Medicare Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 759 **Date: AUGUST 25, 2000**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
442.1 - 442.7	4-423 - 4-426 (4 pp.)	4-423 - 4-426 (4 pp.)
452 (Cont.) - 453	4-500.1 - 4-500.2 (2 pp.)	4-500.1 - 4-500.2 (2 pp.)
460 - 460 (Cont.)	4-501 - 4-502 (2 pp.)	4-501 - 4-502 (2 pp.)
460 (Cont.) - 460 (Cont.)	4-552.5 - 4-552.6 (2 pp.)	4-552.5 - 4-552.6 (2 pp.)

REFER TO CHANGE REQUEST 1265

NEW/REVISED MATERIAL--EFFECTIVE DATE: June 05, 2000

Section 442.6, Reporting Hospital Outpatient Services Using HCFA Common Procedure Coding System (HCPCS), changes the effective date of editing for line item dates of service.

Section 452, Billing for Hospital Outpatient Partial Hospitalization Services, changes the effective date of editing for line item dates of service.

Section 460, Completion of Form HCFA-1450 for Inpatient and/or Outpatient Billing, changes the date of line item expansion and line item date of service reporting.

NEW/REVISED MATERIAL--EFFECTIVE DATE: September 25, 2000

Section 442.2, Addition, Deletion and Change of Local Codes, revised to reflect that request for local codes will not be accepted for services paid under the hospital outpatient prospective payment system.

Section 442.6, Reporting Hospital Outpatient Services Using HCFA Common Procedures Coding System (HCPCS), is revised as follows:

- Removes the requirement that CAHs have to HCPCS code for all services they provide;
- Removes the requirement that indian health service hospitals and hospitals located in American Samoa, Guam and Saipan are not subject to line item date of service reporting;
- Expands the list of references for reporting of HCPCS and modifiers.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

442. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS is based upon the American Medical Association's (AMA) Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). It includes three levels of codes and modifiers. HCFA monitors the system to ensure uniformity. Level I contains only the AMA's CPT-4 codes. This level consists of all numeric codes. The second level contains the codes for physician and nonphysician services which are not included in CPT-4, e.g., ambulance, DME, orthotics and prosthetics. These are alpha-numeric codes maintained jointly by HCFA, the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). Level III (local assignment) contains the codes for services needed by individual contractors or State agencies to process Medicare and Medicaid claims. They are used for services which are not contained in either other level. The local codes are also alpha-numeric, but are restricted to the series beginning with W, X, Y, and Z.

There are certain HCPCS codes that are not used by Medicare. If you report them on a claim with other services which are covered, your intermediary will deny the line item as non-covered. They will attach the appropriate ANSI code for the denial to their RA and to the crossover record sent to any subsequent payer. Do not RTP the claim unless you have failed to also include parallel codes. If so, they will notify you to submit the correct codes to Medicare in order to obtain payment. Usually, the codes not used by Medicare are Level I codes and Medicare makes payment using Level II codes instead.

Level I (CPT-4) codes/modifiers can be purchased in hardcopy form or a tape/cartridge from:

American Medical Association
P.O. Box 7046
Dover, DE 19903-7046

Telephone 1-800-621-8335

Level II (non-CPT-4) codes/modifiers can be purchased in hardcopy form from:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Telephone (202) 512-1800
Fax: (202) 512-2250

Level II codes/modifiers are also available on computer tape from the National Technical Information Services (NTIS). Their address is:

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161

Sales Desk: (703) 487-4650, Subscriptions: (703) 487-4630, TDD (hearing impaired only):(703) 487-4639, RUSH Service (available for an additional fee): 1-800-553-NTIS, Fax: (703) 321-8547, and E-Mail: orders@ntis.fedworld.gov

442.1 Use and Maintenance of CPT-4 in HCPCS.--The text contains over seven thousand service codes, plus titles and modifiers. The AMA entered into an agreement with HCFA which states:

o The AMA permits HCFA, its agents, and other entities participating in programs administered by HCFA, and the health care field in general, to use CPT-4 codes and terminology in
HCPCS;

o HCFA shall adopt and use CPT-4 in connection with HCPCS for reporting services under Medicare and Medicaid;

o HCFA agrees to include a statement in HCPCS that participants are authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in HCFA programs and that permission for any other use must be obtained from the AMA;

o HCPCS shall be prepared in format(s) approved in writing by the AMA which include(s) appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA. You may publish, edit, and abridge CPT-4 terminology for Medicare use within your own hospital. You are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of your hospital. This would violate copyright laws. You may print the codes and approved narrative descriptions for internal processing purposes in billing or in development requests relating to individual Medicare or Medicaid claims;

o Both AMA and HCFA will encourage health insurance organizations to adopt CPT-4 for the reporting of services to achieve the widest possible acceptance of the system and the uniformity of services reporting consistent therewith;

o The AMA recognizes that HCFA and other users of CPT-4 may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, HCFA and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are used within their operations; and

o The AMA Editorial Panel has the sole responsibility to revise, update, or modify CPT-4 codes.

