INQUIRY MENU

DIRECT DATA ENTRY (DDE) MANUAL

CHAPTER 3

CGS®
A CELERIAN GROUP COMPANY

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Inquiry Menu Options

The Inquiries option (FISS Main Menu option 01) allows you to:

- Check the status of submitted billing transactions
- Locate claims in an ADR (Additional Development Request) status
- View a summary of all claims currently being processed in the system
- Verify revenue codes, diagnosis codes, HCPCS codes, adjustment reason codes, reason codes, and ANSI (American National Standards Institute) codes
- View the amount and payment date of the last three checks issued to your facility

Access the Inquiry Menu

1. From the FISS Main Menu (Map 1701), type 01 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1701                    CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/
YY
XXXXXX                          MAIN MENU                   C20112WS HH:MM:SS

                        01    INQUIRIES

                        02    CLAIMS/ATTACHMENTS

                        03    CLAIMS CORRECTION

                        04    ONLINE REPORTS


  ENTER MENU SELECTION: 01

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

2. The Inquiry Menu (Map 1702) appears:

```
MAP1702               CGS J15 MAC -  Part A REGION     ACPFA052 MM/DD/YY
  XXXXXX                    INQUIRY MENU                C20112WS HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE            19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY   1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY      56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS  67

      HCPC CODES               14    ANSI REASON CODES        68

      DX/PROC CODES ICD-9      15    CHECK HISTORY            FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10     1B

      REASON CODES             17    CMHC PAYMENT TOTALS      1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER  1D

                                     NEW HCPC SCREEN          1E

  ENTER MENU SELECTION:

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

Enter the two-characters for the inquiry option you want to access and press Enter. All of the options are described in this chapter.

- All of the options are represented by two numerals, except for OSC Repository Inquiry (1A),

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Check History (FI), DX/PROC Codes ICD-10 (1B), and CMHC Payment Totals (1C).

- All FISS direct data entry (DDE) screens display two lines of information in the top right corner that identifies the region (ACPFA052), the current date, release number (e.g., C20112WS) and the time of day. This information is for internal purposes only and is used to assist CGS staff in researching issues when screen prints are provided.

Beneficiary/CWF (Option 10)

This option is helpful **only** if you need to view the beneficiary's address. The beneficiary's address is not available on the CWF (Common Working File) eligibility screens, ELGA and ELGH, but is available by using this option.

1. From the Inquiry Menu, type 10 in the **Enter Menu Selection** field and press Enter.

```
MAP1702         CGS J15 MAC - Part A REGION    ACPFA052 MM/DD/YY
 XXXXXX          INQUIRY MENU              C20112WS HH:MM:SS


     BENEFICIARY/CWF           10    ZIP CODE FILE             19

     DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY    1A

     CLAIM SUMMARY             12    CLAIM COUNT SUMMARY       56

     REVENUE CODES             13    HOME HEALTH PYMT TOTALS   67

     HCPC CODES                14    ANSI REASON CODES         68

     DX/PROC CODES ICD-9       15    CHECK HISTORY             FI

     ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10      1B

     REASON CODES              17    CMHC PAYMENT TOTALS       1C

     INVOICE NO/DCN TRANS      88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 10

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

- Although, this option includes several screen pages with eligibility information, only screen examples and field descriptions for the first screen page are explained below. **The remaining screen pages should not be used to verify Medicare eligibility because it may not be as current as the CWF information that you access via ELGA.** For information about accessing ELGA, refer to Chapter 2 of this guide.
- You may also access this screen by typing ***10*** in the **SC** field if you are in an inquiry or claim entry screen.

2. The Eligibility Detail Inquiry screen (Map 1751) appears:

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```
MAP1751                    CGS J15 MAC - Part A REGION            ACPFA052 MM/DD/YY
XXXXXX   SC                  ELIGIBILITY DETAIL INQUIRY           C20112WS HH:MM:SS

 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, AND DOB.
           PRESS PF3-EXIT   PF8-NEXT PAGE
```

3. As indicated at the bottom of the Map 1751, you must have the following five pieces of information about the beneficiary to access information:

   Medicare Beneficiary Identifier (MBI) (e.g., Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI))
   Last Name
   First Name
   Gender
   Date of Birth (MMDDCCYY format)

   You can use the following function keys to move around the screens:

   F3 – Exit (return to the Inquiry Menu)
   F7 – Move one page back
   F8 – Move one page forward

4. Start by entering the beneficiary's Medicare ID number as it appears on their Medicare card in the **MID** field.
5. Tab to the **LN** field. Type the beneficiary's last name as it appears on their Medicare card.
6. Tab to the **FN** field. Type the beneficiary's first name as it appears on their Medicare card.
7. Tab to the **SEX** field. Type the gender of the beneficiary. M = male; F = female
8. The cursor will automatically move to the **DOB** field. Type the beneficiary's date of birth (MMDDCCYY) and press ***Enter***.
9. The following example shows how the screen would look after entering the five identifying pieces of information, but before pressing ***Enter***.

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```
MAP1751                    CGS J15 MAC - Part A REGION            ACPFA052 MM/DD/YY
XXXXXX   SC                  ELIGIBILITY DETAIL INQUIRY           C20112WS HH:MM:SS

 MID XXXXXXXXXXX      CURR XREF HIC                PREV XREF HIC
 TRANSFER HIC                    C-IND      LTR DAYS
 LN LAST                  FN FIRST              MI    SEX  M
 DOB 01011931  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, AND DOB.
           PRESS PF3-EXIT   PF8-NEXT PAGE
```

9. After you press ***Enter***, the system will search for the beneficiary's eligibility file. If a match is found, additional information will display on Map 1751. If no match is found, verify that you have entered the correct information, make any necessary corrections, and press ***Enter*** again.
   - Information will only display if CGS has processed a claim for the beneficiary. If no match is found, a claim for the beneficiary has not been submitted/processed in FISS by CGS.
   - Do not use this option to verify Medicare eligibility because it may not be as current as the CWF (Common Working File) information that you access via ELGA or myCGS. Use option 10 only if you need information about the beneficiary's address Chapter 2 of this guide for information about accessing beneficiary eligibility information.
10. Once a match is found with the beneficiary information entered, the beneficiary's home address will appear in the ADDRESS and ZIP fields.
11. Press ***F8*** to access additional eligibility screens. Screen descriptions follow.
12. Press ***F3*** to exit and return to the Inquiry Menu.

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Field Descriptions for Option 10 - Beneficiary/CWF Screen

Map 1751 (Page 1) Screen Example

```
MAP1751                    CGS J15 MAC - Part A REGION            ACPFA052 MM/DD/YY
XXXXXX   SC                  ELIGIBILITY DETAIL INQUIRY           C20112WS HH:MM:SS

 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, AND DOB.
           PRESS PF3-EXIT  PF8-NEXT PAGE
```

Map 1751 Field Descriptions	
MID	The beneficiary's Medicare number.
LN	Last name of the beneficiary.
FN	First name of the beneficiary.
MI	Middle initial of the beneficiary.
SEX	Sex of the beneficiary. **F** Female **M** Male
DOB	Date of birth of the beneficiary (MMDDCCYY format).
ELIG FROM	Eligibility from date (MMDDCCYY format). Only required when the Medicare number is inactive.
ELIG THRU	Eligibility through date (MMDDCCYY format). Only required when the Medicare number is inactive.
DOD	Date of death of the beneficiary (MMDDCCYY format).
ADDRESS (1-6)	Beneficiary's street address, city and state.
ZIP	Zip code for beneficiary's residence.

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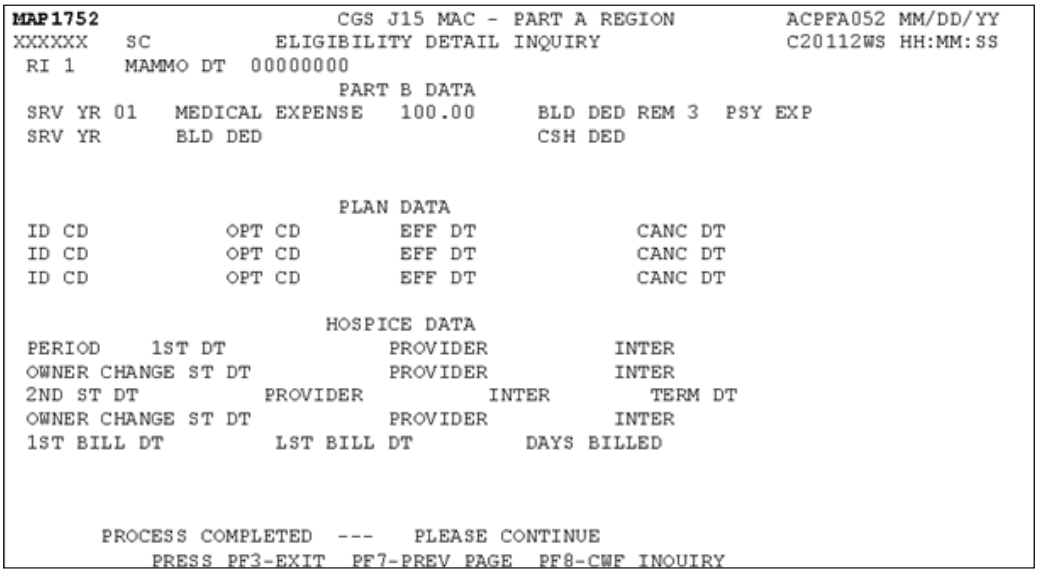
Map 1752 Screen Example



```
MAP1752                    CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC           ELIGIBILITY DETAIL INQUIRY                C20112WS HH:MM:SS
 RI 1    MAMMO DT  00000000
                           PART B DATA
 SRV YR 01   MEDICAL EXPENSE   100.00     BLD DED REM 3   PSY EXP
 SRV YR      BLD DED                     CSH DED


                           PLAN DATA
 ID CD           OPT CD        EFF DT             CANC DT
 ID CD           OPT CD        EFF DT             CANC DT
 ID CD           OPT CD        EFF DT             CANC DT

                          HOSPICE DATA
 PERIOD    1ST DT             PROVIDER          INTER
 OWNER CHANGE ST DT           PROVIDER          INTER
 2ND ST DT          PROVIDER          INTER        TERM DT
 OWNER CHANGE ST DT           PROVIDER          INTER
 1ST BILL DT         LST BILL DT         DAYS BILLED



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

Map 1752 Field Descriptions	
RI	This identifies the CWF inquiry type
MAMMO DT	The date of the last mammogram
SRV YR	The calendar year for current Medicare Part B services that are associated with the cash deductible amount entered in the Medical Expense field and Blood Deductible field.
MEDICAL EXPENSE	The amount of cash deductible that has been satisfied by the beneficiary for the specific service year.
BLD DED REM	The number of blood pints deductible remaining to be met for Part B services, for the specific service year.
PSY EXP	The dollar amount associated with psychiatric services
SRV YR	The calendar year for current Medicare Part B services
BLD DED	Not used.
CSH DED	Not used.
ID CD	The Plan Identification Code for a beneficiary who is enrolled in a Medicare Advantage (MA) Plan. The structure of the code is: Position 1 H Position 2 & 3 State Code Positional 4 & 5 Plan number within state
OPT CD	The current Plan services are restricted or unrestricted. The valid values are: **Unrestricted** 1 – Medicare contractor to process all Part A and B provider claims 2 – Plan to process claims for directly provided service and for services from providers with effective arrangements. **Restricted** A – Medicare contractor to process all Part A and B provider claims B – Plan to process claims only for directly provided services C – Plan to process all claims
EFF DT	Effective date of the Plan benefits.
CANC DT	Termination date of the Plan benefits.
HOSPICE DATA	
PERIOD	Specific hospice election period. Valid values are: 1 – The first time a beneficiary uses Hospice benefits 2 – The second time a beneficiary uses Hospice benefits.

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Map 1752 Field Descriptions	
1ST DT	First hospice start date.
PROVIDER	The hospice's six-digit Medicare provider number
INTER	The Medicare contactor number for the hospice provider
OWNER CHANGE ST DT	Displays the start date of a change of ownership within the period for the first provider.
PROVIDER	The Medicare hospice provider
INTER	The Medicare contactor number for the hospice provider
2ND ST DATE	The start date for of the 2nd period with the hospice provider
PROVIDER	The hospice's six-digit Medicare provider number
INTER	The Medicare contactor number for the hospice provider
TERM DT	The termination date for hospice services for this hospice provider
OWNER CHANE ST DT	The start date of a change of ownership within the period for the second provider.
PROVIDER	The Medicare hospice provider
INTER	The Medicare contactor number for the hospice provider
1ST BILL DT	The date of the first billing
LST BILL DT	The date of the last billing
DAYS BILLED	The number of hospice days billed to date

Map 1753 Screen Example

```
MAP1753              CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                   NOT IN FILE                 C20112WS HH:MM:SS

 CLAIM                 NAME                 DOB          SEX     INTER

 APP DT          REASON CD    DATE/TIME                      REQ ID
 DISP CD        TYPE
                          ERROR MESSAGE:
                          ERROR MESSAGE:
```

Map 1753 Field Descriptions	
CLAIM	Identifies the beneficiary's Medicare ID number
NAME	The name of the beneficiary
DOB	The date of birth of the beneficiary
SEX	The sex of the beneficiary (F – female; M – male)
INTER	The intermediary number for the provider
APP DT	Applicable Date – used for spell determination, i.e., admission date, and current date.
REASON CD	The reason for the inquiry. Valid values: 1 – Status inquiry 2 – Inquiry related to an admission
DATE/TIME	The date and time stamp
REQ ID	Identifies the individual who submitted the inquiry.
DISP CD	The code assigned when the request is processed through the CWF host site. Valid values: 01 – Part A inquiry approved; beneficiary have never used Part A services 02 – Part A inquiry approved; beneficiary has had some prior utilization 03 – Part A inquiry rejected 04 – Qualified approval; may require further investigation 05 – Qualified approval; according to CMSs records, this inquiry begins a new benefit period.
TYPE	Identifies the type of CWF reply. (3 – accepted)
ERROR MESSAGE	Identifies the error message.

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Map 1754 Screen Example

```
MAP1754          CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                 NOT IN FILE               C20112WS HH:MM:SS

 CLAIM                NAME              DOB          SEX     INTER

 APP DT         REASON CD   DATE/TIME                    REQ ID
 DISP CD        TYPE
                      ERROR MESSAGE:
```

Map 1754 Field Descriptions	
CLAIM	Identifies the beneficiary's Medicare ID number
NAME	The name of the beneficiary
DOB	The date of birth of the beneficiary
SEX	The sex of the beneficiary (F – female; M – male)
INTER	The intermediary number for the provider
APP DT	Applicable Date – used for spell determination, i.e., admission date, and current date.
REASON CD	The reason for the inquiry. Valid values: 1 –Status inquiry 2 –Inquiry related to an admission
DATE/TIME	The date and time stamp
REQ ID	Identifies the individual who submitted the inquiry.
DISP CD	The code assigned when the request is processed through the CWF host site. Valid values: 01 – Part A inquiry approved; beneficiary have never used Part A services 02 – Part A inquiry approved; beneficiary has had some prior utilization 03 – Part A inquiry rejected 04 – Qualified approval; may require further investigation 05 – Qualified approval; according to CMSs records, this inquiry begins a new benefit period.
TYPE	Identifies the type of CWF reply. (3 – accepted)
ERROR MESSAGE	Identifies the error message.

Map 1755 Screen Example

```
MAP1755                CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                    ACCEPTED                     C20112WS HH:MM:SS

   APP DT          REASON CD    DATE/TIME              REQ ID
   DISP CD       TYPE     CENT D.O.B  D.O.D
   A:CURR-ENT DT          TERM DT          PRI-ENT DT          TERM-DT
   B:CURR-ENT DT          TERM DT          PRI-ENT DT          TERM-DT

   LIFE: RSRV   PYSCH

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

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

Map 1755 Field Descriptions	
CLAIM	Identifies the beneficiary's Medicare ID number
NAME	The name of the beneficiary

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Map 1755 Field Descriptions	
DOB	The date of birth of the beneficiary
SEX	The sex of the beneficiary (F – female; M – male)
INTER	The intermediary number for the provider
APP DT	Applicable Date – used for spell determination, i.e., admission date, and current date.
REASON CD	The reason for the inquiry. Valid values: 1 – Status inquiry 2 – Inquiry related to an admission
DATE/TIME	The date and time stamp
REQ ID	Identifies the individual who submitted the inquiry.
DISP CD	The code assigned when the request is processed through the CWF host site. Valid values: 01 – Part A inquiry approved; beneficiary have never used Part A services 02 – Part A inquiry approved; beneficiary has had some prior utilization 03 – Part A inquiry rejected 04 – Qualified approval; may require further investigation 05 – Qualified approval; according to CMSs records, this inquiry begins a new benefit period.
TYPE	Identifies the type of CWF reply. (3 – accepted)
CENT D.O.B	Century Code for Date of Birth - The beneficiary/patients date of birth. This is a one-position alphanumeric field. The valid values are: This field is not used by FISS. **Value – Description:** 8 - 18th Century 9 - 19th Century
D.O.D	Date of Death - The date of death of the beneficiary/patient.
A CURR ENT DT	Part A Current Entitlement Date - The current Part A entitlement date.
TERM DT	Part A Termination Date - The termination date of the current entitlement.
PRI-ENT DT	Part A Prior Entitlement Date - The prior Part A entitlement.
TERM DT	Part A Prior Termination Date - The termination date of the prior Part A entitlement.
B CURR-ENT DT	Part B Current Entitlement Date - The current Part B entitlement date.
TERM DT	Part B Termination Date - The termination date of the current entitlement.
B: CURR-ENT DT	Part B Prior Entitlement Date - The prior Part B entitlement date.
TERM DT	Part B Prior Termination Date - The termination date of the prior Part B entitlement.
PRE-ENT DT	Lifetime Reserve Days - The number of lifetime reserve days remaining.
TERM DT	Part A Termination Date - The termination date of the current entitlement.
LIFE: RSRV	Part A Prior Entitlement Date - The prior Part A entitlement.
PYSCH	Psychiatric Days Remaining - The number of lifetime psychiatric days remaining.
CURRENT BENEFIT PERIOD DATA	
FRST BILL DT	First Bill Date - The earliest billing action in the current benefit period.
LST BILL DT	Last Bill Date - The date of the latest billing action in the current benefit period.
HSP FULL DAYS	Hospital Full Days - The number of regular hospital full days the remaining in the current benefit period.
HSP PART DAYS	Hospital Coinsurance Days - The number of hospital coinsurance days remaining in the current benefit period.
SNF FULL DAYS	Skilled Nursing Facility Full Days - The number of SNF full days remaining in the current benefit period.
SNF PART DAYS	Skilled Nursing Facility Coinsurance Days - The number of SNF coinsurance days remaining in the current period.
INP DED REMAIN	Inpatient Deductible Amount Remaining - The amount of inpatient deductible amount remaining to be met for the benefit period.
BLD DED PNTS	Blood Deductible Pints - The number of blood deductible pints remaining to be met for the benefit period.

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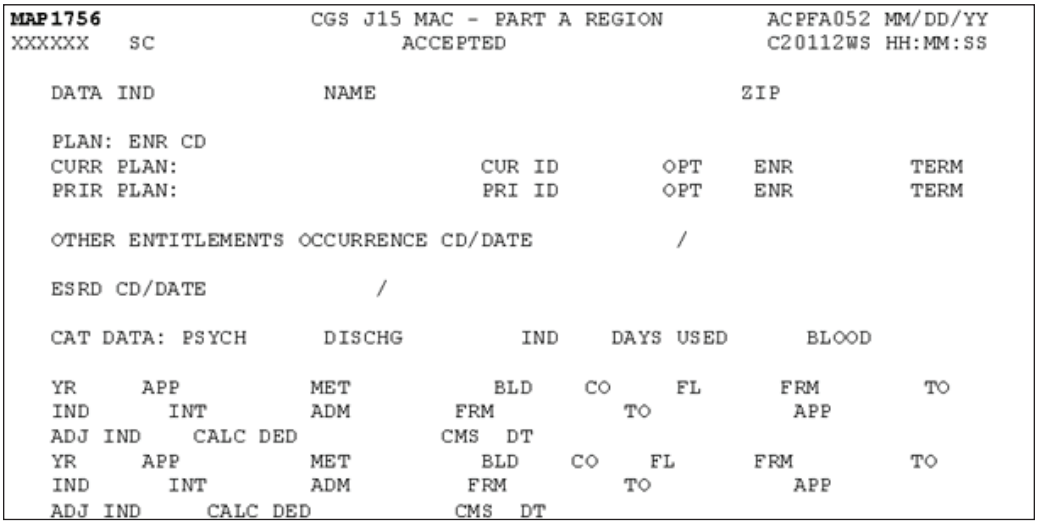
Map 1755 Field Descriptions	
PRIOR BENEFIT PERIOD DATA	
FRST BILL DT	First Bill Date - This field identifies the date of the earliest billing action in the prior benefit period.
LST BILL DT	Last Bill Date - This field identifies the date of the latest billing action in the prior benefit period.
HSP FULL DAYS	Hospital Full Days - The number of regular hospital full days remaining in the prior benefit period.
HSP PART DAYS	Hospital Coinsurance Days - The number of hospital coinsurance days remaining in the prior benefit period.
SNF FULL DAYS	Skilled Nursing Facility Full Days - The number of SNF full days remaining in the prior benefit period.
SNF PART DAYS	Skilled Nursing Facility Coinsurance Days - The number of SNF coinsurance days remaining in the prior period.
INP DED REMAIN	Inpatient Deductible Amount Remaining - The amount of inpatient deductible amount remaining to be met for the benefit period.
BLD DED PNTS	Blood Deductible Pints - The number of blood deductible pints remaining for the benefit period.
CURR B: YR	Most Recent Part B Year - The most recent Medicare Part B benefit year.
CASH	Medicare Part B Cash Deductible Remaining to be Met - The amount of cash deductible remaining for the most recent Part B year.
BLOOD	Medicare Part B Blood Deductible Remaining to be Met -The amount of blood deductible pints remaining for the most recent Part B year.
PSYCH	Medicare Part B Psychiatric Limit Remaining - The Part B psychiatric limit remaining for the benefit year.
PT	Medicare Part B Physical Therapy Limit. - The Part B physical therapy limit amount applied year to date for the most recent Medicare Part B benefit year.
OT	Medicare Part B Occupational Therapy Limit - The Part B occupational therapy limit amount applied year to date for the most recent Medicare Part B benefit year.
PRIR B: YR	Prior Part B Year - The prior Medicare Part B benefit year.
CASH	Medicare Part B Cash Deductible Remaining to be Met - The amount of cash deductible remaining to be met for the prior Part B benefit year.
BLOOD	Medicare Part B Blood Deductible Remaining to be Met - The amount of blood deductible remaining to be met for the prior Part B benefit year.
PSYCH	Medicare Part B Psychiatric Limit Remaining - The Part B psychiatric limit remaining for the prior Part B benefit year.
PT	Medicare Part B Physical Therapy Limit - The Part B physical therapy limit amount applied year to date for the prior Part B benefit year.
OT	Medicare Part B Occupational Therapy Limit - The Part B occupational therapy limit amount applied year to date for the prior Part B benefit year.



