all necessary release statements are on file.

FL 53A, B, and C - Assignment of Benefits Certification Indicator

Not used. Data entered will be ignored.

FLs 54A, B, and C - Prior Payments

Situational. Required when the indicated payer has paid an amount to the provider towards this bill.

FL 55A, B, and C - Estimated Amount Due From Patient

Not required.

FL 56 – Billing Provider National Provider ID (NPI)

Required on or after May 23, 2008.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)

Not used. Data entered will be ignored.

FLs 58A, B, and C - Insured's Name

Required. The name of the individual under whose name the insurance benefit is carried.

FL 59A, B, and C - Patient's Relationship to Insured

Required. If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

FLs 60A (Required), B (Situational), and C (Situational) – Insured's Unique ID (Certificate/Social Security Number/*Medicare beneficiary identifier)*

The unique number assigned by the health plan to the insured.

FL 61A, B, and C - Insurance Group Name

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a Worker's Compensation (WC) or an Employer Group Health Plan (EGHP) is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C - Insurance Group Number

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63 - Treatment Authorization Code

Situational. Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever Quality Improvement Organization (QIO) review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

FL 64 – Document Control Number (DCN)

Situational. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 - Employer Name (of the Insured)

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

75.6 - Form Locators 66-81

(Rev. 3435, Issued: 12-31-15, Effective: 07-01-15, Implementation: 03-31-16)

FL 66 – Diagnosis and Procedure code Qualifier (ICD Version Indicator)
Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision.

FL 67 - Principal Diagnosis Code

Required. The hospital enters the ICD code for the principal diagnosis. The code **must** be the full ICD diagnosis code, including all five digits where applicable for ICD-9 or all seven digits for ICD-10. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of "V" codes where ICD-9-CM is applicable. Where the proper code has fewer than five digits (ICD-9-CM) or seven digits (ICD-10-CM), the hospital may not fill with zeros. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a Diagnosis

Related Group (DRG) and cause the hospital to be incorrectly paid under PPS. The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported. If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis. When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations.

FLs 67A-67Q - Other Diagnosis Codes

Situational. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.

FL 68 – Reserved

Not used. Data entered will be ignored.

FL 69 - Admitting Diagnosis

Required. For inpatient hospital claims subject to QIO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL70A – 70C - Patient's Reason for Visit

Situational. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.

If the Patient's Reason for Visit is not required, it may be reported on other 013x and 085x bill types that fail to meet the criteria in a) or b) above at the sender's discretion when this information substantiates the medical necessity of services.

FL71 – Prospective Payment System (PPS) Code

Not used. Data entered will be ignored.

FL72 - External Cause of Injury (ECI) Codes

Not used. Data entered will be ignored.

FL 73 – Reserved

Not used. Data entered will be ignored.

FL 74 - Principal Procedure Code and Date

Situational. Required on inpatient claims when a procedure was performed. Not used on outpatient claims.

FL 74A – 74E - Other Procedure Codes and Dates

Situational. Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.

FL 75 – Reserved

Not used. Data entered will be ignored.

FL 76 - Attending Provider Name and Identifiers (including NPI)

Situational. Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter.

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FL 77 - Operating Provider Name and Identifiers (including NPI)

Situational. Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FLs 78 and 79 - Other Provider Name and Identifiers (including NPI)

Situational. The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim.

Provider Type Qualifier Codes/Definition/Situational Usage Notes:

DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send.

ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send.

82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send.

Secondary Identifier Qualifiers:

0B - State License Number

1G - Provider UPIN Number

G2 – Provider Commercial Number

FL 80 – Remarks

Situational. For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's A/B MAC (A or HHH) may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)

FL 81 - Code-Code Field

Situational. To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

80 – Reserved

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10880CP	08/06/2021	Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)	11/08/2021	12009
R4194CP	01/11/2019	Update to Publication (Pub.) 100-04 Chapter 25 to Provide Language-Only Changes for the New Medicare Card Project	02/12/2019	11091
R3709CP	02/03/2017	Internet Only Manual (IOM) Chapter 25 Revision	04/04/2017	9964
R3435CP	12/31/2015	Clarification on Patient's Reason for Visit Necessary to Capture HIPAA Compliant Fields	03/31/2016	9450
R2922CP	04/03/2014	Medicare Claims Processing Pub. 100-04 Chapter 25 Update	04/18/2014	8577
R2874CP	02/06/2014	Medicare Claims Processing Pub. 100-04 Chapter 25 Update – Rescinded and replaced by Transmittal 2922	03/07/2014	8577
R2683CP	04/05/2013	Non-systems Internet Only Manual (IOM) Changes	06/05/2013	8220
R2250CP	07/01/2011	Non-systems Internet Only Manual (IOM) Changes	08/01/2011	7437
R1973CP	05/21/2010	Internet Only Manual (IOM) Chapter 25 Revisions	09/01/2010	6907
R1946CP	04/15/2010	Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)	07/06/2010	6777
R1934CP	03/19/2010	Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs) – Rescinded and replaced by Transmittal 1946	07/06/2010	6777