The AMA updates and republishes CPT-4 annually and provides HCFA with the updated data. HCFA updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS file. The file is duplicated and distributed to Medicare contractors and State agencies. Your intermediary furnishes you with Level II of the codes as appropriate, or you may purchase them.

442.2 Addition, Deletion, and Change of Local Codes.--Under the hospital outpatient prospective payment system, payment is made based on HCPCS coding. As a result, requests for local codes are not accepted by your intermediary for services paid under this system since there is no mechanism for pricing local codes. For any procedure not covered under the hospital outpatient prospective payment system, furnish your intermediary with the procedure's full description, projected volume, and charge. Your intermediary assigns a local code and coordinates its use.

442.3 Use and Acceptance of HCPCS.--Use the CPT-4 portion of HCPCS for ambulatory surgical procedures and clinical diagnostic lab services. Use HCPCS codes for coding DME when you bill electronically.

HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. HCFA provides a file containing the updated HCPCS codes to contractors and Medicaid State agencies 90 days in advance of the implementation of the annual update.

442.5 HCPCS Training.--Your intermediary is responsible for training you in the use of HCPCS for Medicare billing. Bring any problems to its attention.

442.6 Reporting Hospital Outpatient Services Using HCFA Common Procedure Coding System (HCPCS).--

A. General.--Section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 requires hospitals to report claims for outpatient services using HCPCS coding. HCPCS includes CPT-4 codes. In preparation of implementation of a hospital outpatient prospective payment system, hospitals are required to report services utilizing HCPCS coding in order to assure proper payment. This applies to acute care hospitals including those paid under alternative payment systems, e.g., Maryland, long-term care hospitals, rehabilitation hospitals, psychiatric hospitals, hospital-based RHCs, and hospital-based FQHCs. These instructions also apply to all-inclusive rate hospitals. If you have your intermediary's approval to combine bill the professional component charges, do not report HCPCS for the professional service revenue code, but report HCPCS for hospital services. Hospital-based ESRD facilities must also use HCPCS to bill for blood and blood products, and to bill for drugs and clinical diagnostic laboratory services paid outside the composite rate. In addition, you are required to report HCPCS and modifiers as described in §433.

CAHs are required to report HCPCS only for services not paid on a reasonable cost basis, e.g., screening mammographies and bone mass measurements.

HCPCS codes are required for surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take home surgical dressings, therapies, preventative services, immunosuppressive drugs, drugs identified in §422, and the other services described in §442.7.

Claims that do not contain a HCPCS code for each service reported where HCPCS coding is required will be returned to you.

B. Line Item Dates of Service.--With the exception of CAHs, indian health service hospitals, and hospitals located in American Samoa, Guam and Saipan, report line item dates of service (FL 45 on Form HCFA-1450) for every line where a HCPCS code is required for services paid under the hospital outpatient prospective payment system (OPPS) on all outpatient bills. This includes bills where the from and through dates are equal.

Effective June 05, 2000, your intemrediary will RTP claims where a line item date of service is not entered for each HCPCS code reported for services paid under OPPS or if the line item dates of service reported are outside of the statement-covers period.

C. Reporting of Service Units.--The definition of service units (FL 46 on the Form HCFA-1450) is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the number of times the service or procedure being reported was performed. You are required to make a numerical entry in FL 46.

EXAMPLES: If the following codes are performed once on a specific date of service, the entry in the service units field is as follows:

90849	Multiple-family group psychotherapy	units = 1
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report	units = 1
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests	units = no. of tests performed

95861	Needle electromyography two extremities with or without related paraspinal areas	units = 1
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes, etc.	1 unit 8 minutes to < 23 minutes 2 units 23 minutes to < 38 minutes 3 units 38 minutes to < 53 minutes 4 units 53 minutes to < 68 minutes 5 units 68 minutes to < 83 minutes 6 units 83 minutes to < 98 minutes 7 units 98 minutes to < 113 minutes 8 units 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. You should not bill for services performed for < 8 minutes. The expectation (based on the work values for these codes) is that a provider s time for each unit will average 15 minutes in length. If you have a practice of billing less than 15 minutes for a unit, these situations will be highlighted by your intermediary for review.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes time.