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Map 1756 Field Descriptions	
DATA IND	Data Indicators - This field identifies the data indicator. Valid values for each position are: **Position 1: Part B Buy In** 0 - Does not apply 1 - State buy-in involved **Position 2: Alien Indicator** 0 - Does not apply 1 - Alien non-payment, provision may apply **Position 3: Psychiatric Pre-Entitlement** 0 - Does not apply 1 - Psychiatric pre-entitlement reduction applied **Position 4: Reason For Entitlement** 0 - Normal entitlement 4 - Old age but has or had ESRD 1 - Disability 8 - Has or had ESRD and is covered under Part A premium 2 - End stage renal disease (ESRD) 9 - Covered under Part A premium 3 - Has or had ESRD, but current DIB **Position 5: Part A Buy-In** 0 - No Part A buy-in 1 - Part A buy-in applies **Position 6: Rep Payee Indicator** 0 - Does not apply 2 - Has Rep Payee 1 - Selected for GEP contract 3 - Both conditions apply **Positions 7-10: Not Used at This Time (pre-filled with zeroes)**
NAME	The full name of the beneficiary in last name, first name, middle initial format.
ZIP	The ZIP code of residence of the beneficiary.
PLAN: ENR CD	The number of periods of Plan enrollment code. The valid values are: 0, 1, 2, and 3 indicating 0, 1, 2, or more than two periods of enrollment.
CURRENT PLAN	
CUR ID	The Current Plan identification code.
OPT	The Plan Option Code - This field identifies whether the current Plan services are restricted or unrestricted. **Unrestricted** 1 – Medicare contractor to process all Part A and B provider claims 2 – Plan to process claims for directly provided service and for services from providers with effective arrangements. **Restricted** A – Medicare contractor to process all Part A and B provider claims B – Plan to process claims only for directly provided services C – Plan to process all claims
ENR	The effective date of the current entitlement..
TERM	The termination date of the current enrollment.
PRIOR PLAN	
PRI ID	The prior Plan identification code.
OPT	The prior Plan Option code. **Unrestricted** 1 – Medicare contractor to process all Part A and B provider claims 2 – Plan to process claims for directly provided service and for services from providers with effective arrangements. **Restricted** A – Medicare contractor to process all Part A and B provider claims B – Plan to process claims only for directly provided services C – Plan to process all claims
ENR	The effective date of the prior HMO entitlement.
TERM	The termination date of the prior HMO enrollment.

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Map 1756 Field Descriptions	
OTHER ENTITLEMENTS OCCURRENCE CD	The first two occurrence codes and dates indicating another federal program or other type of insurance that may be a primary payer. The valid values are: Value – Description: 1 - Workers Compensation coverage. 2 - Black Lung. A - Working Aged beneficiary or spouse covered by employer health plan. B - End stage renal disease (ESRD) beneficiary in his 12 month coordination period and covered by an employer health plan. C - Medicare has made a conditional payment pending final resolution. D - Automobile no-fault or other liability insurance involvement. E - Workers Compensation and/or Black Lung. F - Veterans Administration program, public health service or other federal agency program. G - Working disabled beneficiary or spouse covered by employer health plan. H - Black Lung. I - Veterans Administration program.
ESRD CD	The home dialysis method selection code. The valid codes are: 1 - The beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits claims for services it renders. 2 - The beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and the beneficiary is responsible for submitting his/her own claims to the Carrier for reimbursement.
ESRD DATE	The home dialysis method selection effective date.
ESRD CD	The home dialysis method selection code. The valid codes are: 1 - The beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits claims for services it renders. 2 - The beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and the beneficiary is responsible for submitting his/her own claims to the Carrier for reimbursement.
ESRD DATE	The home dialysis method selection effective date.
PSYCH	The the number of lifetime psychiatric days remaining for the beneficiary/patient.
DISCHG	The last or through discharge date.
IND	This field identifies whether or not the discharge date is an interim date. The valid values are: 0 - Initialized 1 - Interim
DAYS USED	The number of pre-entitled psychiatric days used by the beneficiary/patient.
BLOOD	The number of blood pints carried over from 1988 to 1989.
YR	The catastrophic trailer year.
APP	This field identifies whether a December inpatient stay has been applied to the current year deductible.
MET	The amount of inpatient hospital deductible to be met according to the catastrophic trailer year.
BLD	The number of blood deductible pints remaining to be met.
CO	The number of co-insurance SNF days remaining.
FL	The 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 indicator. This is a one-position alphanumeric field. This field provides the following information: **Position 1** 0 - Not used 2 - Clerical involvement 3 - Religious Non-Medical Healthcare Institution/SNF usage 4 - Both 1 and 2 **Position 2** Value – Description: 0 - Not used 1 - Through date is interim

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Map 1756 Field Descriptions	
INT	The intermediary number for the earliest hospital bill processed with a deductible.
ADM	The admission date for the earliest hospital bill processed 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	The deductible amount applied for the earliest hospital bill processed with a deductible.
ADJ IND	The type of adjustment made. The valid values are: 0 - No adjustment 1 - Downward adjustment 2 - Upward adjustment
CALC DED	The amount of deductible calculated.
CMS DATE	The date the claim was processed by CMS.

Map 1757 Screen Example

```
MAP1757                  CGS J15 MAC - PART A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC                        ACCEPTED                 C20112WS HH:MM:SS

   HH-REC  CN                 NM          IT     DB              SX


                           TECHCOM    PROCOM
   MAMMO RSK     MAMMO DATES


   TRANSPLANT INFO:    COV IND    TRAN IND    DIS DATE




          EPISODE       EPISODE        DOEBA         DOLBA
           START          END
```

Map 1757 Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary/patient.
IT	The first initial of the beneficiary/patient name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
MAMMO RSK	Mammography Risk Indicator - This field identifies whether or not the beneficiary is at risk. The valid values are: Y - Yes N - No
TECHCOM	The date of mammography screening interpreted by a technician. Up to three technical component dates may be displayed.
PROCOM	The date of mammography screening requiring interpretation by a physician. Up to three professional component dates may be displayed.
COV IND	This field identifies whether or not the transplant was a covered procedure. Up to three coverage indicators may be displayed. The valid values are: N - Non-covered transplant. Y - Covered transplant.
TRAN IND	Transplant Indicator - This field identifies the type of transplant performed. Up to three transplant indicators may be displayed. The valid values are: 1 - Allogeneous bone marrow 2 - Autologous bone marrow B - Lung Transplant C - Heart and Lung Transplant D - Kidney and Pancreas Transplant H - Heart transplant I - Intestinal Transplant K - Kidney transplant L - Liver transplant P - Pancreas Transplant

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Map 1757 Field Descriptions	
DIS DATE	The date of discharge for the beneficiary/patient for the transplant procedure.
EPISODE START	The start date of an episode.
EPISODE END	The end date of an episode.
DOEBA	The first service date of the HHPPS period.
DOLBA	The last service date of the HHPPS period.

Map 1758 Screen Example

```
MAP1758              CGS J15 MAC - PART A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC                    ACCEPTED                 C20112WS HH:MM:SS

HOSPICE INFO FOR PERIODS 1 AND 2:

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

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

Map 1758 Field Descriptions	
PERIOD	The specific Hospice Election Period. This is a one-position alphanumeric field with two occurences. The valid values are: 1 - The first time a beneficiary uses hospice benefits. 2 - The second time a beneficiary uses hospice benefits.
1ST ST DATE	The start date of the beneficiary's effective period with the Hospice provider.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
OWNER CHANGE ST DATE	The new owner of the Hospice provider if a change of ownership occurs within an election period.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
2NDT ST DATE	The start date of the beneficiary's effective period with the Hospice provider.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
TERM DATE	The ending date of a beneficiary's election period.
OWNER CHANGE ST DATE	The new owner of the Hospice provider if a change of ownership occurs within an election period.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
1ST BILLED DATE	The first billed date of the beneficiary's effective period with the Hospice provider.
LAST BILLED DATE	The last billed date of the beneficiary's effective period with the Hospice provider.
DAYS BILLED	The number of hospice days billed to date for a particular beneficiary/patient.
REVO IND	The revocation indicator.

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Map 1759 Screen Example

```
MAP1759                  CGS J15 MAC - PART A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC                       ACCEPTED                  C20112WS HH:MM:SS

                                MSP DATA  PAGE    OF

    EFFECTIVE DATE:           SUBSCRIBER NAME:
  TERMINATION DATE:           POLICY NUMBER:
         MSP CODE:              INSURER TYPE:
                          PATIENT RELATIONSHIP:
                              REMARKS CODES:

             INSURER INFORMATION
     NAME:                                        GROUP NO:
  ADDRESS:                                            NAME:


            EMPLOYER DATA
     NAME:                                        EMPLOYEE ID:
  ADDRESS:                                     EMPLOYEE INFO:
```

Map 1759 Field Descriptions	
PAGE	The sequence number of the Medicare Secondary Payer (MSP) data page being displayed.
OF	The sequence number of the highest MSP data page that will be displayed.
EFFECTIVE DATE	The date of the Medicare Secondary Payer (MSP) coverage.
SUBSCRIBER NAME	The first name of the individual subscribing to the MSP coverage.
SUBSCRIBER NAME	The last name of the individual subscribing to the MSP coverage.
TERMINATION DATE	The date the coverage terminates under the payer listed.
POLICY NUMBER	The policy number with the payer listed.
MSP CODE	The MSP source code.
INSURER TYPE	This field is not used in DDE.
PATIENT RELATIONSHIP	The relationship of the beneficiary to the insured under the policy listed.
REMARKS CODES	This field is the MSP Remark Code #1 and it identifies information needed by the contractor to assist in additional development.
REMARKS CODES	This field is the MSP Remark Code #2 and it identifies information needed by the contractor to assist in additional development.
REMARKS CODES	This field is the MSP Remark Code #3 and it identifies information needed by the contractor to assist in additional development.
INSURER INFORMATION	
NAME	The name of the insurance company which may be primary over Medicare.
ADDRESS	The street, city, state, and ZIP code for the insurer.
GROUP NO	The group number for the policyholder with this insurer name.
NAME	The name of the insurer group.
EMPLOYER DATA	
NAME	The name of the employer that provides or may provide health care coverage for the beneficiary/patient.
ADDRESS	The street of the employer.
NO TITLE	The city of the employer.
NO TITLE	The state of the employer.
NO TITLE	The zip code of the employer.
EMPLOYEE ID	The identification number assigned by the employer to the beneficiary.
EMPLOYEE INFO	This field is not used in DDE.

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Map 175A Screen Example

```
MAP175A              CGS J15 MAC - PART A REGION         ACPFA052 MM/DD/YY
XXXXXX   SC                        ACCEPTED              C20112WS HH:MM:SS

 CLAIM                 NAME                DOB          SEX      INTER
 PROV                  PROV IND
 APP DT          REASON CD    DATE/TIME                        REQ ID
 DISP CD        TYPE
                          DATE TRANSFER INITIATED TO CMS:

                       DATE CMS INDICATED NIF/AT OTHER SITE:
```

Map 175A Field Descriptions	
CLAIM	The beneficiary's Medicare ID number.
NAME	The first initial and last name of the beneficiary.
DOB	The date of birth of the beneficiary.
SEX	The sex of the beneficiary. The valid values are: F - Female M - Male
INTER	The intermediary number for the provider.
APP DT	Applicable Date - This field is used for spell determination, i.e., admission date, and current date.
REASON CD	The reason for the inquiry. The valid values are: 1 - Status inquiry 2 - Inquiry related to an admission
DATE/TIME	Date and Time Stamp (Julian).
REQ ID	The individual who submitted the inquiry.
DISP CD	CWF Disposition Code - This field identifies a code assigned when the request is processed through the CWF host site.
TYPE	The type of CWF reply. The valid values are: 4 - Not in file
DATE TRANSFER INITIATED TO CMS	The date the transfer was initiated to CMS.
DATE CMS INDICATED NIF/AT OTHER SITE	The date CMS indicated the beneficiary Medicare number was not in file at another site.

Map 175B Screen Example

```
MAP175B              CGS J15 MAC - PART A REGION         ACPFA052 MM/DD/YY
XXXXXX   SC                        ACCEPTED              C20112WS HH:MM:SS

CLAIM                NAME            DOB          SEX     INTER

APP DT          REASON CD     DATE/TIME                REQ ID
DISP CD       TYPE
                        CORRECTED CLAIM NUMBER:









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

Map 175B Field Descriptions	
CLAIM	The beneficiary's Medicare ID number.
NO TITLE	The middle initial of the beneficiary.
NAME	The first initial and last name of the beneficiary.
DOB	The date of birth of the beneficiary.

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Map 175B Field Descriptions	
SEX	The sex of the beneficiary. The valid values are: F - Female M - Male
INTER	The intermediary number for the provider.
APP DT	Applicable Date - This field is used for spell determination, i.e., admission date, and current date.
REASON CD	The reason for the inquiry. The valid values are: 1 - Status inquiry 2 - Inquiry related to an admission
DATE/TIME	Date and Time Stamp (Julian).
REQ ID	The individual who submitted the inquiry.
DISP CD	A code assigned when the request is processed through the CWF host site.
TYPE	The type of CWF reply. The valid values are: 5 - Not in file on CMS batch but is another potential claim number for this beneficiary.
CORRECTED CLAIM NUMBER	The corrected Medicare ID number.

Map 175C Screen Example

```
MAP175C                CGS J15 MAC - PART A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC                      ACCEPTED                 C20112WS HH:MM:SS

  HOSPICE INFO FOR PERIODS 3 AND 4:

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

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

Map 175C Field Descriptions	
PERIOD	The specific Hospice Election Period. The valid values are: 1 - The first time a beneficiary uses hospice benefits. 2 - The second time a beneficiary uses hospice benefits.
1ST ST DATE	The start date of the beneficiary's effective period with the Hospice provider.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
OWNER CHANGE ST DATE	The new owner of the Hospice provider if a change of ownership occurs within an election period.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
2NDT ST DATE	The start date of the beneficiary's effective period with the Hospice provider.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.
TERM DATE	The ending date of a beneficiary's election period.
OWNER CHANGE ST DATE	The new owner of the Hospice provider if a change of ownership occurs within an election period.
PROV	The identification number assigned by Medicare to the Hospice provider.
INTER	The intermediary number of the Hospice provider.

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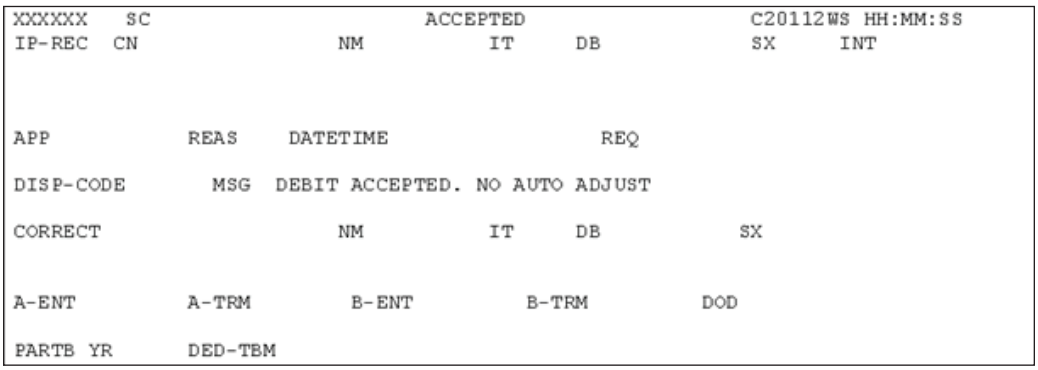
Map 175C Field Descriptions	
1ST BILLED DATE	The first billed date of the beneficiary's effective period with the Hospice provider.
LAST BILLED DATE	The last billed date of the beneficiary's effective period with the Hospice provider.
DAYS BILLED	The number of hospice days billed to date for a particular beneficiary/patient.
REVO IND	The revocation indicator.

Map 175D Screen Example



```
XXXXXX   SC                      ACCEPTED                    C20112WS HH:MM:SS
IP-REC   CN                 NM          IT     DB            SX     INT


APP           REAS    DATETIME                  REQ

DISP-CODE       MSG  DEBIT ACCEPTED. NO AUTO ADJUST

CORRECT                   NM          IT     DB           SX


A-ENT         A-TRM        B-ENT         B-TRM         DOD

PARTB YR      DED-TBM
```

Map 175D Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first Initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
INT	The intermediary number for the earliest hospital bill processed with a deductible.
APP	This field identifies spell determination, i.e. admission date and current date.
REAS	The reason for the inquiry. The valid values are: 1 - Status inquiry 2 - Inquiry related to an admission
DATETIME	The date and time stamp of the inquiry.
REQ	The operator ID of the person submitting the inquiry.
DISP-CODE	The code assigned when the request is processed through the CWF host site.
MSG	The process of the episode (i.e. paid, suspended, RTP, etc.)
CORRECT	The crossover reference of a Medicare ID number and populates the correct Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
A-ENT	The current Part A entitlement.
A-TRM	The Part A termination date of the current entitlement.
B-ENT	The current Part B entitlement.
B-TRM	The Part B termination date of the current entitlement.
DOD	The date of death of the beneficiary.
PARTB YR	The most recent Medicare Part B benefit year.
DED-TBM	The Part B deductible amount.

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Map 175E Screen Example

```
MAP175E                CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                        ACCEPTED                 C20112WS HH:MM:SS
   HH-REC  CN                 NM          IT     DB            SX

   SPELL   QUALIFYING    PARTA VISITS   EARLIEST    LATEST    PARTB VISITS
   NUM        IND        REMAINING      BILLING     BILLING   APPLIED
```

Map 175E Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
SPELL NUM	The spell number, up to 14 episodes.
QUALIFYING IND	The beneficiary qualified for Part A or Part B Medicare.
PARTA VISITS REMAINING	This field identifies how many visits are remaining for the beneficiary/patient.
EARLIST BILLING	The earliest date of an episode.
LATEST BILLING	The latest date of an episode.
PARTB VISITS APPLIED	This field identifies how many Part B visits were applied to the episode.

Map 175F Screen Example

```
MAP175F                CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                        ACCEPTED                 C20112WS HH:MM:SS
   HH-REC  CN                 NM          IT     DB            SX

      START    END      INTER   PROV   DOEBA    DOLBA      PATIENT
      DATE     DATE     NUM     NUM                        STAT ID
```

Map 175F Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
START DATE	The start date of an episode.
END DATE	The end date of an episode.
INTER NUM	The Hospice provider intermediary number.
PROV NUM	The identification number assigned by Medicare to the Hospice provider.
DOEBA	The first service date of the HHPPS period.
DOLBA	The last service date of the HHPPS period.
PATIENT STAT ID	The patient status during the episode.

Map 175G Screen Example

```
MAP175G                CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                        ACCEPTED                 C20112WS HH:MM:SS
   MSP-REC  CN                NM          IT     DB            SX

   REC  MSP   DESCRIPTION   EFF DTE     TRM DTE      INTER     DOA
```


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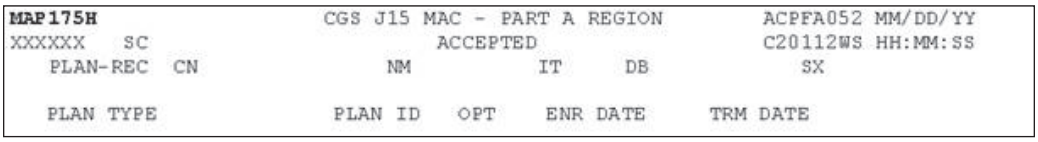
Map 175G Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
REC	The sequence record number of the paid claims starting with 00 and occurs up to 16 times.
MSP	This field identifies MSP source.
DESCRIPTION	The value in the MSP code field. The valid values are: 1 - MEDICAID E - WORKERS COMP 2 - BLUECROSS F - PUB HLTH SRV 3 - OTHER G - DISABLED 4 - NONE H - BLACK LUNG A - WORKING AGED I - VETERANS B - ESRD BENE L - LIABILITY C - COND PAYMENT W - WC SET-ASIDE D - NO-FAULT Z - MEDICARE
EFF DTE	The effective date of the Medicare Secondary Payer (MSP) coverage.
TRM DTE	The termination date of the Medicare Secondary Payer (MSP) coverage termination.
INTER	The Hospice provider intermediary number.
DOA	The date the entry was added.

Map 175H Screen Example



Map 175H Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
PLAN TYPE	This field identifies the type of plan.
PLAN ID	The Plan Identification code. The structure of the identification number is: Position 1 - H Position 2 & 3 - State Code Position 4 & 5 - Plan number within the state
OPT	The current Plan services are restricted or unrestricted. The valid values are: **Unrestricted** 1 – Medicare contractor to process all Part A and B provider claims 2 – Plan to process claims for directly provided service and for services from providers with effective arrangements. **Restricted** A – Medicare contractor to process all Part A and B provider claims B – Plan to process claims only for directly provided services C – Plan to process all claims

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Map 175H Field Descriptions	
ENR DATE	The enrollment date of the Plan for a beneficiary Plan entitlement.
TRM DATE	The termination date of the Plan for a beneficiary Plan entitlement.

Map 175I Screen Example

```
MAP175I                  CGS J15 MAC - PART A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC                      ACCEPTED                   C20112WS HH:MM:SS
   HOSP-REC  CN              NM             IT     DB            SX