Rev #	Issue Date	Subject	Impl Date	CR#
R1932CP	03/17/2010	Dialysis Adequacy, Infection and Vascular Access Reporting	07/06/2010	6782
R1929CP	03/09/2010	Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List	07/06/2010	6801
1917CP	02/05/2010	Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List - Rescinded and replaced by Transmittal 1929	07/06/2010	6801
R1915CP	02/05/2010	Non-systems Internet Only Manual Chapter 25 Changes	04/14/2010	6788
R1898CP	01/29/2010	Dialysis Adequacy, Infection and Vascular Access Reporting - Rescinded and replaced by Transmittal 1932	07/06/2010	6782
R1877CP	12/18/2009	Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict	04/05/2010	6638
R1839CP	10/28/2009	Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict - Rescinded and replaced by Transmittal 1877	04/05/2010	6638
R1775CP	07/24/2009	Point of Origin Codes Update to the UB-04 (CMS-1450) Manual Code List	01/04/2010	6478
R1767CP	07/10/2009	IOM Chapter 25 Revenue Code 076X Description Change	08/10/2009	6561
R1718CP	04/24/2009	New Patient Discharge Status Code 21 to Define Discharges or Transfers to Court/Law Enforcement	10/05/2009	6385
R1555CP	07/18/2008	Revision of the Requirements for Denial of Payment for New Admissions (DPNA) for Skilled Nursing Facility (SNF) Billing	01/05/2009	6116

Rev #	Issue Date	Subject	Impl Date	CR#
R1496CP	05/02/2008	Medicare Shared Systems Modifications Necessary to Capture and Crossover Medicaid Drug Rebate Data Submitted on form UB-04 Paper Claims and Direct Data Entry (DDE) Claims	10/06/2008	5950
R1395CP	12/14/2007	Updated National Uniform Billing Committee (NUBC) Codes and Other Internet Only Manual Chapter 25 Revisions	01/07/2008	5850
R1361CP	11/02/2007	New Patient Status Discharge Code 70 to Define Discharges or Transfers to Other Types of Health Care Institutions not Defined Elsewhere in the UB-04 (CMS-1450) Manual Code List	04/07/2008	5764
R1254CP	05/25/2007	National Uniform Billing Committee (NUBC) Update to Chapter 25	06/11/2007	5593
R1104CP	11/03/2006	Uniform Billing (UB-04) Implementation	03/01/2007	5072
R1078CP	10/13/2006	Updating the Medicare Secondary Payer (MSP) Manual for Consistency on Instructing Part A Contactors on Handling MSP Claims with Condition Code (cc) 08	04/02/2007	5266
R1018CP	07/28/2006	Uniform Billing (UB-04) Implementation	03/01/2007	5072
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R901CP	04/07/2006	New National Uniform Billing Committee (NUBC) Codes and Other Chapter 25 Revisions	05/08/2006	4384
R529CP	04/22/2005	Update to Current National Uniform Billing Committee (NUBC) Codes.	07/05/2005	3794

Rev #	Issue Date	Subject	Impl Date	CR#
R493CP	03/04/2005	Revision to Chapter 1 and Removal of Section 70 from Chapter 25 of the Medicare Claims Processing Manual	04/04/2005	3671
R368CP	11/12/2004	Instructions for Completion of Form CMS-1450	04/04/2005	3543
R311CP	10/08/2004	Relocation of Sections 20 and 30 to Chapter 24 Clarification of Noncovered Days, Patient Status Codes and Revenue Codes New Condition Codes and Value Codes	1/5/2005	3417
R303CP	09/24/2004	Relocation of Sections 20 and 30 to Chapter 24 Clarification of Noncovered Days, Patient Status Codes and Revenue Codes New Condition Codes and Value Codes	01/05/2005	3417
R199CP	06/10/2004	Rejection of Any Outpatient Claim Containing a Range of Dates in the Line Item Date of Service (LIDOS) Field	10/04/2004	3337
R167CP	4/30/2004	Replacement of Revenue Code 0910 by Revenue Code 0900 to Report Certain Psychiatric/ Psychological Treatment and Services. Addition of Provider Range 4900-4999 to the Applicable Provider Ranges for Community Mental Health Centers	10/04/2004	3194
R149CP	04/23/2004	Update for New Condition Code, and to Clarify Patient Status Codes and Revenue Code 0910	10/04/2004	3183
R107CP	02/24/2004	Changes in X12N937 Institutional Edits	07/06/2004	3031
R081CP	02/06/2004	New Condition and Value Codes Approved by the National Uniform Billing Committee	07/06/2004	3012

Rev #	Issue Date	Subject	Impl Date	CR#
		(NUBC) and Addition of All NUBC Approved Codes that Were Not Previously in Medicare Instructions, to Be Complaint With the HIPAA Requirements		
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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