The beginning and ending time of the treatment should be recorded in the patient s medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded instead.) If more than one CPT code is billed during a calender day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of 97112 and 23 minutes of 97110 was furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took more time.

Your intermediary will RTP claims that do not contain service units for a given HCPCS code.

442.7 HCPCS Codes for Diagnostic Services and Medical Services.--The following instructions apply to reporting medical and additional diagnostic services other than radiology. They also include some diagnostic services subject to payment limitations. (See §443.) These reporting requirements apply to hospital services provided in clinics, emergency departments, and other outpatient departments. (See §437 for procedures for reporting laboratory services, §443 for reporting radiology, and §441 for reporting DME and prosthetics and orthotics.) In most cases, CPT-4 codes are used to code hospital services. However, for some categories of services, the use of CPT-4 codes would be so problematic that special HCPCS codes have been assigned. Use them in lieu of the CPT-4 codes.

CPT-4 codes are used by physicians to report physician services, and do not necessarily reflect the technical component of a service furnished by the hospital. Therefore, ignore any wording in the CPT-4 codes that indicates that the service must be performed by a physician. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, use the code that represents the technical component. If there is no technical component code for the service, use the code that represents the complete procedure.

The following codes are required when the services you identify are provided. The codes are in the same order as they appear in CPT-4. Where CPT-4 codes are not appropriate, show the required HCPCS codes.

Visit - Do not report code 99201 if the sole reason for the visit was to undergo a laboratory, radiology, or diagnostic test, a surgical or medical procedure, or to receive psychiatric services, chemotherapy, physical therapy,occupational therapy, speech-language pathology, or cardiac

C. Reporting of Service Units.--Visits should no longer be reported as units. Instead, you are required to report in FL 46, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for the following partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100 which is defined in one hour intervals) for a total of 3 hours during one day. The provider reports revenue code 918 in FL 42, HCPCS code 96100 in FL 44, and three units in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any time frame (either minutes, hours or days), do not bill for sessions of less than 45 minutes.

Your intermediary will RTP claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172, or that do not contain service units for a given HCPCS code.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

D. Line Item Date of Service Reporting.--You are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 Service Date (MMDDYY). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	915	90849	19980505	1	$ 80.00
61	915	90849	19980529	2	$160.00

For the hard copy UB-92 (HCFA Form-1450), report as follows:

FL 42	FL44	FL45	FL46	FL47
915	90849	05-05-98	1	$ 80.00
915	90849	05-29-98	2	$160.00

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report as follows:

LX*1~
SV2*915*HC:90849*80*UN*1~
DTP*472*D8*19990505~
LX*2~
SV2*915*HC:90849*160*UN*2~
DTP*472*D8*19990529~

Your intermediary will RTP claims if a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported fall outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 05, 2000.

E. Payment.--Your intermediary makes payment to you on a reasonable cost basis until August 1, 2000 for partial hospitalization services. The Part B deductible and coinsurance apply.

During the year, your intermediary will make payment at an interim rate based on a percentage of your billed charges. At the end of the year, you will be paid the reasonable costs incurred in furnishing partial hospitalization services, based upon the Medicare cost report you file with your intermediary. Information applicable to determining interim rates for partial hospitalization services furnished as hospital outpatient services are contained in §2400ff. of the Provider Reimbursement Manual. Beginning with services provided on or after August 1, 2000, payment is made under the hospital outpatient prospective payment system for partial hospitalization services. You must continue to maintain documentation to support medical necessity of each service provided, including beginning and ending time.

453. BILLING FOR HOSPITAL OUTPATIENT SERVICES FURNISHED BY CLINICAL SOCIAL WORKERS (CSWs)

Payment may be made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting.

A. Fee Schedule to be Used for Payment of CSW Services.--The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists

B. Payment Limitation.--CSW services are subject to the outpatient mental health services limitation in §1833(c) of the Act. Carriers apply the limitation of 62.5 percent to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation.

C. Coinsurance and Deductible.--The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

D. Billing.--

1. Hospital Outpatient Services--CSWs do not bill directly for these services. Hospital outpatient services are bundled and you bill the carrier for the services on Form HCFA-1500. These services are not billed to your intermediary.

2. Partial Hospitalization Services--CSW services furnished under the partial hospitalization program are also bundled. However, bill your intermediary for these services. Payment is made on a reasonable cost basis.

(See §452 for an explanation.)

454. MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA)

A. Background.--The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the FDA to continue to operate. On September 30, 1994, HCFA stopped conducting surveys of screening mammography facilities. The responsibility for collecting certificate fees and surveying mammography facilities (screening and diagnostic) was transferred to the FDA, Center for Devices and Radiological Health.