   HOSPICE DATE    PERIOD    OWNER CHANGE    PERIOD   OWNER CHANGE
   START DATE
   TERM DATE 1
   PROV 1

   INTER 1
   DOEBA DATE
   DOLBA DATE
   DAYS USED
   START DATE 2
   PROV 2


   INTER 2
   REVOCATION IND
```

Map 175I Field Descriptions	
CN	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: F - Female M - Male
PERIOD	The Hospice election period. The valid values are: 1 - The first time a beneficiary uses Hospice benefits. 2 - The second time a beneficiary uses Hospice benefits. 3 - The third time a beneficiary uses Hospice benefits. 4 - The fourth time a beneficiary uses Hospice benefits.
START DATE 1	The start date of the beneficiary's first election period with the Hospice provider.
OWNER CHANGE	The date of the Hospice provider change of ownership within an election period.
TERM DATE 1	The ending date of the beneficiary's first election period.
PROV 1	The first Hospice provider identification number assigned by Medicare.
INTER 1	The intermediary number of the first Hospice provider.
DOEBA DATE	The first service date of the HHPPS period.
DOLBA DATE	The last service date of the HHPPS period.
DAYS USED	The number of days used by the beneficiary/patient.
START DATE 2	The start date of the beneficiary's second election period with the Hospice provider.
OWNER CHANGE	The date of the Hospice provider change of ownership within an election period.
PROV 2	The second Hospice provider identification number assigned by Medicare.
INTER 2	The intermediary number of the second Hospice provider.
REVOCATION IND	The revocation indicator number.

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Map 175J Screen Example

```
MAP175J                    CGS J15 MAC -  Part A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC                          ACCEPTED                  C20112WS HH:MM:SS
 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   ....  ....  DIAB/82951 ..... .....  AAA /      ..... .....
  CARD/82465  ..... .....  PCBE/G0101 ..... .....  PTWR/G9143 ..... .....
  CARD/83718  ..... .....             ..... .....  IPPE/G0402 ..... .....
  CARD/84478  ..... .....  PROS/G0102 ..... .....  IPPE/G0403 ..... .....
  COLO/G0104  ..... .....  PROS/G0103 ..... .....  IPPE/G0404 ..... .....
  COLO/G0105  ..... .....  PAPT/Q0091 ..... .....  IPPE/G0405 ..... .....
  COLO/G0106  ..... .....  GLAU/       ..... .....  PULM/G0424 ..... .....
  COLO/G0120  ..... .....  MAMM/       ..... .....  CR /       ..... .....
  COLO/G0121  ..... .....  PAPT/       ..... .....  ICR /      ..... .....
  FOBT/G0107  ..... .....  HIBC/G0445 ..... .....  AWV /G0438 ..... .....
  FOBT/G0328  ..... .....  HBV/        ..... .....  AWV /G0439 ..... .....
  FOBT/82270  ..... .....  SETS/93668 ..... .....  BEHV/G0447 ..... .....
  IPPE/G0344  ..... .....             ..... .....             ..... .....
  IPPE/G0366  ..... .....             ..... .....             ..... .....
  IPPE/G0367  ..... .....             ..... .....             ..... .....
  IPPE/G0368  ..... .....             ..... .....             ..... .....
  DIAB/82947  ..... .....             ..... .....             ..... .....
  DIAB/82950  ..... .....             ..... .....             ..... .....
      ..........................................................................
```

Map 175J Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
TECH D	**Technical Date -** This field identifies the date the beneficiary is eligible for preventative service coverage. **NOTE:** When there is not a date, one of the following messages display to explain why the beneficiary is not eligible. **PTB -** Beneficiary not entitled to Part B **AGE -** Beneficiary not eligible due to age **RCVD -** Beneficiary already received service **SRV -** Beneficiary not eligible for the service **DOD -** Beneficiary not eligible due to DOD **VAC -** Beneficiary already vaccinated **GDR -** Beneficiary not eligible due to gender **0000 -** Service not applicable
PROF D	**Professional Date -** This field identifies the date the beneficiary is eligible for preventative service coverage. **NOTE:** When there is not a date, one of the following messages display to explain why the beneficiary is not eligible. **PTB -** Beneficiary not entitled to Part B **AGE -** Beneficiary not eligible due to age **RCVD -** Beneficiary already received service **SRV -** Beneficiary not eligible for the service **DOD -** Beneficiary not eligible due to DOD **VAC -** Beneficiary already vaccinated **GDR -** Beneficiary not eligible due to gender **0000 -** Service not applicable

Map 175K Screen Example

```
MAP175K                    CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
 XXXXXX   SC                          ACCEPTED                  C20112WS HH:MM:SS
          MID                  LN          FI    DOB            SEX
  COUNSELING PERIOD:
     TOTAL SESSIONS:
  HCPCS    FROM       THRU    PER QT TP PRF  HCPCS   FROM      THRU    PER QT TP PRF
```

Map 175K Field Descriptions	
MID	The beneficiary's Medicare ID number.
LN	The last name of the beneficiary.

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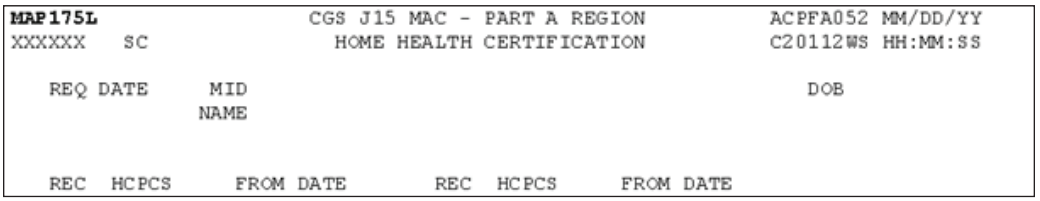
Map 175K Field Descriptions	
FI	The first initial of the beneficiary name.
DOB	The date of birth of the beneficiary.
SEX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
TOTAL SESSIONS	**Total Sessions -** This field identifies the number of sessions billed for each beneficiary. This occurs five times This is a one-position alphanumeric field. **Note:** 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).
Note: The following fields display up to 28 occurrences of the maximum session occurrences from the most recent to the oldest received from CWF.	
HCPCS	The HCPC code of G0375 or G0376.
FROM	The from date of the claim.
THRU	The through date of the claim.
PER	Period - This field identifies up to five years of counseling data. The valid values are: 1 - One year 2 - Two years 3 - Three years 4 - Four years 5 - Five years
QT	Quantity - This field identifies the number of services billed for each date.
TP	The claim type. The valid values are: O - Outpatient B - Part B
PRF	The technicaland professional remaining sessions.

Map 175L Screen Example



Map 175L Field Descriptions	
MID	The beneficiary's Medicare ID number.
DOB	The date of birth associated with the Medicare ID number.
REQ DAT	The date of request.
NAME	The name associated with the Medicare ID number.
REC	Record Number First Ten Occurrences – This field displays the Home Health Certification records one through ten on the CWF Reply Record. This number is incremented by one for each of the first ten records found.
HCPCS	Record HCPCS First Ten Occurrences – This field identifies the health insurance record number.
FROM DATE	From Date First Ten Occurrences – This field identifies the Home Health from date.
REC	Record Number Second Ten Occurrences – This field displays the Home Health Certification records eleven through 20 on the CWF Reply Record. This number is incremented by one for each of the second ten records found.
HCPCS	Record HCPCS Second Ten Occurrances – This field identifies the health insurance record number.
FROM DATE	From Date Second Ten Occurrences – This field identifies the Home Health from date.

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Map 175M Screen Example

```
MAP175M                        CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX SC                             ACCEPTED                      C20112WS HH:MM:SS
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                 BONE/77085
  TELH/99232                 PREP/G0464
  TELH/99233                 LDCT/G0297
  TELH/99307                 HIVS/G0476
  TELH/99308                 HIVS/
  TELH/99309                 BONE/0508T
  TELH/99310                 BONE/0554T
  BEHV/G0442                 BONE/0555T
  BEHV/G0443                 BONE/0556T
  BEHV/G0444                 BONE/0557T
  BEHV/G0446                 BONE/0558T
  BONE/77078                 ABPM/93784
  BONE/77080                 ACUP/
  BONE/77081
  BONE/76977
  BONE/G0130
  BEHV/G0473
  HCAS/G0472
```

Map 175M Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
TECH D	The date the beneficiary is eligible for preventative service coverage. Note: When there is not a date, one of the following messages display to explain why the beneficiary is not eligible. PTB - Beneficiary not entitled to Part B RCVD - Beneficiary already received service DOD - Beneficiary not eligible due to DOD GDR - Beneficiary not eligible due to gender AGE - Beneficiary not eligible due to age SRV - Beneficiary not eligible for the service VAC - Beneficiary already vaccinated 0000 - Service not applicable
PROF D	The date the beneficiary is eligible for preventative service coverage. Note: When there is not a date, one of the following messages display to explain why the beneficiary is not eligible. PTB - Beneficiary not entitled to Part B RCVD - Beneficiary already received service DOD - Beneficiary not eligible due to DOD GDR - Beneficiary not eligible due to gender AGE - Beneficiary not eligible due to age SRV - Beneficiary not eligible for the service 0000 - Service not applicable

Map 175N Screen Example

```
MAP175N                    CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                         ACCEPTED                    C20112WS HH:MM:SS
MID                   NM          IT     DB            SX

HCPC       TECH      RISK         DATE          DATE          DATE

CODE       CODE       CD        CCYYMMDD      CCYYMMDD      CCYYMMDD
```


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Map 175N Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
HCPC CODE	The HCPC code.
TECH CODE	This field identifies the technical code.
RISK CD	The breast cancer risk indicator for the beneficiary. The valid values are: Y - High Risk N - Not High Risk
DATE	Date 1 - This field identifies the date the HCPC code was returned from CWF.
DATE	Date 2 - This field identifies the date the TECH code was returned from CWF.
DATE	Date 3 - This field identifies the date the RISK code was returned from CWF.

Map 175O Screen Example

```
MAP175O                CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                      ACCEPTED                   C20112WS HH:MM:SS
   MID                 NAME          INTITIAL     DOB          SEX
   MCCM DATA
    PROV               START     TERM       TRANSFER
   NUMBER              DATE      DATE       DATE
```

Map 175O Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
PROVIDER NUMBER	The identification number assigned by Medicare to the Hospice provider.
START DATE	The beginning date of a beneficiary's election of the MCCM Hospice provider.
TERM DATE	The ending date of a beneficiary's election of the MCCM Hospice provider.
TRANSFER DATE	The date of the MCCM Hospice provider change of ownership.

Map 175P Screen Example

```
MAP175P                CGS J15 MAC - PART A REGION          ACPFA052 MM/DD/YY
XXXXXX                   HOSPICE ELECTION PERIOD            C20112WS HH:MM:SS

MID                 NAME          INITIAL                SEX


ELECTION
REC    START        RECEIPT       REVOCATION    REV      PROVIDER
NO     DATE         DATE          DATE          IND      NUMBER
01
02
03
04
```

Map 175P Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
IT	The first initial of the beneficiary name.

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Map 175P Field Descriptions	
DB	The date of birth of the beneficiary.
SX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
START DATE	Hospice election start date (MMDDCCYY)
RECEIPT DATE	Receipt date of the Notice of Election (NOE) (MMDDCCYY).
REVOCATION DATE	Hospice revocation date (MMDDCCYY)
REV IND	Hospice revocation indicator
PROVIDER NUMBER	Hospice provider number.

Map 175Q Screen Example

```
MAP175Q                      CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC              PBRO AUXILIARY DETAILS                    C20112WS HH:MM:SS

MID                  NAME          INITIAL            DOB          SEX


PROF - HCPCS     ACT-SOE-DT    ACT-EOE-DT   PROF-DIAG-CD    RENDERING-NPI    TAX-ID-NBR
 TECH-HCPCS       TEMP-SOE-DT    TEMP-EOE-DT    TECH-DIA-CD     CCN/TIN




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

Map 175Q Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
INITIAL	The first initial of the beneficiary name.
SEX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
PROF-HCPCS	The professional radiation oncology model-specific HCPCS code.
ACT-SOE-DT	Actual starte of episode date.
ACT-EOE-DT	Actual end of episode date.
PROF-DIAG-CD	Professional line item diagnosis code.
RENDERING-NPI	The National provider Identifier (NPI) of the radiation oncologists performing the service.
TAC-ID-NBR	The Tax Identification Number (TIN) of the radiation oncologists performing the service.
TECH-HCPCS	The technical readiation oncoloby model-specific HCPCS code.
TEMP-SOE-DT	Temporary start of episode date.
TEMP-EOE-DT	Temporary end of episode date
TECH-DIAG-CD	Technical line item diagnosis code.
CCN/TIN	Facility/Technical participant provider number.

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Map 175R Screen Example

```
MAP175R                      CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC              PPV HCPCS AUX FILE SCREEN                C20112WS HH:MM:SS

MID                 NAME          INITIAL            DOB          SEX


REC     HCPCS     FROM  DATE   NPI        REC     HCPCS     FROM  DATE    NPI




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

Map 175R Field Descriptions	
MID	The beneficiary's Medicare ID number.
NM	The last name of the beneficiary.
INITIAL	The first initial of the beneficiary name.
DOB	The date of birth of the beneficiary.
SEX	The sex of the beneficiary. The valid values are: **F -** Female **M -** Male
REC	Record number
HCPCS	Pneumococcal pneumonia vaccination HCPCS – up to 10 occurrences
FROM DATE	The most recent 'from' date of service – up to 10 occurrences
NPI	Provider's National Provider Identifier – up to 10 occurrences

DRG Pricer/Grouper (Option 11)

This option allows you to view specific DRG (diagnostic related group) assignment and PPS (prospective payment system) information for inpatient hospital stays as calculated by the Pricer/Grouper software programs within FISS.

1. From the Inquiry Menu, type ***11*** in the **Enter Menu Selection** field and press Enter.
   - You may also access this screen by typing ***11*** in the **SC** field if you are in an inquiry or claim entry screen.
2. The DRG/PPS Inquiry screen (Map 1781) appears:

```
MAP1781                      CGS J15 MAC - XXX REGION          ACPFA052 MM/DD/YY
 XXXXXXX   SC                    DRG/PPS INQUIRY              C201424F HH:MM:SS
DIAGNOSES:   1          2          3          4          5
             6          7          8          9          POA
PROCEDURES:  1          2          3          4          5
             6          7          8          9          NPI
 SEX      C-I      DISCHARGE STATUS          DT          PROV
 REVIEW CODE       TOTAL CHARGES             DOB         OR AGE
 APPROVED LOS      COV DAYS                  LTR DAYS    PAT LIAB
 RETURNED FROM GROUPER:                            GROUPER VERSION
    DRG        INIT          MAJOR DIAG CAT          RETURN CODE
    PROC CD USED           DIAG CD USED             SEC DIAG USED
 RETURNED FROM PRICER:                             PRICER VERSION
    RTN CD     WAGE INDEX                 OUTLIER DAYS
    AVG# LENGTH OF STAY                   OUTLIER DAYS THRESHOLD
    OUTLIER COST THRES                    INDIRECT TEACHING ADJ#
    TOTAL BLENDED PAYMENT                 HOSPITAL SPECIFIC PORTION
    FEDERAL SPECIFIC PORTION              DISP# SHARE HOSPITAL AMT
    PASS THRU PER DISCHARGE               OUTLIER PORTION
    PTPD + TEP                            STANDARD DAYS USED
    LTR DAYS USED                         PROV REIMB

     PLEASE ENTER DATA, PF3-EXIT, PF6-FWD, PF8-COST DISCLOSURE, ENTER-PROCESS
```


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Map 1781 Field Descriptions	
DIAGNOSIS	ICD diagnosis codes that identify up to nine codes for coexisting conditions on a particular claim. The admitting diagnosis is not entered.
No Title	This field follows the ICD diagnosis code field and identifies the Present On Admission (POA) indicator for every principal and secondary diagnosis and whether the patient's condition is present at the time the order for inpatient admission to a general acute care hospital occurs.
POA	The End of POA Indicator. This is the last character of the POA Indicator. Valid values: **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. **Z –** The end of POE indicators for principal and, if applicable other diagnoses. **Blank –** Not acute care, POA's do not apply.
PROCEDURES	ICD procedure codes that identify the principal procedure performed and up to eight additional procedures during the billing period.
NPI	The providers National Provider Identifier (NPI) number.
SEX	The beneficiary's gender.
C – I	Century indicator – Valid values are: **8 =** 1800-1899 **9 =** 1900-1999 **2 =** 2000
DISCHARGE STATUS	The beneficiary's discharge status code.
DT	The date the beneficiary was discharged (MMDDYY format).
PROV	The provider's Medicare number
REVIEW CODE	Identifies the code used to calculate the standard payment. Valid values are: **00 =** Pay with outlier **01 =** Pay days outlier **02 =** Pay cost outlier **03 =** Pay per diem days **04 =** Pay average stay only **05 =** Pay transfer with cost **06 =** Pay transfer no cost **07 =** Pay without cost **09 =** Pay transfer special DRG post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 **11 =** Pay transfer special DRG no cost post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483
TOTAL CHARGES	The total charge as submitted on the claim.
DOB	The beneficiary's date of birth (MMDDCCYY format).
OR AGE	The beneficiary's age at the time of discharge. This field may be used instead of the DOB field.
APPROVED LOS	The approved length of stay (LOS). This is necessary for 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.
COV DAYS	Identifies 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.
LTR DAYS	Identifies the number of Lifetime Reserve (LTR) days used for a claim.
PAT LIAB	Identifies the patient liability that is due, which is the dollar amount owed by the beneficiary to cover any coinsurance days or non-covered days or charges.

Press ENTER to allow FISS to assign the DRG. The following information will display on the screen under RETURNED FROM GROUPER or RETURNED FROM PRICER

RETURN FROM GROUPER:	
GROUPER VERSION	The version of the Grouper program used.
DRG	Identifies the Diagnosis Related Group code assigned by the grouper program.
INIT	INIT identifies the initial DRG code assigned. Used in the event a Hospital Acquired Condition (HAC) impacts the final MS-DRG assignment.
MAJOR DIAG CAT	INIT Identifies the Major Diagnostic Category in which the DRG resides. Valid values are:
RETURN CODE	Identifies the status of the claim when it has returned from the Grouper program.
PROC CD USED	Identifies the procedure code used by the Grouper program for calculation.
DIAG CD USED	Identifies the primary diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	Identifies the secondary diagnosis code used by the Group program for calculation.

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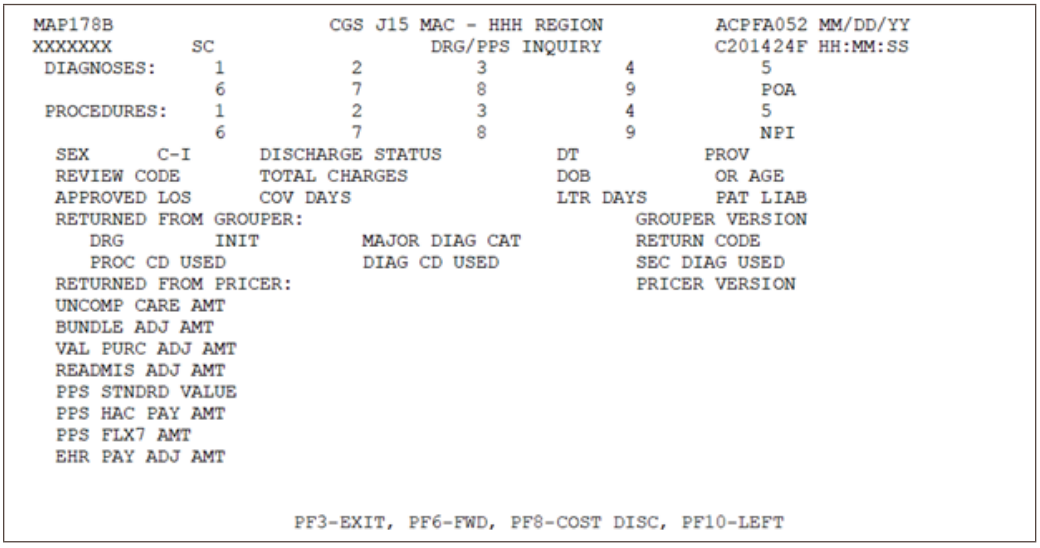
RETURN FROM PRICER:	
PRICER VERSION	The version of the Pricer program used.
RTN CD	The Return Code that identifies the status of the claim when is is returned from the Pricer program
WAGE INDEX	Identifies the providers' wage index factor for the state where the services were provided to determine reimbursement rates for the services provided.
OUTLIER DAYS	Identifies 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	Identifies the number of days of utilization permissible for the claim's DRG code. Day outlier payment is made when the length of stay exceeds the length of stay for a specific DRG plus the CMS-mandated adjustment calculation.
OUTLIER COST THRES	Identifies the Outlier Cost Threshold when the claim has extraordinarily high charges and does not qualify as a day outlier.
INDIRECT TEACHING ADJ#	The amount of adjustment calculated by the Pricer for teaching hospitals.
TOTAL BLENDED PAYMENT	The total PPC payment amount consisting of the Federal, hospital, outlier and indirect teaching portions.
HOSPITAL SPECIFIC PORTION	The hospital specific portion of the total blended payment.
FEDERAL SPECIFIC PORTION	The Federal specific portion of the total blended payment.
DISP# SHARE HOSPTIAL AMT	The percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also SSI.
PASS THRU PER DISCHARGE	The pass through per discharge cost.
OUTLIER PORTION	The dollar amount calculated that reflects the outlier portion of the charges.
PTPD + TEP	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 REIMB	The actual payment amount to the provider for this claim.

MAP178B – DRG/PPS Inquiry Screen



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MAP178B – The top half of the screen displays the same fields as MAP 1781; therefore the field descriptions below begin with the fields located under RETURNED FROM PRICER.

Map 178B Field Descriptions	
RETURN FROM PRICER:	
UNCOMP CARE AMT	Uncompensated Care Payment Amount. This amount is published by CMS to the MACs (by provider) entitled to an uncompensated care payment amount add on.
BUNLDE ADJ ATM	The adjustment amount for hospitals participating in the Bundled Payments for Care Improvement Initiative (BPCI) Model 1 (demo code 61).
VAL PURC ADJ AMT	The adjustment amount for hospitals participating in the Value Based Purchase Program.
READMIS ADJ AMT	The reduction adjustment for those hospitals participating in the Hospital Readmissions Reduction program.
PPS STNDRD VALUE	The final standardized amount.
PPS HAC PAY AMT	The Hospital Acquired Condition (HAC) payment reduction amount.
PPS FLX7 AMT	Reserved for future use.
EHR PAY ADJ AMT	The reduction adjustment amount for hospitals not meaningful users of EHR.

MAP1782 – DRG Cost Disclosure Inquiry

```
MAP1782              CGS J15 MAC - Part A REGION            ACMFA552 MM/DD/YY
 XXXXXXX                  DRG COST DISCLOSURE INQUIRY        C201821P HH:MM:SS
PVDR:                                                       VERSION:

D-DT: MMDDYY                                 FROM DT:          THRU DT:
 DRG       DSH FACTOR          IME FACTOR          IME RATIO         XIX     SSI
NUMBER  OPERATING CAPITAL  OPERATING CAPITAL  OPERATING CAPITAL  RATIO   RATIO
 - - -

  NEW        URBAN/              NUMBER     LOW-VOL          DSH      COUNTY
PROVIDER      RURAL              OF BEDS     PYMNT          RATIO      CODE


RELATIVE          OUTLIER DAY     OPERATING PAYMENT           CAPITAL PAYMENT
  WEIGHT   ALOS     CUTOVER         DSH        IME              DSH       IME

      OPERATING PAYMENT         CAPITAL PAYMENT         TOTAL PAYMENT



         PLEASE ENTER DATA  -  PRESS PF3 FOR DRG/PPS INQUIRY
```

Map 1782 Field Descriptions	
PVDR	**Identifies the provider number**
VERSION	Identifies the program version number of the Pricer program.
D – DT	This date identifies which Pricer version to obtain data from.
FROM DT	The provider's effective start date on the provider file.
THRU DT	The provider's end date on the provider file.
DRG NUMBER	The number identifying the specific Diagnosis Related Group (DRG).
DSH OPERATING FACTOR	The operating payment for hospitals serving a disproportionate share of low income patients.
DSH CAPITAL FACTOR	The capital payment for hospitals serving a disproportionate share of low-income patients.
IME OPERATING FACTOR	Identifies the actual IME add-on to operating federal payments.
IME CAPTIAL FACTOR	Identifies the actual IME add-on to operating federal payments.
IME OPERATING RATIO	Identifies the ratio of interns and residents to available beds.
IME CAPITAL RATIO	Identifies the Capital Indirect Medical Education Ration which is the ratio of interns and residents to the average daily census.

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Map 1782 Field Descriptions	
XIX RATIO	Identifies the ratio of Medicaid days to total days.
SSI RATIO	Identifies the supplemental security income ratio to covered days.
NEW PROVIDER	Identifies a new provider for capital prospective payment.
URBAN / RURAL	Identifies the type of location and is determined by the DRG Pricer
NUMBER OF BEDS	The number of hospital beds available for lodging inpatients.
LOW-VOL PYMNT	The low-volume payment amount calculated by the IPPS Pricer.
DSH RATIO	The disproportionate share adjustment percentage.
COUNTY CODE	The County Code.
RELATIVE WEIGHT	The relative weight of the DRG amount.
ALOS	The CMS predetermined length of stay based on certain claim data.
OUTLIER DAY CUTOVER	The cut off point for determining day outliers.
OPERATING PAYMENT DSH	The operating payment for those hospitals serving a disproportionate share of low-income patients.
OPERATING PAYMENT IME	The capital payment for indirect medical education.
CAPITAL PAYMENT DSH	The capital payment for hospitals serving disproportionate share of low-income patients.
CAPITAL PAYMENT IME	The capital payment for indirect medical education.
OPERATING PAYMENT	The accumulated FSP and HSP total amount for Operating Payments.
CAPITAL PAYMENT	The accumulated HSP, FSP and Harmless total amount for Capital Payments.
TOTAL PAYMENT	The total amount of payments.

MAP1783 – DRG Cost Disclosure Inquiry

```
MAP1783                CGS J15 MAC - Part A REGION            ACMFA552 MM/DD/YY
 XXXXXXX                    DRG COST DISCLOSURE INQUIRY         C201821P HH:MM:SS
PVDR:                                                         VERSION:

D-DT:                                        FROM DT:         THRU DT:
                    O P E R A T I N G   P O R T I O N
COST OUTLIER  CASE MIX  COST TO CHARGE  LOW-VOL  BLEND RATIO     BLEND RATIO
 THRESHOLD      INDEX       RATIO        PYMNT    TARGET/DRG       REG/NAT

  TARGET                   WAGE AMOUNT                   NON-WAGE AMOUNT
  AMOUNT            NATIONAL         REGIONAL         NATIONAL         REGIONAL

             WAGE    WAGE     NON WAGE FED                  TOTAL
            AMOUNT   INDEX     AMOUNT RATIO      AMOUNT     FEDERAL     TOTALS
FED REG
FED NAT
TOT FED
HOSPITAL AMOUNT
BLEND AMOUNT
HSA AMOUNT
HSA CALCULATION: (TARGET AMT - (TOT FED / OUTLIER * OPER DSH)) * HSA FCTR
DRG WT         HSA TOT
           BAD RETURN FROM PPS PRICER - PPS RETURN CODE:  52
           PRESS PF3 FOR DRG/PPS INQUIRY  PF7 FOR PREV PAGE  PF8 FOR NEXT PAGE
```

Map 1783 Field Descriptions	
PVDR	**Identifies the provider number**
VERSION	Identifies the program version number of the Pricer program.
D-DT	The date for which the DRG information is being selected.
FROM DT	The beginning date of service (MMDDYY format)
THRU DT	The ending date of service (MMDDYY format)
OPERATING PORTION	
COST OUTLIER THRESHOLD	The cost outlier threshold amount.

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Map 1783 Field Descriptions	
CASE MIX INDEX	The case mix index from the operating PPS base year.
COST TO CHARGE RATIO	The Cost to Charge ratio of operating costs to charges
LOW-VOL PYMNT	The low-volume payment amount calculated by the IPPS PRICER.
BLENDED RATIO TARGET/DRG	The ratio target amount used during operating PPS transition periods.
BLEND RATIO REG/NAT	The ratio DRG amount used during operating PPS transition periods
TARGET AMOUNT	The target amount (the updated specific rate). Used to determine Health Service Area (HAS) add-on amounts for sole community and Medicare dependents hospitals.
WAGE AMOUNT NATIONAL	The national wage-related rate used to determine the labor portion of the operating federal rate.
WAGE AMOUNT REGIONAL	The regional wage-related amount.
NON-WAGE AMOUNT NATIONAL	The national non-wage-related rate used to determine the labor portion of the operating federal rate.
NON-WAGE AMOUNT REGIONAL	The regional non-wage-related amount.
FED REG – WAGE AMOUNT	The regional wage-related amount.
FED REG – WAGE INDEX	The regional wage index as supplied by CMS to be used for the state in which the services were provided to determine reimbursement rates for services rendered.
FED REG – NON WAGE FED AMOUNT	The total Regional Non-Wage Federal amount.
FED REG – NON WAGE FED RATIO	The Non-Wage Federal Amount Ratio.
FED REG – AMOUNT	The Federal Regional amount.
FED REG – TOTALS	The Federal Regional total.
FED NAT – WAGE AMOUNT	The Federal National wage-related amount.
FED NAT – WAGE INDEX	The National Wage Index as supplied by CMS to be used for the state in which the services were provided to determine reimbursement rates for the services rendered.
FED NAT – NON WAGE FED AMOUNT	The National Non-Wage Federal total amount.
FED NAT – NON WAGE FED RATIO	The Non-Wage Federal Amount Ratio.
FED NAT – AMOUNT	The Federal National amount.
FED NAT – TOTALS	The Federal National total.
TOTAL FED – TOTALS	The accumulated amount by adding the Federal Regional Totals and the Federal National Totals.
HOSPITAL AMOUNT – AMOUNT	The hospital amount.
HOSPITAL AMOUNT – TOTALS	The hospital totals.
BLEND AMOUNT – TOTALS	The blended accumulated amount total by adding the Federal Regional Totals and the Federal National Totals.
HSA AMOUNT	The hospital rate amount.
HSA CALCULATION	Health Service Area (HAS) Calculation – (TARGET AMOUNT – (TOT FED / OUTLIER * OPER DSH)) * HAS FCTR
DRG WT	The payment weight of the Diagnosis Related Group (DRG).
HSA TOT	The total of the Health Service Area (HSA) amount multiplied by the DRG Weight.

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MAP1784 – DRG Cost Disclosure Inquiry

```
MAP1784                CGS J15 MAC - Part A REGION            ACMFA552 MM/DD/YY
 XXXXXXX                    DRG COST DISCLOSURE INQUIRY         C201821P HH:MM:SS
PVDR:                                                         VERSION:

D-DT:                                        FROM DT:         THRU DT:
                      C A P I T A L   P O R T I O N
                                                  LOW-VOL
COST OUTLIER THRESHOLD  COST TO CHARGE RATIO    PYMNT    PAYMENT METHODOLOGY

            GEOG   ADJUSTED   LARGE    BLEND    NEW       OLD       HOSPITAL
             ADJ   FEDERAL    URBAN    RATIO  CAPITAL   CAPITAL    SPECIFIC
          FACTOR    RATE     ADD-ON HOSP/FED  RATIO    PAYMENT      RATE



FEDERAL
HOSPITAL

                          TOTAL FEDERAL AMOUNT :
                          TOTAL HOSPITAL AMOUNT:
                          TOTAL :

          BAD RETURN FROM PPS PRICER - PPS RETURN CODE:  52
          PRESS PF3 FOR DRG/PPS INQUIRY  PF7 FOR PREV PAGE  PF8 FOR NEXT PAGE
```

Map 1784 Field Descriptions	
PVDR	**Identifies the provider number**
VERSION	Identifies the program version number of the Pricer program.
D-DT	The date for which the DRG information is being selected.
FROM DT	The beginning date of service (MMDDYY format)
THRU DT	The ending date of service (MMDDYY format)
CAPITAL PORTION	
COST OUTLIER THRESHOLD	The cost outlier threshold amount, which is the standard operating threshold for computing cost outlier payments.
COST TO CHARGE RATIO	The Cost to Charge ratio of operating costs to charges.
LOW-VOL PYMT	The Low-Volume Payment amount calculated by the IPPS Pricer.
PAYMENT METHODOLOGY	The capital PPS payment methodology based on the value of the PPS Pay Code. Valid values are: **A –** Hold Harmless **B –** Hold Harmless Fed **C –** Fully Prospective
GEOG ADJ FACTOR	The Geographical Adjustment Factor used to adjust the capital federal rate, based on the applicable wage index.
ADJUSTED FEDERAL RATE	The base adjusted federal capital rate.
LARGE URBAN ADD-ON	The federal rate applicable to those hospitals located in a large urban SMSA.
BLEND RATION HOSP/FED	The blended ratio of the Hospital Specific Rate (HSA) and the Federal Rate used to compute capital payments under PPS.
NEW CAPITAL RATIO	The capital to total capital and is applicable for hospitals being reimbursed under the hold harmless payment method for capital.
OLD CAPITAL PAYMENT	The old capital cost per discharge as provided by the hospital or as provided by the latest filed cost report under capital PPS and is applicable for those hospitals being reimbursed under the hold harmless payment method for capital.
HOSPITAL SPECIFIC RATE	The capital base period cost per discharge updated to applicable fiscal year-end.
FEDERAL HOSPITAL	
TOTAL FEDERAL AMOUNT	The Total Federal amount.
TOTAL HOSPITAL AMOUNT	The Total Hospital amount
TOTAL	The total Federal and Hospital amounts.

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MAP1785 – DRG Cost Disclosure Inquiry

```
MAP1785              CGS J15 MAC - Part A REGION          ACMFA552 MM/DD/YY
 XXXXXXX                  DRG COST DISCLOSURE INQUIRY      C201821P HH:MM:SS
PVDR:                                                     VERSION:

D-DT:                                      FROM DT:       THRU DT:

 BM1 %                                  BASE OPER DRG AMT
 BPCI DEMO CODE 1                       OPER HSP AMT
 BPCI DEMO CODE 2                       VBP IND
 BPCI DEMO CODE 3                       VBP ADJ
 BPCI DEMO CODE 4                       HRR IND
 HAC RED IND                            HRR ADJ
 EHR RED IND
 UNCOMP CARE AMT

            PRESS PF3 FOR DRG/PPS INQUIRY  PF7 FOR PREV PAGE
```

Map 1785 Field Descriptions	
PVDR	Identifies the provider number
VERSION	Identifies the program version number of the Pricer program.
D-DT	The date for which the DRG information is being selected.
FROM DT	The beginning date of service (MMDDYY format)
THRU DT	The ending date of service (MMDDYY format)
BM1%	The Bundle Model 1 Discount Percentage.
BASE OPER DRG AMT	The Base Operating DRG Payment Amount. This is the amount a hospital would normally receive for the discharge of a Medicare patient.
BPCI DEMO CODE 1	The Bundled Payment for Care Improvement Indicator. Valid values are: 61 – Bundled Payment for Care Model 1 62 - Bundled Payment for Care Model 2 63 - Bundled Payment for Care Model 3 64 - Bundled Payment for Care Model 4
OPER HSP AMT	The Operating HSP (Hospital Specific Payment) DRG amount.
BPCI DEMO CODE 2	The Bundled Payment for Care Improvement Indicator. Valid values are: 61 – Bundled Payment for Care Model 1 62 - Bundled Payment for Care Model 2 63 - Bundled Payment for Care Model 3 64 - Bundled Payment for Care Model 4
VBP IND	The Value Based Pricing Indicator.
BPCI DEMO CODE 3	The Bundled Payment for Care Improvement Indicator. Valid values are: 61 – Bundled Payment for Care Model 1 62 - Bundled Payment for Care Model 2 63 - Bundled Payment for Care Model 3 64 - Bundled Payment for Care Model 4
VBP ADJ	The Value Based Pricing Adjustment.
BPCI DEMO CODE 4	The Bundled Payment for Care Improvement Indicator. Valid values are: 61 – Bundled Payment for Care Model 1 62 - Bundled Payment for Care Model 2 63 - Bundled Payment for Care Model 3 64 - Bundled Payment for Care Model 4
HRR IND	The Hospital Readmission Reduction (HRR) Program Indicator.
HAC RED IND	Reserved for future use. Valid values for IPPS. Blank – Hospital Acquired Condition Reduction Program – Non PPS N – Hospital Acquired Condition Reduction Program - PPS
HRR ADJ	The Hospital Readmission Reduction (HRR) Adjustment.

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Map 1785 Field Descriptions	
EHR RED IND	**The Electronic Health Record Adjustment Reduction Indicator for provides that are subject to claim adjustments when the provider does not meet the guidelines for use of EHR technology.**
UNCOMP CARE AMT	The Uncompensated Care Payment Amount. This is the amount published by CMS for MACs (by provider) entitled to an uncompensated care payment amount add on. The MACs enter the amount for each Federal Fiscal year begin date based on published information.

Claims (Option 12)

You will use this option often because it allows access to a variety of claim processing information. The following provides instructions on how to:

- Check the status of your billing transactions / beneficiary claim history
- Check for Additional Development Requests (ADRs)
- View line item denial information

1. From the Inquiry Menu, type ***12*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                    CGS J15 MAC - Part A REGION    ACPFA052 MM/DD/YY
XXXXXX                      INQUIRY MENU                  C20112WS HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE            19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY   1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY      56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS  67

      HCPC CODES               14    ANSI REASON CODES        68

      DX/PROC CODES ICD-9      15    CHECK HISTORY            FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10     1B

      REASON CODES             17    CMHC PAYMENT TOTALS      1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER  1D

                                     NEW HCPC SCREEN          1E


   ENTER MENU SELECTION: 12


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

2. The Claim Summary Inquiry screen (Map 1741) appears:

```
MAP1741                  CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
XXXXXX    SC             CLAIM SUMMARY INQUIRY              C20112WS HH:MM:SS
                            NPI
      MID                PROVIDER                S/LOC     TOB
  OPERATOR ID XXXXXX     FROM DATE       TO DATE         DDE SORT
  MEDICAL REVIEW SELECT           DCN           DCN
    MID           PROV/MRN  S/LOC     TOB    ADM DT FRM DT THRU DT REC DT
SEL  LAST NAME  FIRST INIT TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS




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

You can use the following function keys to move within the Claim Summary Inquiry screen and within the different claim pages:

- F3 – Exit (return to the Inquiry Menu)
- F5 –Scroll back through a list of claims or revenue code pages

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- F6 – Scroll forward through a list of claims or revenue code pages
- F7 – Move one claim page back
- F8 – Move one claim page forward
- F10 – Move to the left page F11 – Move to the right page

Shift+Tab– Move from the right to left in valid fields (ex. Move from the HIC field to the NPI field)

Checking the Status of Your Claims/Beneficiary Claim History

When the Claim Summary Inquiry screen displays, your cursor will be located in the MID field. However, to check the status of claims, you must first enter your facility's NPI. Therefore, to move the cursor to the NPI field, hold down the Shift key and press the Tab key. You cursor will automatically move to the NPI field.

There are two primary ways that you can view the status of your claims using option 12: by beneficiary's HICN, or by status/location within FISS.

1. **To view information using a beneficiary Medicare number,** follow these instructions:

   a. Type your facility's NPI number in the **NPI** field.

   b. Type the beneficiary's Medicare ID number in the **MID** field. Press ***Enter***.

```
 MAP1741                  CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
 XXXXXX    SC           CLAIM SUMMARY INQUIRY               C20112WS HH:MM:SS
                           NPI XXXXXXXXXX
       MID XXXXXXXXX    PROVIDER              S/LOC         TOB
  OPERATOR ID XXXXXX    FROM DATE       TO DATE           DDE SORT
  MEDICAL REVIEW SELECT          DCN
    MID            PROV/MRN   S/LOC     TOB   ADM DT FRM DT THRU DT  REC DT
SEL LAST NAME   FIRST INIT  TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS




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

Only the billing transactions that your facility submitted under the beneficiary's Medicare ID number and NPI will display. You will not have access to claims submitted by other providers.

   c. After you press ***Enter***, FISS will search and display all claims submitted by your facility for that specific beneficiary. A maximum of 5 claims will display. If 5 claims display, press your F6 key to scroll forward to see if there are additional claims.

```
 MAP1741                   CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
 XXXXXX    SC           CLAIM SUMMARY INQUIRY                C20112WS HH:MM:SS
                           NPI XXXXXXXXXX
       MID XXXXXXXXXX    PROVIDER              S/LOC         TOB
  OPERATOR ID XXXXXX     FROM DATE       TO DATE           DDE SORT
  MEDICAL REVIEW SELECT          DCN
    MID            PROV/MRN   S/LOC     TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS
 XXXXXXXXXX   XXXXXX          P B9997   131   0817XX 0817XX 0817XX   0902XX
  SMITH              J              684.00   0908XX 1030XX  37185

 XXXXXXXXXX   XXXXXX          P B9997   131   0817XX 0817XX 1015XX   1019XX
  SMITH              J     1089.00  1140.00   1030XX         37185




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

If no claims appear after you press Enter, check the Medicare number to ensure it is entered correctly. You may need to verify whether the Medicare number was changed by accessing the beneficiary's eligibility information.

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When the information appears, you will see a two-line summary of each claim's information. To see more detail, you can select a specific claim, which will provide six pages of complete claim information. Additional pages will display when a claim has been selected for Medical Review and requires additional information be submitted via the ADR process.

d. To select a claim, press your Tab key until your cursor moves under the **SEL** field and is to the left of the Medicare number of the claim detail you want to view. Type ***S*** in the **SEL** field and press ***Enter***. You can only select one claim at a time.

```
  MAP1741              CGS J15 MAC - Part A REGION                ACPFA052 MM/DD/
YY
  XXXXXX    SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                               NPI XXXXXXXXXX
        MID XXXXXXXXXX     PROVIDER                S/LOC          TOB
   OPERATOR ID XXXXXX      FROM DATE          TO DATE           DDE SORT
   MEDICAL REVIEW SELECT           DCN
     MID              PROV/MRN    S/LOC      TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT   TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
S XXXXXXXXXX   XXXXXX            P B9997    131    0817XX 0817XX 0817XX    0902XX
   SMITH                J                684.00    0908XX 1030XX  37185



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

Note in the above example that the cursor is one space away from (or to the left of) the Medicare number of the claim detail you want to select. If the cursor is immediately next to the Medicare number (_123… instead of _ 123), the cursor is not in the correct position.

e. Page 01 of the "Inst Claim Inquiry" screen appears. You may view all pages of the claim by pressing the F7 and F8 function keys to page back and page forward through the claim. Refer to the following page for an example of page 01 of the claim.

Claim Example

```
MAP1711   PAGE 01         CGS J15 MAC - Part A REGION            ACPFA052 MM/DD/YY
XXXXXX    SC                  INST CLAIM INQUIRY                 C20112WS HH:MM:SS
  MID XXXXXXXXXX     TOB XXX   S/LOC P B9997 OSCAR XXXXXX       SV:   UB-FORM
NPI XXXXXXXXXX TRANS HOSP PROV                  PROCESS NEW MID
PAT.CNTL#:                        TAX#/SUB:                TAXO.CD:
  STMT DATES FROM 0817XX  TO 1015XX  DAYS COV      N-C       CO      LTR
  LAST SMITH                    FIRST JAMES          MI E  DOB 01011931
  ADDR 1 101 MAIN ST                  2 ANYTOWN, IA
  3                                4                                CARR:
  5                                6                                 LOC:
ZIP 520012233 SEX M MS   ADMIT DATE 0817XX HR 01 TYPE 9 SRC 1 D HM      STAT 30
  COND CODES  01    02    03    04    05    06    07    08    09    10
OCC CDS/DATE  01          02          03          04          05
              06          07          08          09          10
  SPAN CODES/DATES  01                02                03
04                  05                06                07
08                  09                10                FAC.ZIP 52111
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 61    99916.00         02                     03
04                        05                     06
07                        08                     09
37186                                                  <== REASON CODES
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

f. After reviewing the claim, press F3 to return to the claim list (Map 1741). You can select a different claim, start a new search, or press F3 to return to the Inquiry Menu.