B. General.--Your intermediary will pay diagnostic and screening mammography services for claims submitted by you only if you have been issued an MQSA certificate by FDA. Your intermediary is responsible for determining that you have a certificate prior to payment. In addition, it is responsible for ensuring that payment is not made in situations where your certificate has expired, or it has been suspended or revoked or you have been issued a written notification by the FDA stating that you must cease conducting mammography examinations because you are not in compliance with certain critical FDA certification requirements.

Uniform Billing

460. COMPLETION OF FORM HCFA-1450 FOR INPATIENT AND/OR OUTPATIENT BILLING

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on Form HCFA-1450 are described, but detailed information is given only for items required for Medicare claims.

This section details only the data elements which are required for Medicare billing. When billing multiple third parties, complete all items required by each payer who is to receive a copy.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

Effective June 05, 2000, HCFA extends the claim size to 450 lines. For the hard copy UB-92 or HCFA-1450, this simply means that your intermediary will accept claims of up to 9 pages. For the electronic format, the new requirements are described in Addendum A.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is your name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

FL 2. (Untitled)
Not Required. This is one of four State use fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit-Type of Facility
1 - Hospital
4 - Religious Non-Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit-Bill Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).

4 - Other - Part B - (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to nonpatients, and referenced diagnostic services).
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9 - Reserved for National Assignment

2nd Digit-Classification (Clinics Only)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free Standing
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center
7-8 Reserved for National Assignment
9 - OTHER

2nd Digit-Classification (Special Facilities Only)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6-8 Reserved for National Assignment
9 - OTHER

3rd Digit-Frequency	Definition
A - Hospice Admission Notice	Use when the hospice is submitting Form HCFA-1450 as an Admission Notice.
B - Hospice Termination/Revocation Notice	Use when the hospice is submitting Form HCFA-1450 as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	Use when Form HCFA-1450 is used as a Notice of Change to the hospice provider.
D - Hospice Election Void/Cancel	Use when Form HCFA-1450 is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	Use when Form HCFA-1450 is used as a Notice of Change in Ownership for the hospice.
F - Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For intermediary use only.
G - CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For intermediary use only.
H - HCFA Initiated Adjustment Claim	Used to identify adjustments initiated by HCFA. For intermediary use only.
I - Intermediary Adjustment Claim (Other Than Pro or Provider)	Used to identify adjustments initiated by the intermediary. For intermediary use only.

98X Professional Fees (Cont.)

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 -Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

FL 43. Revenue Description
Not Required. Enter 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 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also see FL 84, Remarks.)

FL 44. HCPCS/Rates
Required. When coding HCPCS for outpatient services, (i.e., outpatient surgery bills, clinical diagnostic laboratory bills for outpatients or nonpatients, radiology, other diagnostic services, orthotic/prosthetic devices, take home surgical dressings, therapies (identified in AB-98-63), preventative services, drugs identified in §443.C.3, and other services described in §442.7 and §442.8), enter the HCPCS code describing the procedure in the space to the right of the dotted line.

On inpatient hospital bills the accommodation rate is shown here.

FL 45. Service Date
Required. With the exception of CAHs, indian health service hospitals, Maryland hospitals, and hospitals located in American Samoa, Guam and Saipan, you are required to report line item dates of service for every line where a HCPCS code is required for services paid under OPPS effective June 05, 2000 including claims where the from and thru dates are equal.

FL 46. Units of Service
Required. Enter the number of digits or units of service on the line adjacent to revenue code and description where appropriate, e.g., number of covered days in a particular type of accommodation, pints of blood. When HCPCS codes are required for hospital outpatient services, the units are equal to the number of times the procedure/service being reported was performed. (See §442.6.) Provide the number of covered days, visits, treatments, tests, etc., as applicable for the following:

Accommodation days - 100s, 150s, 200s, 210s (days)
Blood pints - 380s (pints)
DME - 290s (rental months)
Emergency room - 450, 452, and 459 (HCPCS code definition for visit or procedure)
Clinic - 510s and 520s (HCPCS code definition for visit or procedure)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (Units are equal to the number of times the procedure/service being reported was performed.)
Outpatient clinical diagnostic laboratory tests - 30X-31X (tests)
Radiology - 32x, 34x, 35x, 40x, 61x, and 333 (HCPCS code definition of tests or services)
Oxygen - 600s (rental months, feet, or pounds)
Hemophilia blood clotting factors - 636

Enter up to seven numeric digits. Show charges for noncovered services as noncovered.

FL 47. Total Charges
Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 "0001" which represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA 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, adjust your provider statistical and reimbursement (PS&R) reports that you derive from the bill.