When you view claims within option 12, it is an "inquiry-only" option. You cannot enter, correct, adjust or cancel claims within option 12. You can only view the claim information. To enter, correct, adjust, and cancel claims, you must use other options in FISS.

2. **To view claims by a status code or by a status and location,** follow these steps.

a. On Map 1741, type your facility's NPI number in the **NPI** field. To move the cursor from the MID field to the NPI field, hold down the Shift key and press the Tab key.

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b. Tab to the **S/LOC** field and type the status code or the status/location that you wish to view and press ***Enter***. You may, for example, want to view claims that are on the payment floor (P B9996). Note that FISS automatically inserts one space between the status and the location codes.

When you view claims by status/location code, you will most likely be inquiring about claims in the following status/locations:

Status/Location	Description
P B9996	Payment floor
P B9997	Processed or paid claim
D B9997	Denied claim
R B9997	Rejected claim
T B9997	Claim needing correction
S B6001	Claim selected for an additional development request (ADR)

Any status/location code that appears on a claim can be entered into the S/LOC field. Entering the status/location in the S/LOC field enables you to see all the claims in that particular area of FISS.

```
MAP1741                CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
XXXXXX   SC              CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
      MID                PROVIDER                S/LOC P B9996 TOB
  OPERATOR ID XXXXX      FROM DATE          TO DATE          DDE SORT
  MEDICAL REVIEW SELECT            DCN
      MID             PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT  REC DT
 SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

For information about FISS status and location codes, refer to "About Status/Location Codes" found in Chapter 1 of this guide.If there are claims in the status/location that you entered, they will appear on Map 1741 after you press ***Enter***. There may be multiple beneficiaries listed. This is normal since the common element you are inquiring about is the status code or status/location code. When you search by a beneficiary's Medicare number, you are inquiring about that particular beneficiary; therefore, multiple beneficiaries will not be listed; however, multiple claims may display.

```
 MAP1741                  CGS J15 MAC -Part A REGION            ACPFA052 MM/DD/YY
 XXXXXX   SC               CLAIM SUMMARY INQUIRY                C20112WS HH:MM:SS
                                NPI XXXXXXXXXX
       MID               PROVIDER                S/LOC P B9996  TOB
  OPERATOR ID XXXXXX     FROM DATE          TO DATE          DDE SORT
  MEDICAL REVIEW SELECT           DCN
     MID             PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
  XXXXXXXXXXX   XXXXXX            P B9996     131  0726XX 0726XX 0923XX   1001XX
   SMITH                A     1600.00    1304.00  1015XX         37186

  XXXXXXXXXX   XXXXXX              P B9996     131  0730XX 0730XX 0927XX   1001XX
   WHITE                J     1200.00    1216.00  1015XX         37186

  XXXXXXXXXX   XXXXXX              P B9996     131  0810XX 0810XX 1008XX   1009XX
   JONES                S     1800.00    1296.00  1023XX         37186




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

c. You can view individual claims by typing S in the SEL field next to the Medicare number of the individual claim.

Map 1741 will display a maximum of 5 claims at any given time. To see if there are additional claims, press your F6 key to scroll forward.

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Claim Status Inquiry Examples

When you are inquiring about specific information, whether it is specific beneficiary claims history information or specific status/location code information, you can tailor your search using one or more additional fields. In addition to entering your NPI, a Medicare number and S/LOC, you can enter data in the **TOB** (type of bill), **FROM DATE**, and **TO DATE** fields (circled and bolded below) to further narrow your search.

```
 MAP1741                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
  XXXXXX   SC               CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                                 NPI
        MID                PROVIDER                 S/LOC            TOB
  OPERATOR ID              FROM DATE                TO DATE        DDE SORT
  MEDICAL REVIEW SELECT              DCN
     MID            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

1. **Type of Bill (TOB)**
   You can narrow the search of a beneficiary's claims by entering a type of bill (TOB). For example, to review outpatient final claims submitted for a beneficiary, type your facility's NPI in the **NPI** field; the beneficiary's Medicare number in the **MID** field; and the home health type of bill code 131 in the **TOB** field.

```
 MAP1741                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
  XXXXXX   SC               CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                                 NPI NNNNNNNNNN
       MID NNNNNNNNNA    PROVIDER                 S/LOC          TOB 131
  OPERATOR ID            FROM DATE              TO DATE        DDE SORT
  MEDICAL REVIEW SELECT              DCN
     MID            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

To search for a beneficiary's claims for specific dates of service **and** specific type of bill, type your facility's NPI, the beneficiary's HICN, the type of bill, and the "from" and "to" dates. Entering a status code or status/location will further narrow your search. (See example below).

```
 MAP1741                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
  XXXXXX   SC               CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                                 NPI NNNNNNNNNN
       MID NNNNNNNNNA    PROVIDER                 S/LOC          TOB 131
  OPERATOR ID            FROM DATE 080113       TO DATE 093013   DDE SORT
  MEDICAL REVIEW SELECT              DCN
     MID            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

It is a good idea to "refresh" your screen between different searches. Do this by pressing F3 to exit option 12. Then type ***12*** in the **Enter Menu Selection** field and press ***Enter***.

2. **From/To Date**
   If the beneficiary has an extensive claim history, you can narrow your search by adding from and to dates. These dates reflect the "from" and "to" dates of service billed on the claim. You may search by only using a "from" date, or both a "from" and "to" date. The "to" date can only be used if a "from" date is also entered. For example, to find claims with dates of service between August 1, 2017, to September 30, 2017, for a particular beneficiary, type your facility's NPI in the **NPI** field, the Medicare number in the **MID** field, and type ***080117*** in the **FROM DATE** field and 093017 in the **TO DATE** field and press ***Enter***.

The top of the next page is an example of how this would appear before pressing ***Enter***.

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```
 MAP1741                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
  XXXXXX   SC               CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                                 NPI NNNNNNNNNN
       MID NNNNNNNNNA   PROVIDER                  S/LOC              TOB
  OPERATOR ID           FROM DATE 080117       TO DATE 093017     DDE SORT
  MEDICAL REVIEW SELECT                DCN
     MID            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

You may also use the **FROM DATE** field when searching for claims in a specific status/location. The example below shows how to access claims that were fully denied (D B9997) with dates of service on and after October 1, 2017, type the status/location D ***B9997*** in the **S/LOC** field, type ***100117*** in the **FROM DATE** field and leave the **TO DATE** field blank.

```
 MAP1741                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
  XXXXXX   SC               CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                                 NPI NNNNNNNNNN
       MID NNNNNNNNNA   PROVIDER                S/LOC D B9997      TOB
  OPERATOR ID           FROM DATE 080117       TO DATE          DDE SORT
  MEDICAL REVIEW SELECT                DCN
     MID            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

Accessing Additional Development Request (ADR) Information

When claims are selected by Medical Review, CGS will request additional documentation from the provider to support the services being billed to Medicare. This request is called the Additional Development Request (ADR)

NOTE: The CMS Medicare Program Integrity Manual, Pub. 100-08, Ch. 3, Section 3.2.3.2 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf) requires providers to submit ADR documentation to CGS by day 30. If the documentation is not received timely, the claim will be denied.

The following pages explain how you can identify claims that CGS has requested additional documentation for, what documentation is being requested, and most importantly, the due date for when the ADR information must be received.

- Please refer to the "Key ADR Information" that follows these instructions. This information will help you avoid claim denials.

Identifying Claims Selected for ADR

You can easily see if claims are selected for ADR by accessing the Inquiry Menu and selecting option 12 (Claim Summary). Claims selected for ADR will appear in status/location S B6001.

CGS recommends that you check the ADR status/location (S B6001) at least once per week to help ensure timely responses.

1. On Map 1741, type your facility's NPI number in the **NPI** field. To move the cursor to the NPI field, hold down the Shift key and press the Tab key.
2. Tab to the **S/LOC** field and type S B6001. Press ***Enter***. If there are claims in the S B6001 status/location, they will appear after you press ***Enter***.

```
 MAP1741                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/
YY
  XXXXXX   SC               CLAIM SUMMARY INQUIRY                  C20112WS HH:MM:SS
                                 NPI NNNNNNNNNN
       MID              PROVIDER                S/LOC D B6001      TOB
  OPERATOR ID           FROM DATE              TO DATE          DDE SORT
  MEDICAL REVIEW SELECT                DCN
     MID            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

3. To identify the additional information being requested for each claim, you must select the

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claim by typing an S in the **SEL** field next to the Medicare number of the claim. Press ***Enter***. You can only select one claim at a time.

```
 MAP1741                CGS J15 MAC -Part A REGION              ACPFA052 MM/DD/YY
 XXXXXX    SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                                NPI XXXXXXXXXX
       MID              PROVIDER                  S/LOC S B6001  TOB
  OPERATOR ID XXXXXX     FROM DATE          TO DATE           DDE SORT
  MEDICAL REVIEW SELECT           DCN
    MID             PROV/MRN     S/LOC      TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT  CHG    PROV REIMB  PD DT  CAN DT REAS NPC #DAYS
  NNNNNNNNA     XXXXXX             S B6001     XXX   1204XX  1204XX 0119XX   0212XX
   LASTNAME               M     1700.00                                39700

S NNNNNNNNA     XXXXXX             S B6001     XXX   1025XX  1025XX 1110XX   0212XX
   LASTNAME               J      300.00                                39700

  NNNNNNNNA     XXXXXX             S B6001     XXX   1115XX  1115XX 1215XX   0212XX
   LASTNAME               R      336.00                                39700

  NNNNNNNNA     XXXXXX             S B6001     XXX   1019XX  1019XX 1217XX   0212XX
   LASTNAME               T     1000.00                                39700



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

4. Page 01 of the claim appears (Map 1711).

```
MAP1711  PAGE 01        CGS J15 MAC -Part A REGION              CPFA052 MM/DD/YY
XXXXXX    SC               INST CLAIM INQUIRY                  C20112WS HH:MM:SS
 MID 444555666A    TOB XXX  S/LOC S B6001 OSCAR XXXXXX          SV:    UB-FORM
NPI NNNNNNNNNNN TRANS HOSP PROV                  PROCESS NEW MID
PAT.CNTL#:                      TAX#/SUB:                 TAXO.CD:
 STMT DATES FROM 1025XX  TO 1110XX  DAYS COV      N-C       CO      LTR
 LAST SMITH                     FIRST JAMES          MI E  DOB 01011931
 ADDR 1 101 MAIN ST                      2 ANYTOWN, IA
 3                                4                                CARR:
```

5. ADR information is electronically attached to the end of the claim, as pages 07 and 08. To view the ADR information, type 07 in the **PAGE** field (if your cursor is not already in this field, press the HOME button found on your keyboard) and press ***Enter***.

The **"ORIG REQ DT"** field on **Page 07** indicates the date CGS requested the additional information. Page 07 also identifies the address to which your documentation should be mailed.

The **"DUE DATE"** field is 45 days from the original request date (**ORIG REQ DT**). Documentation not received by day 46 will result in the claim being denied.

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Example: FISS Page 07

```
REPORT: 001                MEDICARE PART A 15XXX        PVDR NO  : XXXXXXXXXX
 DATE  : MM/DD/CCYY   ADDITIONAL DOCUMENTATION REQUEST    BILL TYPE: XXX
 CASE ID: 15004XXXXXXXXXXXXXXPAR0PR     MAC JURIS:     NPI:
                  ANYNAME HEALTH CENTER
                  1111 MAIN ST
                  ANYTOWN            IA 52001 1111

 WE HAVE REVIEWED THIS CLAIM RECORDS AND FOUND THAT ADDITIONAL DEVELOPMENT
 WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED.  TO ASSIST YOU IN
 PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE
 AFFECTED CLAIM RECORD (SEE BELOW)FOR YOUR REVIEW.  PLESAE REFER TO THE
 ACCOMPANYING LIST FOR EXPLANATION OF THE ASSIGNED CODES.  SOLICITED LETTERS
 CAN BE ANY ADR LETTERS AT CONTRACTORS' DISCRETION, AND NOT SOLEY FOR
                  CGS J15 MAC
                  J15 - HHH CORRESPONDENCE
                  P O BOX 20014
                  NASHVILLE            TN 37202
 PATIENT CNTRL NBR: XXXXXX-XXXXXX       DUE DATE: MM/DD/CCYY
 MEDICAL REC NO:                   DCN: XXXXXXXXXXXXXXPAR
 MEDICARE ID: XXXXXXXXXX     PATIENT NAME: JAMES        SMITH
 FROM DATE: XX/XX/XXXX  THRU DATE: XX/XX/XXXX  OPR/MED ANALYST:
 TOTAL CHARGES:      1000.00     ORIG REQ DT: MM/DD/CCYY  CLM RCPT DT: XX/XX/XXXX
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

Press ***F6*** to view the entire message. Press ***F5*** to scroll backward.

```
REPORT: 001                MEDICARE PART A 15004        PVDR NO  : XXXXXXXXXX
 DATE  : MM/DD/CCYY   ADDITIONAL DOCUMENTATION REQUEST    BILL TYPE: XXX
 CASE ID: 15004XXXXXXXXXXXXXXPAR0PR     MAC JURIS:     NPI:
                  ANYNAME HEALTH CENTER
                  1111 MAIN ST
                  ANYTOWN            IA 52001 1111

  MEDICAL REVIEW. WE MUST RECEIVE THE REQUESTED INFORMATION BEFORE THE DUE
  DATE LISTED BELOW, OR THE CLAIM WILL BE DENIED LACK OF RESPONSE. CONTRACTOR
  ACCEPTS SOLICITED DOCUMENTATION VIA THE MYCGS PORTAL ON THE CGS WEBPAGE,
  ELECTRONIC SUBMISSION OF MEDICAL DOCUMENTATION (ESMD); FOR MORE
  INFORMATION ABOUT ESMD, SEE WWW.CMS.GOV/ESMD. OR FAX YOUR RESPONSE TO:
  615-660-5981 OR MAIL YOUR RESPONSE TO THE ATTENTION OF:
                   CGS J15 MAC
                   J15 - HHH CORRESPONDENCE
                   P O BOX 20014
                   NASHVILLE            TN 37202
PATIENT CNTRL NBR: XXXXXX-XXXXXX       DUE DATE: MM/DD/CCYY
 MEDICAL REC NO:                   DCN: XXXXXXXXXXXXXXPAR
 MEDICARE ID: XXXXXXXXXX     PATIENT NAME: JAMES        SMITH
 FROM DATE: XX/XX/XXXX  THRU DATE: XX/XX/XXXX  OPR/MED ANALYST:
 TOTAL CHARGES:      1000.00     ORIG REQ DT: MM/DD/CCYY  CLM RCPT DT: XX/XX/XXXX
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

6. To determine what documentation is being requested, press your F8 key to review the reason code narrative on FISS Page 08. The edit that the claim was selected for will appear in the upper left hand corner in the REASONS: field. Refer to the following page for an example of FISS Page 08.

You may need to press ***F6*** to see the remaining reason code narrative that identifies the documentation that you need to submit. Press F5 to go back.

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Example: FISS Page 08

```
REASONS: 59BX9
REASON CODE NARRATIVES FOR MID/DCN: NNNNNNNNNA XXXXXXXXXXXXXXXXR

59BX9 MEDICARE NEEDS TO RECEIVE THE RETURNED ADR INFORMATION BY THE 30TH DAY.
      THIS ALLOWS FOR MAIL TIME AND FOR US TO MOVE THE CLAIM INTO THE MEDICAL
      REVIEW STATUS/LOCATION SM50MR BY DAY 45 OR IT WILL BE DENIED WITH REASON
      CODE 56900 ON THE 46TH DAY. SEND THE FOLLOWING CHECK-LIST OF INFORMATION
      TO SUPPORT THE TERMINAL ILLNESS AND SERVICES BILLED:
      *INITIAL ASSESSMENT,ALL VISIT NOTES
      *PLAN OF CARE/CHANGES AND INTERDISCIPLINARY GROUP NOTES,
      *PHYSICIAN ORDERS AND VISIT NOTES
      *HOSPITAL DISCHARGE AND/OR PHYSICIAN SUMMARIES
      *HISTORY AND PHYSICAL EXAM, LAB, X-RAY, AND/OR SURGICAL REPORTS
      *SIGNED/DATED: CERTIFICATION, TRANSFER, REVOCATIONS
      *ANY PERTINENT INFORMATION PRIOR TO/AFTER THIS BILLING PERIOD
      *DATES AND TIMES OF SERVICE CHANGES, WHEN BILLING MULTIPLE LEVELS OF CARE
      *THE BENEFICIARY SIGNED AND DATED HOSPICE ELECTION STATEMENT.
      * SIGNED AND DATED HHABN OR NOTICE OF NON-COVERAGE IF ONE WAS ISSUED TO THE
      BENEFICIARY
      THIS EDIT SELECTS CLAIMS DUE TO PREVIOUS DENIALS FOR THIS BENEFICIARY.
      MEDICARE REQUIRES THAT MEDICAL RECORD ENTRIES FOR SERVICES PROVIDED/ORDER
      BE AUTHENTICATED BY THE AUTHOR.  THE METHOD USED SHALL BE A HANDWRITTEN ON
      AN ELECTRONIC SIGNATURE.  PATIENT IDENTIFICATION, DATE OF SERVICE, AND
```

Press ***F6*** to see the remaining reason code narrative that identifies the documentation that you need to submit.

```
REASONS: 59BX9

REASON CODE NARRATIVES FOR MID/DCN: NNNNNNNNNA XXXXXXXXXXXXXXXPAR

     PROVIDER OF THE SERVICE/ORDER MUST BE CLEARLY AND LEGIBLY IDENTIFIED ON
     THE SUBMITTED DOCUMENTATION.
     THE DOCUMENTATION YOU SUBMIT IN RESPONSE TO THIS REQUEST SHOULD COMPLY
     WITH THESE REQUIREMENTS.  IF YOU QUESTION THE LEGIBILITY OF ANY SIGNATURE
     YOU MAY SUBMIT AN ATTESTATION STATEMENT OR SIGNATURE LOG WITH YOUR ADR
     RESPONSE. FOR MORE INFORMATION SEE THE MLN MATTERS ARTICLE MM6698 WMIDH CAN
     BE FOUND AT WWW.CMS.HHS.GOV/MLNMATTERSARTICLES.
     OMB CONTROL #: XXXX-XXXX
```

To go back to FISS Page 07, press your F7 key.

7. **Make a copy of Page 07 and attach it to the top page of your medical record documentation.** This ensures that the documentation will be matched with the correct claim. Mail it to the address listed on Page 07 as soon as possible. Another option is to submit your ADR documentation by using the myCGS Portal (https://www.cgsmedicare.com/parta/pubs/news/2015/0415/cope28413.html).

You may also want to keep a printed a copy of pages 07 and 08 (reason code narrative) as a reference of what was requested and to document when you submitted the information. Pages 07 and 08 will no longer display after the documentation is received and the claim is moved from status/location S B6001 to S M50MR. For information on how to screen print FISS claim pages, refer to the FISS Overview chapter of this guide.

8. Press ***F3*** to exit back to Map 1741 or press ***F7*** to move back through the claim pages. If you have additional claims in the ADR status/location, you must select each claim individually to determine what documentation needs to be submitted to CGS and by what date.

You may want to "refresh" your screen to ensure accurate information displays. Press ***F3*** to exit option 12. Then type ***12*** in the **Enter Menu Selection** field and press ***Enter***. Retype your NPI and the status/location ***S B6001*** in the **S/LOC** field.

You are responsible for checking your claims to see if they are in the ADR status/location, as this is the only notification you will receive regarding your claims that have been selected for Medical Review by CGS. In addition, you should keep track of the claims for which you have submitted ADR documentation.

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Key ADR Information

- **CMS requires providers to submit ADR documentation to CGS by day 30.** However, CGS must receive and process the additional information by the 45th day after the date of request (Orig Req Dt) shown on FISS Page 07.
- Make a copy of Page 07 and attach it to the top page of your medical record documentation. Mail the documentation to the address that appears on FISS Page 07.
- Once received by CGS, the documentation is scanned into the Optical Character Recognition (OCR) software, and CGS staff will move the claim from status/location S B6001 into status/location S M50MR pending review of the documentation.
- If CGS does not receive the requesteds information by day 45, the claim will automatically deny on day 46 and move to status/location D B9997 with reason code 56900 and your only recourse for Medicare payment is to request a Reopening. Refer to the Reopenings Web page for additional information (http://www.cgsmedicare.com/parta/appeals/reopenings.html).

NOTE: If the documentation was received timely (by day 45), but the claim automatically denied on day 46, CGS will proceed with reviewing the documentation, and there is no need to request a Reopening.

- CGS's review of your documentation can take up to 60 days from when the documentation was received. Once the review is completed, the claim is moved to status/location S M5CLM for additional processing.
- **Missing or Illegible Signature Documentation:** If, during review of your documentation, it is determined that a signature is missing or illegible, the claim will be re-ADRd to status/location S B6001. Page 08 will show the **Reasons** field with 5ADR2, and the narrative will indicate that additional documentation is required to support the signatures. The **Remarks** field on FISS Page 04 will specify the documentation being requested. **The additional signature documentation must be sent to CGS within 15 days of the request.**
- You may choose to submit documentation electronically. See the esMD (http://www.cgsmedicare.com/parta/pubs/news/2012/0312/288.html) article for more information about electronic submission of documentation. Documentation can also be submitted through the CGS Web Portal, myCGS. Refer to the myCGS User Manual, Chapter 7 at https://www.cgsmedicare.com/pdf/mycgs/chapter7_parta.pdf for additional information.

Map 171A field descriptions can be found later in this chapter, directly following the field descriptions for Map 1741.

Field Descriptions for Option 12 – Claims

Map 1741 Screen Example

```
MAP1741                  CGS J15 MAC Part A REGION            ACMFA552 XX/XX/XX
 XXXXXXX   SC              CLAIM SUMMARY INQUIRY              C201821P XX:XX:XX
                                NPI
       MID               PROVIDER               S/LOC          TOB
  OPERATOR ID XXXXXXX    FROM DATE          TO DATE           DDE SORT
  MEDICAL REVIEW SELECT          DCN
      MID            PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
 SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS




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


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Map 1741 Field Descriptions	
NPI	National provider identifier.
MID	The beneficiary's Medicare number.
PROVIDER	Not applicable.
S/LOC	Status and location code assigned to the claim by FISS.
TOB	The type of bill submitted on the CMS-1450 claim form. The first two positions are required for a search. The third position is optional.
OPERATOR ID	Identifies the operator ID utilizing the screen.
FROM DATE	"From" date of service (MMDDYY format).
TO DATE	"Through" date of service (MMDDYY format).
DDE SORT	This field is not functional through the Inquiry Menu. Refer to the Claims Corrections chapter of this guide for more information.
MEDICAL REVIEW SELECT	Not in use.
DCN	The claim document control number. This field can be used in conjunction with the Invoice NO/DCN Trans, Option 88 on the Inquiry Menu screen.
First Line of Data	
MID	The beneficiary's Medicare ID number.
PROV/MRN	Medicare provider number assigned to your facility.
S/LOC	Status/location. This code is assigned to the claim by FISS. Refer to Chapter 1 of this guide for additional information.
TOB	Type of bill. The type of bill code submitted on the CMS-1450 claim form.
ADM DT	Admission date. The date the beneficiary was admitted for care.
FRM DT	"From" date of service (MMDDYY format).
THRU DT	"Through" date of service (MMDDYY format).
REC DT	Received date. The date CGS originally received the claim or the date the claim was corrected from the Return to Provider (RTP) file.
Second Line of Data	
SEL	Selection. This field is used to select the claim you wish to view.
LAST NAME	Last name of the beneficiary.
FIRST INIT	First initial of the beneficiary's name.
TOT CHG	Total charge. The total charge submitted on the CMS-1450 claim form.
PROV REIMB	Provider reimbursement. The amount reimbursed to the provider for an individual claim.
PD DT	Paid date. The date the claim will pay (for claims in P B9996) or was paid (P B9997). For claims in RTP (T B9997), this is the date the claim went to the RTP status/location. For claims rejected (R B9997) or denied (D B9997), this is the date the claim rejected or denied.
CAN DT	Cancel date. The date the original claim was canceled.
REAS	Reason code. The code assigned by FISS describing what is happening to the claim (edit).
NPC	Non-payment code. The code indicating why payment was not made. Values are: **B** Benefits exhausted **N** All other reasons **P** Payment requested **R** Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely,ro Waiver of Liability **W** Workers compensation **X** MSP cost avoided **Z** System set for type of bills 322 and 332 – MSP Primary Payer
# DAYS	Number of days. The number of days the claim has been in the Return to Provider (RTP) status. This field is only functional through the Claim and Attachments Corrections Menu. Refer to Chapter 5 of this guide for additional information.

FISS Inquiry Screens MAP 171E, MAP 171A, and MAP 171D

Once you have selected to view a claim from the Claim Summary Inquiry screen (MAP 1741), and press F8 to access Page 02 of the claim, you have the ability to press F11 to move to the

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right, which will display MAP171E. Press F11 again, and MAP171A will display, press F11 again, and MAP171D displays. Refer to the following screen prints and field descriptions.

Field Descriptions for Map 171E

Map 171E Screen Example

```
MAP171E   PAGE 02          CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
XXXXXXX    SC               INST CLAIM INQUIRY                 C201524F HH:MM:SS
                                                        NDC CD PAGE 01
MID                TOB      S/LOC          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


                                                                <== REASON CODES
PRESS PF2-1712 PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF10-LEFT PF11-RIGHT
```

Map 171E Field Descriptions The MID, TOB, and S/LOC fields are system generated from Page 01 of the claim.	
CL	Claim line item number (1 – 450).
NDC FIELD	National Drug Code (NDC) information. Used by hospice providers.
NDC QUANTITY	The NDC quantity. Used by hospice providers.
QUALIFIER	The units of measurement qualifier. Used by hospice providers.
RETURN HIPPS1	Identifies the HIPPS codes returned from the Quality Information Evaluation System (QIES). Applicable to inpatient rehabilitation, home health agency or skilled nursing facility/swing bed facilities.
RETURN HIPPS2	Identifies the HIPPS codes returned from the Quality Information Evaluation System (QIES). Applicable to skilled nursing facility/swing bed.
MOLDX	Identifies the Molecular Diagnostic Services test ID. Not applicable to home health and hospice claims.
LLR NPI	Line Level Rendering Physician's NPI number.
L	Last name of the physician.
F	First name of the physician.
M	Middle name of the physician.
SC	Special Code.
LLO NPI	Line Level Ordering National Provider Identifier (NPI). For institutional outpatient claims with advanced diagnostic imaging services subject to the Appropriate Use Criteria (AUC). Review SE20002 at https://www.cms.gov/files/document/se20002.pdf for additional information.

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Field Descriptions for Map 171A

Map 171A Screen Example

```
MAP171A      PAGE 02          CGS J15 MAC -  Part A REGION       ACPFA052 XX/XX/XX
XXXXXX       SC                  INST CLAIM INQUIRY              C201135E XX:XX:XX
DCN                               MID               RECEIPT DATE          TOB
STATUS       LOCATION             TRAN DT           STMT COV DT           TO
                              SERV       SERV
 REV   HCPC  MODIFIERS        DATE       RATE   TOT-UNT  COV-UNT  TOT-CHRG COV-CHRG

 ANES CF              ANES BV                                PC/TC IND
HCPC TYPE             DEDUCTIBLES          COINSURANCE        ESRD-RED/  VALCD-05/
              BLOOD           CASH      WAGE-ADJ      REDUCED  PSYCH/HBCF    OTHER
PAT ->
MSP ->                                                 ANSI ->            PAY/HCPC
MSP ->                                               OUTLIER ->           APC CD
              PAYER-1      PAYER-2       OTAF     DENIAL       OCE FLAGS
MSP ->                                             IND  1  2  3  4  5  6  7  8  9
 ID ->
          REIMB       RESP          PAID          REDUCT-AMT                 ANSI
 PAT ->                                                      LABOR          NON-LABOR
PROV ->
 MED ->                                  PRICER        PAY                     ASC
        ADJUSTMENT  ANSI            AMT    RTC    METHOD   IDE/NDC/UPC       GRP %
 CONTR-
                                                                <== REASON CODES
PRESS PF2-1712 PF3-EXIT PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT  PF11-RIGHT
```

Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
UNTITLED	Claim line item number (1 –450).
REV	Revenue code – identifies the revenue code for specific billed service.
HCPC	Healthcare Common Procedure Code –identifies the HCPC code that further defines the revenue code.
MODIFIERS	Healthcare Common Procedure Code System Modifier.
SERV DATE	Date service was provided.
SERV RATE	Per unit rate for revenue code line item service.
TOT-UNT	Total units.
COV-UNT	Covered units.
TOT-CHRG	Total charges per revenue code.
COV CHRG	Covered charges per revenue code.
ANES CF	Anesthesia Conversion Factor.
ANES BV	Anesthesia Base Units Value.
PC/TC IND	Professional Component/Technical Component. Not applicable to home health and hospice providers.
HCPC TYPE	An 'M' indicator will display when the HCPCS associated with the revenue line originated from the Medicare physician fee schedule.
PAT BLOOD DEDUCTIBLES	Patient Blood Deductibles.
PAT CASH DEDUCTIBLES	Patient Cash Deductibles.
REDUCED COINSURANCE	Reduced Coinsurance.
ESRD-RED/ PSYCH/HBCF	ESRD Reduction Amount/Psychiatric Reduction Amount/Hemophilia Blood Clotting Factor Amount.
VALCD-05/ OTHER	Value Code 05/Other. Identifies whether value code 05 is present on the claim.
MSP BLOOD DEDUCTIBLES	Medicare Secondary Payer Blood Deductibles.
MSP CASH DEDUCTIBLES	Medicare Secondary Payer Cash Deductibles.
MSP COINSURANCE	Medicare Secondary Payer Coinsurance.
ANSI ESRD-RED/ PSYCH/HBCF	ANSI End Stage Renal Disease Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor.

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Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
ANSI VALCD-05/OTHER	ANSI Value Code-05/Other. Identifies the 2-position ANSI group code and 3-position ANSI reason (adjustment) code. The ANSI data for the value codes are reported on the Remittance Advice for the Value Code 05/Other amount.
MSP PAYER-1	Medicare Secondary Payer Payer-1. Identifies the amount entered by the provider (if available) or apportioned by FISS as payment from the primary payer. FISS, based on the amount used in payment calculation and the value code for the primary payer, apportions this amount.
MSP PAYER-2	Medicare Secondary Payer Payer-2. Identifies the amount entered by the provider (if available) or apportioned by FISS as payment from the secondary payer. FISS, based on the amount used in payment calculation and the value code for the secondary payer, apportions this amount.
OTAF	Obligated to Accept Payment in Full. Identifies the line item apportioned amount entered by the provider (if applicable) or apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full, when value code 44 is present.
MSP DENIAL IND	Medicare Secondary Payer Denial Indicator. Identifies to the MSPPAY module that an insurer primary to Medicare has denied this line item. The valid values are: " " – not denied D – denied
OCE FLAGS	**Flag 1 – Service Indicator – valid values are:** B – Non-allowed item or service for OPPS M – Medical Review changes a HIPPS code P – Pricer upcode/downcode; The Pricer program in FISS changes the HIPPS code to "early" or "late" based on the beneficiary's adjacent episode history posted to the Common Working File (CWF) and/or the claim contains more or less therapy revenue codes than indicated by the HIPPS code submitted. **Flag 2 – Payment Indicator** **Flag 3 – Discounting Formula Number** **Flag 4 – Line Item Denial or Rejection Flag** **Flag 5 – Packing Flag** **Flag 6 – Payment Adjustment Flag** **Flag 7 – Payment Method Flag** **Flag 8 – Line Item Action Flag** **Flag 9 – Composite Adjustment**
PAY/HCPC APC CD	Payment Ambulatory Patient Classification Code or HCPC Ambulatory Patient Classification Code.
MSP PAYER –1 ID	Medicare Secondary Payer Payer-1 ID - Displays 1-position alphanumeric code identifying the specific payer. If Medicare is primary, this field will be blank. The valid values are: **1** – Medicaid **2** – BlueCross **3** – Other **4** – None **A** – Working Aged **B** – ESRD beneficiary in a 30-month coordination period with an employer group health plan **C** – Conditional payment **D** – Auto no-fault **E** – Worker's Compensation **F** – Public Health Service or other Federal Agency **G** – Disabled **H** – Black Lung **L** – Liability
MSP PAYER –2 ID	Medicare Secondary Payer Payer-2 ID - Displays 1-position alphanumeric code identifying the specific payer. If Medicare is secondary, this field will be blank. The valid values are: **1** – Medicaid **2** – BlueCross **3** – Other **4** – None **A** – Working Aged **B** – ESRD beneficiary in a 12-month coordination period with an employer group health plan **C** – Conditional payment **D** – Auto no-fault **E** – Worker's Compensation **F** – Public Health Service or other Federal Agency **G** – Disabled **H** – Black Lung **L** – Liability
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 Page 03 of the claim, in the "Due From PAT" field.

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Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
PAT RESP	Patient Responsibility. Identifies the amount for which the individual receiving services is responsible. The amount is calculated as follows: If Payer 1 indicator is C or Z, the amount equals: cash deductible + coinsurance + blood deductible. If Payer 1 indicator is not C or Z, the amount equals: MSP blood + MSP cash deductible + MSP coinsurance.
PAT PAID	Patient paid. 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 Page 03 of the claim).
REDUCT-AMT	Reduction amount. A 10 percent reduction in conjunction with Group Code "CO." Not applicable to home health and hospice providers.
ANSI	ANSI Group Code and the Claim Adjustment Reason Codes related to the reduction amount. Not applicable to home health and hospice providers.
PROV REIMB	Provider Reimbursement. Identifies the system generated calculated line amount to be paid to the provider.
LABOR	Identifies the labor amount of the payment as calculated by Pricer.
NON-LABOR	Identifies the non-labor amount of the payment as calculated by Pricer.
MED REIMB	Medicare Reimbursement. 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. Identifies the total contractual adjustment. The calculation is: submitted charge – deductible – wage adjusted coinsurance – blood deductible – value code 71 – psychiatric reduction – value code 05/other – reimbursement amount. Note: For MSP claims, the MSP deductible, MSP blood deductible, and MSP coinsurance is used in the above calculation in place of the deductible, blood deductible, and coinsurance amounts.
ANSI	ANSI Group – ANSI Adjustment Code - Identifies the 2-position ANSI group code and 3-position ANSI reason (adjustment) code. The ANSI data for the value codes are reported on the Remittance Advice.
PRICER AMT	Pricer Amount. Identifies the total reimbursement received from Pricer.
PRICER RTC	Pricer Return Code. Identifies the return code from the OPPS Pricer.
PAY METHOD	Payment Method. Identifies the payment method returned from OCE. **Valid values are:** 1 – paid standard OPPS amount (status indicators S, T, V, X, or P) 2 – services not paid under OPPS (status indicator A) 3 – not paid (status indicators W, Y, or E) or not paid under OPPS (status indicators B, C or Z) 4 – acquisition cost paid (status indicator F) 5 – additional payment for drug or biological (status indicator G) 6 – additional payment for device (status indicator H) 7 – additional payment for new drug or new biological (status indicator J) 9 – no additional payment included in line items with APCS (status indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy), or G0177 (partial hospitalization program services)
IDE/NDC/UPC	Identifies IDE, NDC, and UPC.
ASC GRP	Identifies the ASC group code for the indicated revenue code.
%	ACS Percentage. Identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code.

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Field Descriptions for Map 171D

Map 171D Screen Example

```
MAP171D   PAGE 02       CGS J15 MAC - Part A REGION          ACMFA552 MM/DD/YY
 XXXXXXX   SC              INST CLAIM ENTRY                   C201822P HH:MM:SS
 DCN                         MID              RECEIPT DATE         TOB
 STATUS    LOCATION          TRAN DT          STMT COV DT          TO
 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
        HCPC/MOD IN    SERV                            -----REASON-CODES------
  REV  HCPC MODIFIERS   DATE  COV-UNT   COV-CHRG   ADR
                                                    FMR
 ORIG                      ORIG REV         MR      ODC
 OCE OVR   CWF OVR   NCD OVR   NCD DOC   NCD RESP   NCD#          OLUAC
        NON       NON    DENIAL OVER ST/LC  MED  ------------ANSI------------
 LUAC  COV-UNT   COV-CHRG  REAS  CODE OVER   TEC  ADJ  GRP ------REMARKS------




 TOTAL                          LINE ITEM REASON CODES
     PROCESS COMPLETED  ---   PLEASE CONTINUE
    PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

Map 171D Field Descriptions	
SC	Screen Control. A feature that allows you to access other FISS inquiry options.
DCN	Document Control Number. Displays the claim's identification number assigned by FISS when the claim is received.
MID	Beneficiary's Medicare number.
RECEIPT DATE	Identifies the actual receipt date. This is automatically entered by FISS.
TOB	Type of Bill. Identifies the type of bill that applies to the claim.
STATUS	Identifies the claim's status in the system (P, D, R, S, or T).
LOCATION	Further identifies the claim's location in the system.
TRAN DT	Transaction Date. Identifies the date of the latest update activity.
STMT COV DT	Statement Covers Date. Identifies the beginning date of service.
TO	Statement Covers "To" Date. Identifies the ending date of service.
PROVIDER ID	Provider Number. Identifies your facility's National Provider Identifier (NPI).
BENE NAME	Beneficiary Name. Identifies the name of the beneficiary.
NONPAY CD	Non-Pay Code. Identifies the reason for Medicare's decision not to make payment. Valid values are: **B** Benefits exhausted **N** All other reasons **P** Payment Requested **R** Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely, ro Waiver of Liability **W** Workers Compensation **X** MSP cost avoided **Z** MSP Primary Payer
GENER HARDCPY	Generate hardcopy. Instructs system to generate a specific type of hard copy document. Valid values are: **2** Medical ADR **3** Non-medical ADR **4** MSP ADR **5** MSP cost avoidance ADR **7** ADR to beneficiary **8** MSN (line item) or partial denial **9** MSN (claim level) or full denial
MR INCLD IN COMP	Composite Medical Review Included in Composite Rate.
CL MR IND	Complex Manual Medical Review Indicator. Identifies if all services on the claim received complex manual medical review. Valid values: **" "** The services did not receive manual medical review. **Y** Medical records received and this service received complex manual medical review. A "Y" will display when the OCE FLAGS field on Map 171A displays an "M" (Medical Review changes a HIPPS code). **N** Medical records were not received and this service received routine manual medical review.

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Map 171D Field Descriptions	
TPE-TO-TPE	Tape to Tape flag. Displays the tape-to-tape flag indicating the system to either perform or skip a function. If the value in this field is "X", the claim data information is not posted to the Common Working File (CWF). If this field is blank, the claim data from the finalized (status/location P B9997, R B9997, or D B9997) billing transaction did post to CWF. Whenever claim data has posted to CWF, a cancel or adjustment must be submitted to remove or change this information. Valid values and the functions include: **Function** / **Transmit To CWF** / **Print On Remittance** Blank: Y / Y A: Y / Y J: N / Y O: N / N Q: N / Y S: Y / Y T: Y / N U: Y / N W: Y / N X: N / Y Z: N / N
USER ACT CODE	User Action Code. For intermediary use for medical review and reconsideration only. Valid values are: **A** – pay per waiver – full technical **B** – pay per waiver – full medical **C** – provider liability – full medical – subject to waiver provision **D** – beneficiary liability – full – subject to waiver provision **E** – pay claim – line full **F** – pay claim partial – claim must be updated to reflect liability **G** – provider liability – full technical – subject to waiver provision **H** – full/partial denial with multiple liabilities – claim must be updated to reflect liability **I** – full provider liability – medical – not subject to waiver provision **J** – full provider liability – technical – not subject to waiver provision **K** – full beneficiary liability – not subject to waiver provision **L** – full provider liability - code changed to reflect actual service **M** – pay per waiver – line or partial line **N** – provider liability – line or partial line **O** – beneficiary liability – line or partial line **P** – open biopsy changed to closed biopsy **Q** – release with no medical review performed **R** – CWF denied but medical review was performed **Z** – force claim to be re-edited by medical policy **5** – set systematically from the reason code file to identify claims for which special processing is required **7** – force claim to be re-edited by medical policy edits in the 5XXXX range **8** – claim was suspended via an OCE MED review reason **9** – claim has been identified as a first claim review
WAIV IND	Waiver Indicator. Identifies whether the provider has their presumptive waiver status. This field is no longer used.
MR REV URC	Medical Review Utilization Review Committee Reversal.
DEMAND	Medical Review Demand Reversal –
REJ CD	Reject Code. Identifies the reason code for which the claim is being denied (on full claim denials only).
MR HOSP RED	Medical Review Hospice Reduced. For hospice claims, this field identifies the line item(s) has been reduced to a lesser charge by medical review. Valid values are: **Y** – Reduced **" "** – Not reduced
ORIG UAC	Original User Action Code. For intermediary use only.
MED REV RSNS	Medical Review Reasons. Identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field only displays medical review reasons specific to claim level.
OCE MED REV RSNS	OCE Medical Review Reasons.
Unlabeled	Identifies the line number of the revenue code. The line number is located above the revenue code field on this Map. To move to another revenue code, press F6 to scroll down and F5 to scroll up.
REV	Revenue Code.
HCPC/MOD IN	HCPCS Code/Modifier. Valid values are: **U** – upcoding **D** – downcoding **" "** – no downcoding
HCPC	Healthcare Common Procedure Coding System. Indicates 5-position HCPCS associated with the revenue code.
MODIFIERS	Healthcare Common Procedure Coding System Modifier.
SERV DATE	Service date. Line item date of service associated with the revenue code.
COV-UNT	Covered units. Reflects the number of covered visits associated with the revenue code.
COV-CHRG	Covered charges. Represents the covered charges associated with the revenue code.
ADR REASON CODES	Additional Development Request. ADR reason codes used when additional information has been requested.

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Map 171D Field Descriptions	
FMR REASON CODES	Focused Medical Review Suspense Codes. Identifies the medical review suspense codes when a claim is edited based on the medical policy parameter file.
ODC REASON CODES	Original Denial Reason Code. Identifies the original denial reason codes.
ORIG	Original HCPCS or HIPPS code, or modifiers billed.
ORIG REV CODE	Original revenue code billed.
MR	Complex Manual Medical Review Indicator. Identifies if all services on the claim received complex manual medical review. Valid values are: **" "** – services did not receive manual medical review **Y** – medical records received and services received complex manual medical review **N** – medical records were not received and services received routine manual medical review
OCE OVR	Override. Overrides the way the OCE module controls the line item. Valid values are: **0** – OCE line item denial or rejection is not ignored **1** – OCE line item denial or rejection is ignored **2** – External line item denial. Line item is denied even if no OCE edits. **3** – External line item reject. Line item is rejected even if no OCE edits. **4** – External line item adjustment. Technical charge rules apply.
CWF OVR	CWF Override. Overrides the way the OCE module controls the line item.
NCD OVR	National Coverage Determination Override Indicator. 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. Valid values are: " " – NCD edits are not bypassed **Y** – the line has been reviewed for medical necessity and bypasses the NCD edits **D** – the line has no covered charges and bypasses the NCD edits
NCD DOC	National Coverage Determination Documentation Indicator. Identifies whether the documentation was received for the necessary medical service. Valid values are: **Y** – the documentation supporting the medical necessity was received. **N** – the documentation supporting the medical necessity was not received.
NCD RESP	National Coverage Determination Response Code. Identifies the response code that is returned from the NCD edits. Valid values are: " " – default **0** – the HCPCS/diagnosis code matched the NCD edit table pass criteria. The line continues through the internal local medical necessity edits. **1** – the line continues through the internal local medical necessity edits because: the HCPCS code was not applicable to the NCD edit table process, the date of services was not within the range of the effective dates for the codes, the override indicator is set to Y or D, or the HCPCS code field is blank. **2** – none of the diagnoses supported the medical necessity of the claim, but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. **3** – the HCPCS/diagnosis code matched the NCD edit table list ICD deny codes. The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to noncoverage by statute. **4** – none of the diagnosis codes on the claim support the medical necessity for the procedure and no additional documentation is provided. This line suspends as not medically necessary and will be denied. **5** – diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and will move to the Return to Provider (RTP) file.
NCD #	National Coverage Determination Number. This field identifies the NCD number associated with the beneficiaries claim denial. This is an eight-position alphanumeric field.
OLUAC	Original Line User Action Code. Identifies the original line user action code and is only used when there is a line user action code and a corresponding medical review denial reason code in the Benefits Savings portion of the claim.
LUAC	Line User Action Code. This is a 2-position field. The 1st position indicates the cause of the denial reason for the specific revenue line (see the USER ACT CODE field of this FISS Guide chapter for valid values). The 2nd position indicates the reconsideration code. A value equal to R indicates that reconsideration has been performed.
NON COV-UNT	Noncovered units. Contains the number of units that are being denied, if applicable.
NON COV-CHRG	Noncovered charges. Identifies the total of denied/rejected/noncovered charges for each line item being denied.
DENIAL REAS	Denial Reason. Identifies the reason code associated with the denial for the revenue code line.

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Map 171D Field Descriptions	
OVER CODE	Override Code. Overrides the system generated ANSI codes from the denial reason code file. The valid values are: **A** – override system generated ANSI code **" "** – system default
ST/LC OVER	Status/location Override. Overrides the reason code file status. Only used by CGS. Valid values are: **D** – denied line item for the reason code. **R** – rejected the line item for the reason code **" "** – processed claim with no override action
MED TEC	Medical Technical Denial Indicator. Identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. The valid values are: **M** – medical denial and waiver was applied **T** – technical denial and waiver was applied **S** – medical denial and waiver was not applied **U** – technical denial and waiver was not applied
ANSI ADJ	ANSI Adjustment Reason Code. Identifies the ANSI adjustment reason code associated with the denial reason for each line item.
ANSI GRP	ANSI Group Code. Contains the ANSI group code associated with the denial reason for each line item.
ANSI REMARKS	ANSI Remarks Code. Contains the ANSI remarks codes associated with the denial reason for each line item.
TOTAL	Contains the sum of all revenue code noncovered units.
LINE ITEM REASON CODES	Identifies the reason code that is assigned for suspending the line item.

Field Descriptions for Map 171G (Home Health only)

MAP 171G is accessed from Claim Page 03 and press F11 until MAP 171G displays.

Map 171G Screen Example

```
MAP171G                    CGS J15 MAC - HHH REGION              ACPFA052 XX/XX/XX
XXXXXX       SC           CLAIM SUMMARY INQUIRY                  C201135E XX:XX:XX

MID XXXXXXXXXXXX  TOB XXX  S/LOC X XXXXX  PROVIDER XXXXXXXXXXXXX

                           QIES/OASIS INFORMATION

M1033-HSTRY-FALL     OA      MR          M1033-WEIGHT-LOSS      OA      MR
M1033-MLTPL-HOSPZTN OA      MR          M1033-MLTPL-ED-VISIT   OA      MR
M1033-MNTL-BHV-DCLN OA      MR          M1033-COMPLIANCE       OA      MR
M1033-5PLUS-MDCTN    OA      MR          M1033-CRNT-EXHSTN      OA      MR
M1033-OTHER-RISK     OA      MR          M1033-NONE-ABOVE       OA      MR
M1800-CRNT-GROOMING OA      MR          M1810-DRESS-UPPER      OA      MR
M1820-DRESS-LOWER    OA      MR          M1830-CRNT-BATHG       OA      MR
M1840-CRNT-TOILTG    OA      MR          M1850-CRNT-TRNSFRNG    OA      MR
M1860-CRNT-AMBLTN    OA      MR
```

Map 171G Field Descriptions	
M1033-HSTRY-FALLS OA (OASIS Assessment) MR (Medical Review)	This field indicates if there are risk factors for hospitalization-falls. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-WEIGHT-LOSS OA MR	This field indicates if there are risk factors for hospitalization-weight loss. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found

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Map 171G Field Descriptions	
M1033-MLTPL HOSPZTN OA MR	This field indicates if there are risk factors for hospitalization-multiple hospitalizations. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-MLTPL-ED-VISIT OA MR	This field indicates if there are risk factors for hospitalization-multiple emergency department visits. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-MNTL-BHV-DCLN OA MR	This field indicates if there are risk factors for hospitalization-mental behavior decline. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-COMPLIANCE OA MR	This field indicates if there are risk factors for hospitalization-compliance. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-5PLUS-MDCTN OA MR	This field indicates if there are risk factors for hospitalization-currently taking 5 or more medications. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-CRNT-EXHSTN OA MR	This field indicates if there are risk factors for hospitalization-exhaustion. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-OTHER RISK OA MR	This field indicates if there are risk factors for hospitalization-other risks. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found
M1033-NONE-ABOVE OA MR	This field indicates if there are risk factors for hospitalization-none of the above. One position numeric field. Valid Values: **0 –** Unchecked (No) **1 –** Checked (Yes) **9 –** No iQIES Assessment found

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Map 171G Field Descriptions	
M1800-CRNT-GROOMING OA MR	This field indicates Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care). Two position numeric field. Valid Values: **00 –** Able to groom self unaided, with or without the use of assistive devices or adapted methods **01 –** Grooming utensils must be placed within reach before able to complete grooming activities. **02 –** Someone must assist the patient to groom self. **03 –** Patient depends entirely upon someone else for grooming needs. **99 –** No iQIES Assessment found
M1810-DRESS-UPPER OA MR	This field indicates Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps. Two position numeric field. Valid Values: **00 –** Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. **01 –** Able to dress upper body without assistance if clothing is laid out or handed to the patient. **02 –** Someone must help the patient put on upper body clothing. **03 –** Patient depends entirely upon another person to dress the upper body. **99 –** No iQIES Assessment found
M1820-DRESS-LOWER OA MR	This field indicates Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes. Two position numeric field. Valid Values: **00 –** Able to obtain, put on, and remove clothing and shoes without assistance. **01 –** Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. **02 –** Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. **03 –** Patient depends entirely upon another person to dress the lower body. **99 –** No iQIES Assessment found
M1830-CRNT-BATHG OA MR	This field indicates Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair). Two position numeric field. Valid Values: **00 –** Able to bathe self in shower or tub independently, including getting in and out of tub/shower. **01 –** With the use of devised, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. **02 –** Able to bathe in shower or tube with the intermittent assistance of another person. (a) For intermittent supervision or encouragement or reminders, OR (b) To get in and out of the shower or tube, OR (c) For washing difficult to reach areas. **03 –** Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. **04 –** Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. **05 –** Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink in bedside chair, or on commode, with the assistance or supervision of another person. **06 –** Unable to participate effectively in bathing and is bathed totally by another person. **99 –** No iQIES Assessment found

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Map 171G Field Descriptions	
M1840-CRNT TOILTG OA MR	This field indicates Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode. Two position numeric field. Valid Values: **00 –** Able to get to and from the toilet and transfer independently with or without a device. **01 –** When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. **02 –** Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). **03 –** Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. **04 –** Is totally dependent in toileting. **99 –** No iQIES Assessment found
M1850-CRNT-TRNSFRNG OA MR	This field indicates Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast Two position numeric field. Valid Values: **00 –** Able to independently transfer. **01 –** Able to transfer with minimal human assistance or with use of an assistive device. **02 –** Able to bear weight and pivot during the transfer process but unable to transfer self. **03 –** Unable to transfer self and is unable to bear weight or pivot when transferred to another person. **04 –** Bedfast, unable to transfer but is able to turn and position slef in bed. **05 –** Bedfast, unable to transfer and is unable to turn and position self. **99 –** No iQIES Assessment found
M1860-CRNT-AMBLTN OA MR	This field indicates Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. Two position numeric field. Valid Values: **00 –** Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). **01 –** With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk or even and uneven surfaces and negotiate stairs with or without railings. **02 –** Requires use of a two-handed device (for example, walker, or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. **03 –** Able to walk only with the supervision or assistance of another person at all times. **04 –** Chairfast, unable to ambulate but is able to wheel self independently. **05 –** Chairfast, unable to ambulate and is unable to wheel self. **06 –** Bedfast, unable to ambulate or be up in a chair. **99 –** No iQIES Assessment found

Archived Claims

FISS archives claim data on processed claims after 18 months from the date the claim is processed. Archived claims can be identified by status/location P O9998 or R O9998 (the letter “O” as in “offline” and not a “0” (zero)).

These claims can be accessed by selecting 12 (Claims) from the Inquiry Menu; typing your NPI in the NPI field, and entering the beneficiary’s Medicare number in the MID field. Then tab to the S/LOC field and, enter P O9998 or R O9998. Press Enter. Archived claims do not display the beneficiary’s name or provider reimbursement (PROV REIMB) amount, and if selected (type an S in the SEL field) all claim pages appear blank. The message “ADJUSTMENT CLAIM IS PRESENTLY OFFLINE PF10 TO RETRIEVE” will display.

Although the claim data is archived, you are able to retrieve an archived claim to inquire into how it was submitted and processed. For additional information on how to retrieve an archived claim, refer to Chapter 5 of this guide.

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Please note, that because Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements to one calendar year after the date of service, adjustments or claim cancellations cannot be done after a claim has been archived, unless a valid exception to timely filing has been met. See the "Medicare Timely Filing Guidelines" (https://www.cgsmedicare.com/Articles/COPE18411.html) Web page for more information.

```
MAP1741                    CGS J15 MAC Part A REGION              ACMFA552 XX/XX/XX
  XXXXXXX   SC                 CLAIM SUMMARY INQUIRY                C201821P XX:XX:XX
                                  NPI
       MID                  PROVIDER                 S/LOC          TOB
   OPERATOR ID LXC6332    FROM DATE          TO DATE           DDE SORT
   MEDICAL REVIEW SELECT           DCN
       MID             PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
  SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
  XXXXXXXXXX   XXXXXX              P O9998  XXX   0523XX 0523XX 0524XX   0603XX
                                3413.57                0617XX            XXXXX
  XXXXXXXXXX   XXXXXX                P O9998  XXX    0603XX 0603XX 0614XX
                                1305.00                0628XX            XXXXX
```

Revenue Codes (Option 13)

This option is helpful if you need to verify revenue codes that can be billed with specific bill types. This screen also provides information to verify what additional information (e.g., units, HCPCS code) must accompany the revenue code.

1. From the Inquiry Menu, type 13 in the **Enter Menu Selection** field and press Enter.

```
MAP1702                CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                     INQUIRY MENU                      C20112WS HH:MM:SS


        BENEFICIARY/CWF          10    ZIP CODE FILE             19

        DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

        CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

        REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

        HCPC CODES               14    ANSI REASON CODES         68

        DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

        ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

        REASON CODES             17    CMHC PAYMENT TOTALS       1C

        INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                       NEW HCPC SCREEN           1E

     ENTER MENU SELECTION:  13


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

You may also access this screen by typing **13** in the SC field if you are in an inquiry or claim entry screen.

2. The Revenue Code Table Inquiry screen (Map 1761) appears:

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```
MAP1761                    CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/YY
XXXXXX      SC               REVENUE CODE TABLE INQUIRY              C201135E HH:MM:SS

               REV CD
EFF DT             IND                              TERM DT

NARR

          ALLOW:              HCPC:                UNITS:                RATE:
TOB          EFF-DT TRM-DT       EFF-DT TRM-DT        EFF-DT TRM-DT       EFF-DT TRM-DT
---       ---------------     ---------------      ---------------     ---------------
```

3. To view revenue code information, type the revenue code in the **REV CD** field and press ***Enter***.

```
MAP1761                          CGS J15 MAC - Part A REGION        ACPFA052 XX/XX/XX
XXXXXX        SC              REVENUE CODE TABLE INQUIRY             C201135E XX:XX:XX

                  REV CD 0420
EFF DT 070166        IND F                          TERM DT

NARR PHYSICAL THERAPY GENERAL CLASSIFICATION - PHYSICAL THERP

       ALLOW:              HCPC:              UNITS:              RATE:
TOB       EFF-DT TRM-DT       EFF-DT TRM-DT       EFF-DT TRM-DT       EFF-DT TRM-DT
---     ---------------     ---------------     ---------------     ---------------
11X      Y 070166            V                   N                   N
12X      Y 070166            Y 010199            Y 070198            N
13X      Y 070166            Y 010199            Y 070166            N
14X      N                   V                   N                   N
18X      Y 070166            V                   N                   N
21X      Y 070166            V                   N                   N
22X      Y 070166            Y 010199            Y 070198            N
23X      Y 070166            Y 010199            Y 070166            N
32X      Y 070166            Y 100199            Y 070166            N
33X      Y 070166            Y 100199            Y 070166            N

       PROCESS COMPLETED --- PLEASE CONTINUE
          PRESS PF3-EXIT  PF6-SCROLL FWD
```

To see all of the revenue code information for all types of bill (TOB), press ***F6*** to scroll forward.

4. To make additional inquiries, simply enter a new revenue code over the previously entered code and press ***Enter***. If you enter a new 3-digit revenue code over the previously entered code, the first digit must be a zero, or enter the 3-digit revenue code in the first 3 positions and delete the 4th digit before pressing ***Enter***.
5. Press ***F3*** to exit the Revenue Code Table Inquiry screen and return to the Inquiry Menu.

Field Descriptions – Option 13 Revenue Codes

Map 1761 Field Descriptions	
REV CD	Revenue code. A 4-digit field that represent the type of service, supply, or equipment being provided.
EFF DT	Effective date. The date the revenue code became effective (MMDDYY format).
IND	Effective date indicator. This date instructs the system to either use the “from” date of the claim or the system run date to perform edits for this revenue code. Values are: **F** Claim from date **R** Claim receipt date **D** Claim discharge date
TRM DT	Termination date. The date the revenue code became invalid. (MMDDYY format).
NARR	Narrative. The English-language description for the revenue code.
TOB	Type of bill. The first two digits of the type of bill followed by an ‘X’ denoting the frequency.
ALLOW:	Allowable. This field indicates whether the revenue code is valid for the type of bill. Values are: **Y** Yes **N** No
EFF-DT	Allowable effective date. The date the revenue code became a valid code (MMDDYY format).

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Map 1761 Field Descriptions	
TRM-DT	Allowable termination date. The date the revenue code was no longer valid (MMDDYY format).
HCPC:	Healthcare Common Procedure Code System. This field indicates whether the revenue code requires a HCPCS. Values are: **Y** Yes **N** No **V** Validation of HCPCS is required
EFF-DT	HCPCS effective date. The beginning date the HCPCS code became required for this revenue code (MMDDYY format).
TRM-DT	HCPCS termination date. The date the HCPCS code was no longer required for this revenue code (MMDDYY format).
UNITS:	Units required. This field indicates whether units must be entered for this revenue code. Values are: **Y** Yes **N** No
EFF-DT	Unit's effective date. The beginning date units became required for this revenue code (MMDDYY format).
TRM-DT	Unit's termination date. The date units were no longer required for this revenue code (MMDDYY format).
RATE:	Rate. This field indicates whether a rate must be entered for this revenue code. Values are: **Y** Yes **N** No Note: This field is currently not functional, and will always show "N".
EFF-DT	Rate's effective date. The beginning date for the requirement to enter a rate for this revenue code (MMDDYY format).
TRM-DT	Rate's termination date. The end date for the requirement to enter a rate for this revenue code (MMDDYY format).

HCPC Codes (Option 14)

This option is helpful if you need to inquire about Healthcare Common Procedure Coding System (HCPCS) code reimbursement or verify which revenue codes are allowable with HCPCS codes.

1. From the Inquiry Menu, type 14 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702              CGS J15 MAC - Part A REGION      ACPFA052 MM/DD/YY
XXXXXX                 INQUIRY MENU                C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 14

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

You may also access this screen by typing ***14*** in the SC field if you are in an inquiry or claim entry screen.

2. The HCPC Information Inquiry screen (Map 1771) appears:

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```
MAP1771                      CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX      SC                  HCPC INFORMATION  INQUIRY         C201135E HH:MM:SS
                                                                        PAGE: 01
CARRIER           LOC       HCPC          MOD          IND
EFF DT            TRM DT              PROVIDER                 DRUG CODE

                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



HCPC DESCRIPTION


      PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

3. Use your Tab key to move to the **HCPC** field, and type the HCPCS code. Press ***Enter***. FISS will automatically insert information in the CARRIER and LOC fields based on your geographic location.

```
MAP1771                      CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX      SC                  HCPC INFORMATION  INQUIRY         C201135E HH:MM:SS
                                                                        PAGE: 01
CARRIER XXXXX    LOC XX     HCPC 83970      MOD          IND R
EFF DT 010107    TRM DT              PROVIDER XXXXXX          DRUG CODE

                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

010114          F 3       0             030X

010113          F 3       0             030X

010112          F 3       0             030X

010111          F 3       0             030X



HCPC DESCRIPTION
PARATHORMONE (parathyroid hormone) level
      PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Use the following function keys to move around the screen:

F3 – Exit (return to the Inquiry Menu)
F5 – Scroll up one page
F6 – Scroll down one page
F11 – Scroll right
F10 – Scroll left

4. Press ***F11*** to move the screen to the right. Map 1772 will display. The type of data that displays will depend on the type of HCPCS code you enter. Press ***F10*** to move back to the left of Map 1771. Refer to the following for more information.

If the code is any other type of HCPCS code, Map 1772 will display the 60 percent, 62 percent, rehabilitation, and professional service rates. Press ***F10*** to move back to the right to Map 1771.

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```
MAP1772                          CGS J15 MAC -  Part A REGION      ACPFA052 MM/DD/YY
XXXXXX      SC                     HCPC RATES  INQUIRY            C201135E HH:MM:SS
                                                                          PAGE:
02
  CARRIER XXXXX    LOC XX     HCPC 83704      MOD          IND

  EFF DT  TRM DT     60%RATE       62%/REDU          REHAB        PROF       NFACPE

  010109               46.070        47.610

  010108               44.080        45.550

  010107               44.080        45.550

  010106               44.080        45.550


  HCPC DESCRIPTION
 Lipoprotein level
```

5. To inquire about other HCPCS codes, enter the HCPCS code over the previously entered HCPC and press ***Enter***.
6. Press ***F3*** to exit the HCPCS Information Inquiry screen and return to the Inquiry Menu.

Field Descriptions for Option 14 – HCPC Codes

Map 1772 Field Descriptions	
CARRIER	Carrier. The carrier number assigned to your provider file. System generated.
LOC	The two position locality code which identifies the area where the provider is located.
HCPC	Healthcare Common Procedure Coding System. The HCPCS code to be reviewed on the screen.
MOD	HCPC Modifier. Multiple fees will be identified for the HCPCS code based on the modifier.
IND	HCPC indicator.
EFF DT	Effective date. The date the rate became effective (MMDDYY format).
TERM DT	Termination date. The termination date for the rate listed (MMDDYY format).
PROVIDER	The Medicare provider number assigned to your facility.
DRUG CODE	This field identifies whether the HCPCS code is a drug. The valid values are: **E** HCPCS is a drug **" "** HCPCS is not a drug
EFF. DATE	Effective date. The effective date for the rate listed (MMDDYY format).
TRM. DATE	Termination date. The termination date for the rate listed (MMDDYY format).
EFF	Effective date indicator. This indicator instructs the system to either use the 'from' and 'through' dates of the claim or the system run date to perform edits for this HCPCS. Values are: **F** Claim from date **R** Claim receipt date **D** Discharge date
OVR	Override code. This field instructs the system in applying the services towards deductible and coinsurance. Values are: **0** Apply deductible and coinsurance **1** Do not apply deductible **2** Do not apply coinsurance **3** Do not apply deductible or coinsurance **4** No need for total charges (used for multiple HCPCS for single revenue code centers) **5** Rural health clinic or comprehensive outpatient rehabilitation facility psychiatric **M** Employer group health plan (EGHP) (only used on the 0001 total line for Medicare Secondary Payer (MSP)) **N** Non-EGHP (only used on the 0001 total line for MSP) **Y** MSP cost avoided
FEE	Fee Indicator. The fee indicator received in the Physician Fee Schedule file. Valid values: **B** Bundled procedure **R** Rehab/Audiology Function Test/CORF Services **" "** Space

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Map 1772 Field Descriptions	
OPH	Outpatient Hospital Indicator. The outpatient hospital indicator received in the physician fee schedule abstract test file. Valid values: **0** Fee applicable in Hospital Outpatient Setting **1** Fee not applicable in Hospital Outpatient Setting **" "** Space
CAT	Category Code. This field identifies the category of the DME equipment.
PC/TC	Professional Component/Technical Component. Valid values are: **0** Pay the Health Professional Shortage Area (HPSA) bonus **1** Globally billed. Professional component for this service qualifies for the HPSA bonus payment **2** Professional component only, pay the HPSA bonus **3** Technical component only, do not pay the HPSA bonus **4** Global test only. Professional component of this service qualifies for the HPSA bonus payment **5** Incident codes, do not pay the HPSA bonus **6** Laboratory physician interpretation codes, pay the HPSA bonus **7** Physical therapy service, do not pay the HPSA bonus **8** Physician interpretation codes, pay the HPSA bonus **9** Concept of PC/TC does not apply, do not pay the HPSA bonus
ANES BASE VAL	Anesthesia base value. The anesthesia base values.
TYP	HCPCS Type. An 'M' indicator will display when the HCPCS associated with the revenue line originated from the Medicare physician fee schedule.
MSI	Multiple services indicator. The value of '5' identifies services that are subject to the multiple procedure payment reduction (MPPR).
ALLOWABLE REVENUE CODES	Allowable revenue codes. The allowable revenue codes this HCPCS code may use in billing. This is a four-position field. When the last digit shows an "X," each variable for that revenue code is allowable. If this field is blank, the system will allow a HCPCS code on any revenue code.
HCPC DESCRIPTION	HCPCS description. The English narrative description of the HCPCS code.

Map 1772 Field Descriptions	
60%RATE	60% reimbursement rate. The rate the system will use for calculating reimbursement for the HCPCS.
62% RATE or 62%/REDU	62% lab reimbursement rate. The rate the system will use for calculating reimbursement for the lab HCPCS. When the MSI field equals a '5', this field will dispay "62%/REDU" or the reduced therapy fee amount.
REHAB	Rehabilitation rate. The rate used by the system to calculate reimbursement for the HCPCS code for rehabilitation services billed.
PROF	Professional service rate. The rate used by the system to calculate reimbursement for the HCPCS code for professional services
NFACPE	Non-facility amount practice expense (PE) relative value units (RVUs). This field reflects the 20 percent reduction in non-facility PE RVUs.

DX/Proc Codes ICD-9 (Option 15)

This option is helpful if you need to confirm the validity of diagnosis or procedure codes.

1. From the Inquiry Menu, type 15 in the **Enter Menu Selection** field and press ***Enter***.

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```
MAP1702              CGS J15 MAC -  Part A REGION      ACPFA052 MM/DD/YY
XXXXXX                 INQUIRY MENU                  C201135E HH:MM:SS


      BENEFICIARY/CWF           10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY             12    CLAIM COUNT SUMMARY       56

      REVENUE CODES             13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES                14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9       15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10      1B

      REASON CODES              17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS      88    PROV PRACTICE ADDR QUER   1D

                                      NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 15

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

You may also access this screen by typing **15** in the SC field if you are in an inquiry or claim entry screen.

2. The ICD-9-CM Code Inquiry screen (Map 1731) appears:

```
MAP1731                    CGS J15 MAC -  Part A REGION           ACPFA052 MM/DD/
YY
XXXXXX   SC            ICD-9-CM CODE INQUIRY                     C201135E HH:MM:SS
STARTING  ICD9 CODE:

ICD9 CODE                          DESCRIPTION:
        EFFECTIVE/TERM DATE       EFFECTIVE/TERM DATE      EFFECTIVE/TERM DATE
```

3. **To inquire about a diagnosis code,** enter the diagnosis code in the **STARTING ICD9 CODE** field and press ***Enter***. Do not type the decimal point or zero-fill the code. To review a complete list of diagnosis codes, press ***Enter***.

While FISS enables you to validate diagnosis codes, you should still have a current ICD-9-CM coding book in your office.

```
MAP1731                      CGS J15 MAC - Part A REGION        ACPFA052 XX/XX/XX
XXXXXX      SC             ICD-9-CM CODE INQUIRY                C201135E XX:XX:XX
STARTING    ICD9 CODE: 1630

ICD9 CODE                        DESCRIPTION:
          EFFECTIVE/TERM DATE     EFFECTIVE/TERM DATE    EFFECTIVE/TERM DATE
 1630       MAL NEO PARIETAL PLEURA
              100185 093015
 1631       MAL NEO VISCERAL PLEURA
              100185 093015
 1638       MALIG NEOPL PLEURA NEC
              100185 093015
 1639       MALIG NEOPL PLEURA NOS
              100185 093015
 1640       MALIGNANT NEOPL THYMUS
              100185 093015
 1641       MALIGNANT NEOPL HEART
              100185 093015
 1642       MAL NEO ANT MEDIASTINUM
              100185 093015
 1643       MAL NEO POST MEDIASTINUM
              100185 093015

 PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```


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If more than one of the same code is listed, be sure to review the description, effective and termination dates, and use the most current code that applies to the service dates on your claim.

Press ***F6*** to scroll forward through the list of diagnosis codes.

4. To make an additional inquiry, type the new diagnosis code over the previously entered diagnosis code and press ***Enter***.
5. **To inquire about a procedure code,** type the letter P followed by the procedure code in the STARTING ICD9 CODE field and press ***Enter***. To review a complete list of procedure codes, enter the letter ***P*** in the **STARTING ICD9 CODE** field and press ***Enter***.
6. Press ***F3*** to exit and return to the Inquiry Menu.

Field Descriptions for Option 15 – DX/PROC Codes ICD-9

Map 1731 Field Descriptions	
STARTING ICD9 CODE	ICD-9-CM code. The ICD-9-CM code identifying a specific diagnosis or procedure.
DESCRIPTION	ICD-9-CM description. The narrative for the ICD-9-CM code.
EFFECTIVE/TERM DATE	Effective/termination date. The effective and/or termination date for the ICD-9-CM code in MMDDYY format. (Up to three occurrences of dates can appear.)

Adjustment Reason Codes (Option 16)

This option allows you to view adjustment reason codes and their narratives. Use these codes to identify reasons for an adjustment. Adjustment reason codes must be submitted on adjustment and cancellation claims when using FISS to submit these type of billing transactions. See Chapter 5 of this guide for additional information about using FISS to submit adjustment and cancellation claims.

1. From the Inquiry Menu, type ***16*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                      CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                         INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 16

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

You may also access this screen by typing **16** in the SC field if you are in an inquiry or claim entry screen.

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2. The Adjustment Reason Codes Inquiry screen (Map 1821) appears:

```
MAP1821                  CGS J15 MAC -  Part A REGION              ACPFA052 MM/DD/
YY
XXXXXX      SC            ADJUSTMENT REASON CODES INQUIRY         C201135E HH:MM:SS
                                SELECTION SCREEN                MNT:

 CLAIM TYPES:
 I = INPATIENT/SNF,   O = OUTPATIENT,    H = HOME HEALTH/CORF,     A = ALL CLAIMS
 PLAN CODE:              REASON CODE:
S PC RC HC TYPE                 NARRATIVE
```

3. Press ***Enter*** to view a complete listing of adjustment reason codes on Map 1821, or type an adjustment reason code in the **REASON CODE** field and press ***Enter*** to display Map 1822.

> On Map 1821, press ***F6*** to scroll forward through the list of adjustment reason codes. Press ***F5*** to scroll backwards.

```
MAP1821                      CGS J15 MAC -  Part A REGION          ACPFA052 XX/XX/XX
XXXXXX      SC             ADJUSTMENT REASON CODES INQUIRY        C201135E XX:XX:XX
                                    SELECTION SCREEN              MNT: XXXXXX

MMDDYY
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
S 1  AA AA A This change is due to an automated adjustment.
  1  AC PI A AUDIT COMPLIANCE
  1  AD AD I This overpayment is a result of a Quality Improvement Organizati
  1  AH HF A ADJUSTMENTS TO DO FULL DENIAL ON PREVIOUSLY PAID CLAIM.
  1  AJ NN A HEARING REOPEN
  1  AM AM I This overpayment is a result of a Quality Improvement Organizati
  1  AP NW A HEARING PARTIAL
  1  AR AR I This claim adjustment is due to a review that reversed the
  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  BL BL A This overpayment is a result of a claim being processed with
  1  BP OR A PART B REVIEW PARTIAL
  1  BR OO A PART B REVIEW REOPEN
     PROCESS COMPLETED --- PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

4. Type ***S*** in the **S** field to select a specific code. Press ***Enter*** to view Map 1822.

> You can only select one code at a time.

```
MAP1822                    CGS J15 MAC - Part A REGION           ACPFA052 XX/XX/XX
XXXXXX      SC         ADJUSTMENT REASON CODE UPDATE SCRN INQUIRY C201135E XX:XX:XX
                                                                 MNT: XXXXXX MMDDYY
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
```

5. The Adjustment Reason Code Update Scrn Inquiry (Map 1822) appears. The difference between Map 1821 and Map 1822 is that Map 1822 allows you to see the full narrative.

6. Press ***F7*** to return to Map 1821.

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Field Descriptions for Option 16 – Adjustment Reason Codes

Map 1821 Field Descriptions	
MNT:	Identifies your operator ID and today's date. For intermediary use only.
CLAIM TYPES:	Claim types. The claim types identified for each adjustment reason code. The claim types are: **I** Inpatient/SNF **O** Outpatient **H** Home Health/CORF **A** All Claims
PLAN CODE:	Plan Code. For intermediary use only.
REASON CODE:	Adjustment reason code. To review a particular adjustment reason code, enter the adjustment reason code value in this field. This field can be used instead of the S (selection) field described below.
S	Selection. This field is used to make a selection to view information for a particular adjustment reason code.
PC	Plan Code. For intermediary use only.
RC	Adjustment reason code. This field displays the adjustment reason codes.
HC	HIGLAS adjustment reason code. This field identifies the HIGLAS (Healthcare Integrated General Ledger Accounting System) adjustment reason code.
TYPE	Claim type. The type of claim associated with this reason code. (Refer to the "CLAIM TYPES" field, above, for valid values.)
NARRATIVE	Narrative. The description for the adjustment reason code.

Map 1822 Field Descriptions	
MNT:	Identifies the last operator who created or revised this screen and the date. For intermediary use only.
CLAIM TYPES:	The claim types identified for each adjustment reason code. Valid claim types are: **I** Inpatient/SNF **O** Outpatient **H** Home Health/CORF **A** All Claims
PLAN CODE:	Plan Code. For intermediary use only.
REASON CODE	Adjustment reason code identifying the reason for an adjustment.
HIGLAS REASON CODE	HIGLAS reason code. Used to crosswalk the FISS adjustment reason code to the HIGLAS adjustment reason code.
CLAIM TYPE	Claim type. The type of claim associated with this reason code. (Refer to the "CLAIM TYPES" field, above, for valid values.)
NARRATIVE	Narrative. The description for the adjustment reason code.

Reason Codes (Option 17)

The Reason Codes Inquiry screen provides an explanation/description of the reason code on your claim. **You will use this option often** to determine what actions are necessary to correct claims in the Return to Provider (RTP) file (T B9997). Rather than selecting option 17 from the Inquiry Menu, you will most likely access the reason codes by pressing F1 when you are in the Claims Entry or Claims Correction options in FISS.

1. From the Inquiry Menu, type ***17*** in the **Enter Menu Selection** field and press ***Enter***.

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```
MAP1702                        CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                           INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF           10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY             12    CLAIM COUNT SUMMARY       56

      REVENUE CODES             13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES                14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9       15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10      1B

      REASON CODES              17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS      88    PROV PRACTICE ADDR QUER   1D

                                      NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 17


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

You may also access this screen by typing **17** in the SC field if you are in an inquiry or claim entry screen or by pressing ***F1*** while you are inquiring, entering or correcting a claim.

2. The Reason Codes Inquiry screen (Map 1881) appears:

```
MAP1881                        CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/
YY
XXXXXX     SC                    REASON CODES INQUIRY               C201135E HH:MM:SS
                                                                        MNT:
PLAN  REAS    NARR    EFF       MSN       EFF        TERM      EMC      HC/PRO    PP
CC
IND   CODE    TYPE    DATE      REAS      DATE       DATE     ST/LOC    ST/LOC    LOC
IND
 1              E
 TPTP   A      B     NPCD   A     B      HD CPY A    B     NB ADR        CAL DY       C/L
-------------------------------NARRATIVE---------------------------------------

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

3. Enter the reason code in the **REAS CODE** field and press ***Enter***.

Reason codes are found at the bottom left corner of the FISS claim pages. Whenever a reason code appears on your claim, the easiest way to access it is to press your F1 key. Note that having a reason code present on your claim does not mean that it needs correction. For example, even when a claim is in a "P" (paid) status, FISS still assigns a reason code to the claim. Refer to the Chapter 5 of this guide to further understand when you need to correct a claim.

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```
MAP1881                        CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX       SC              REASON CODES INQUIRY                    C201135E HH:MM:SS
                                                                       MNT: XXXXXX
MMDDYY
PLAN  REAS   NARR    EFF        MSN       EFF        TERM      EMC        HC/PRO    PP
CC
IND   CODE   TYPE    DATE       REAS      DATE       DATE     ST/LOC      ST/LOC    LOC
IND
 1    32402    E    052394                                      T          T
 TPTP  A     B     NPCD A       B       HD CPY A      B      NB ADR        CAL DY
C/L C
-----------------------------------NARRATIVE-------------------------------------
HCPCS CODE REPORTED ON THIS CLAIM HAS NOT BEEN BILLED WITH A VALID
REVENUE CODE FOR THE DATES OF SERVICE.
VERIFY BILLING AND IF APPROPRIATE, CORRECT.
** ONLINE PROVIDERS:  PRESS PF9 TO STORE THE CLAIM
** OTHER PROVIDERS:   RETURN TO THE INTERMEDICARY.

        PROCESS COMPLETED --- PLEASE CONTINUE
 PRESS PF3-EXIT    PF6-SCROLL FWD     PF8-NEXT
```

NOTE: Please note that you may need to press ***F6*** to scroll forward to see all of the reason code narrative.

4. To see the ANSI reason code that corresponds to the FISS reason code press your F8 key. The ANSI Related Reason Codes Inquiry screen (Map 1882) appears.

```
MAP1882                          CGS J15 MAC - Part A REGION       ACPFA052 MM/DD/YY
XXXXXX     SC            ANSI RELATED REASON CODES INQUIRY        C201135E HH:MM:SS
                                                                   MNT: XXXXXX
MMDDYY REASON CODE: 38107
PIMR ACTIVITY CODE:                DENIAL CODE:                       MR
INDICATOR:
                                   PCA INDICATOR:                     LMRP/NCD
ID :
ANSI CODES
  ADJ REASONS:

  GROUPS     :

  REMARKS    :

  APPEALS (A):

  APPEALS (B):

  CATEGORY   :   EMC P1                  HC P1

  STATUS     :   EMC 0020                HC 0020

           PRESS PF3-EXIT PF7-PREV PAGE
```

Field Descriptions for Option 17 – Reason Codes

Map 1881 Field Descriptions	
MNT:	Identifies the last operator who created or revised this screen and the date. For intermediary use only.
PLAN IND	Plan indicator. For intermediary use only.
REAS CODE	Reason code. The reason code identifies a specific condition assigned to the claims during processing. The following identifies the meaning of the first digit of the reason code.

First Digit of Reason Code	Meaning	Example
1	Consistency Edits	11801 (missing/invalid point of origin, previously known as source of admission)
3	FISS	37402 (claims not submitted sequentially) 38107 (system cannot match final claim to processed RAP)
5	Medical Review	56900 (no response to additional development request)

NARR TYPE	Narrative type. An “E” indicates the narrative is for external users.

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Map 1881 Field Descriptions	
EFF DATE	Effective date. The effective date of the reason code.
MSN REAS	Medicare Summary Notice Reason. If a denial is made on the claim, the denial reason code in this field generates the narrative for the Notes section of the Medicare Summary Notice (MSN).
EFF DATE	Effective Date. The effective date for the alternate reason.
TERM DATE	Termination Date. The termination date for the alternate reason.
EMC ST/LOC	Electronic media claims status and location. The status and location set up for automated claims that encounter the reason code. If this field is blank, the HC/PRO ST/LOC field will apply.
HC/PRO ST/LOC	Hardcopy/Quality Improvement Organization (QIO) Status/Location. The status and location set up for hardcopy or QIO claims, which encounter the reason code.
PP LOC	Post-pay location. This field identifies the post-pay location for postpay development activities.
CC IND	Clean claim indicator. This field instructs the system whether to pay interest. Values are: **A** PIP other. **B** PIP clean. **C** Non-PIP other. **D** Non-PIP clean. **E** Additional information was requested (non-PIP). **F** Additional information was requested (PIP). **G** A reply was received from the Common Working File (CWF) providing a date of death, which required development in order to process the claim (non-PIP). **H** A reply was received from CWF providing a date of death, which required development in order to process the claim (PIP). **I** A non-definitive response was received from CWF requiring development (non-PIP). **J** A non-definitive response was received from CWF requiring development (PIP). **K** A definitive response was not received from CWF within 7 days (delayed response) (non-PIP). **L** A definitive response was not received from CWF within 7 days (delayed response) (PIP). **M** The claim was manually set to non-clean. This will only occur in rare situations such as a claim requiring development external to the intermediary's operation (non-PIP). **N** The claim was manually set to non-clean. This will only occur in rare situations such as a claim requiring development external to the intermediary's operation (PIP). **O** The claim is a sequential claim in which the prior claim was pending (non-PIP). **P** The claim is a sequential claim in which the prior claim was pending (PIP).
TPTP A - B	For intermediary use only.
NPCD A - B	For intermediary use only.
HD CPY A - B	For intermediary use only.
NB ADR	For intermediary use only.
CAL DY	For intermediary use only.
C/L	For intermediary use only.
NARRATIVE	Narrative for the specific reason code.

Map 1882 Field Descriptions	
MNT:	Identifies the last operator who created or revised this screen and the date. For intermediary use only.
REASON CODE:	Reason code. The reason code identifies a specific condition assigned to the claims during processing.
PIMR ACTIVITY CODE:	Program integrity management reporting (PIMR) activity code. The PIMR activity code for which the reason code is being categorized. Valid values are: **AI** Automated CCI edit **AL** Automated locally developed edit **AN** Automated national edit **CP** Prepay complex probe review **DB** TPL or demand bill claim review **MR** Manual routine review **PS** Prepay complex provider specific review **RO** Reopening **SS** Prepay complex service specific review

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Map 1882 Field Descriptions	
DENIAL CODE:	PIMR denial reason code. The denial reason code for which the reason code is being categorized. Valid values are: **100001** Documentation Does Not Support Service **100002** Investigation/Experimental **100003** Item/Services Excluded From Medicare Coverage **100004** Requested Information Not Received **100005** Services Not Billed Under The Appropriate Revenue Or Procedure Code (Include Denials Due To Unbundling In This Category **100006** Services Not Documented In Record **100007** Services Not Medically Reasonable And Necessary **100008** Skilled Nursing Facility Demand Bills **100009** Daily Nursing Visits Are Not Intermittent/ Part Time **100010** Specific Visits Did Not Include Personal Care Service **100011** Home Health Demand Bills **100012** Ability To Leave Home Unrestricted **100013** Physician's Order Not Timely **100014** Service Not Ordered/Not Included In Treatment Plan **100015** Services Not Included In Plan Of Care **100016** No Physician Certification (E.G. Home Health) **100017** Incomplete Physician Order **100018** No Individual Treatment Plan **100019** Other
MR INDICATOR:	Complex manual medical review. Identifies whether the service received complex manual medical review. Valid values are: **" "** The services did not receive manual medical review. **Y** Medical records received. This service received complex manual medical review. **N** Medical records were not received. This service received routine manual medical review
PCA INDICATOR	Progressive Correction Action. Identifies the progressive correction action indicator. Valid values are: **" "** The medical policy parameter is not PCA-related and is not included in the PCA transfer files. **Y** The medical policy parameter is PCA-related and is included in the PCA transfer files. **N** The medical policy parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID:	Local medical review policy (LMRP) (currently known as local coverage determination (LCD)) and/or national coverage determination (NCD) identification number. The LMRP/NCD ID number that are assigned to the FMR reason code for reporting on the Medicare Summary Notice. Intermediary/CMS defined.
ADJ REASONS	Adjustment reasons. This field provides the American National Standards Institute (ANSI) code that explains why an adjustment is being processed.
GROUPS	Groups. This field provides the ANSI code indicating the financial responsibility for the amount of the adjustment or identifies a postinitial adjudication adjustment in the X12 835 case segment. The five group codes are: **PR** Patient responsibility **CO** Contractual obligations **OA** Other adjustment **CR** Correction to or reversal of a prior decision **96** Noncovered charges
REMARKS	Remarks. This field provides the ANSI code that identifies the reason for non-payment. This is a five-position alphanumeric field, with four occurrences.
APPEALS (A)	Appeals (A). This field provides the ANSI code indicating the appeal rights related to the initial Part A determination.
APPEALS (B)	Appeals (B). This field provides the ANSI code indicating the appeal rights related to the initial Part B determination.
EMC CATEGORY	Electronic media claim category code. This field provides the ANSI code that identifies the EMC category of the claim returned on a 277 claim status response.
HC CATEGORY	Hard copy claim category code. This field provides the ANSI code that identifies the hard copy category of the claim returned on a 277 claim status response.
EMC STATUS	Electronic media claim status code. This field provides the ANSI code that identifies the EMC status of the claim returned on a 277 claim status response.
HC STATUS	Hard copy claim status code. This field provides the ANSI code that identifies the hard copy status of the claim returned on a 277 claim status response.

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Invoice NO/DCN Trans (Option 88)

This option gives provides the ability to look up claims associated with an Accounts Receivalbe (AR) by using the document control number (DCN).

1. From the Inquiry Menu, type 88 in the Enter Menu Selection field and press Enter.

```
MAP1702                CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
  XXXXXX                    INQUIRY MENU                  C201135E HH:MM:SS


    BENEFICIARY/CWF           10    ZIP CODE FILE              19

    DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY     1A

    CLAIM SUMMARY             12    CLAIM COUNT SUMMARY        56

    REVENUE CODES             13    HOME HEALTH PYMT TOTALS    67

    HCPC CODES                14    ANSI REASON CODES          68

    DX/PROC CODES ICD-9       15    CHECK HISTORY              FI

    ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10       1B

    REASON CODES              17    CMHC PAYMENT TOTALS        1C

    INVOICE NO/DCN TRANS      88    PROV PRACTICE ADDR QUER    1D

                                    NEW HCPC SCREEN          1E

  ENTER MENU SELECTION: 88


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

You may also access this screen by typing 88 in the SC field if you are in an inquiry or claim entry screen.

2. The INVOICE NO/DCN TRANSLATOR Inquiry screen (Map HDCN) appears:

```
MAPHDCN                        CGS J15 MAC - HHH REGION              ACPFA052 MM/
DD/YY
XXXXXX                        INQUIRY MENU                           C201135E
HH:MM:SS
                          INVOICE NUMBER/DCN TRANSLATOR

    PLEASE ENTER UP TO 5 DCNS ON THE LEFT OR 5 DCNS ON THE RIGHT. PRESS PF9.
    THE EQUIVALENT DCNS WILL BE DISPLAYED IN THE OPPOSITE FIELD.

         F I S S    D C N                      INVOICE NUMBER

         XXXXXXXXXXXXXXXXXXXXXXX                XXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX                XXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX                XXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX                XXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX                XXXXXXXXXXXXXXXXX
```

```
MSG:          PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PF1=             PF2=          PF3=END       PF4=          PF5=          PF6=
PF7=             PF8=          PF9=PROCESS   PF10=         PF11=         PF12=
```

Field Descriptions for Option 88 – Invoice NO/DCN Trans	
FISS DCN	Enter the FISS document control number (DCN) of the claim to populate the Invoice Number field. Up to five DCNs can be entered.
INVOICE NUMBER	Enter the HIGLAS invoice number to populate the FISS DCN field. Up to five DCNs can be entered.

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Zip Code File (Option 19)

This option is applicable to ambulance providers. It provides the geographic area definitions (rural, urban, and super rural) by zip code and by state.

1. From the Inquiry Menu, type ***19*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                      CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                         INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE              19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY     1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY        56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS    67

      HCPC CODES               14    ANSI REASON CODES          68

      DX/PROC CODES ICD-9      15    CHECK HISTORY              FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10       1B

      REASON CODES             17    CMHC PAYMENT TOTALS        1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER    1D

                                     NEW HCPC SCREEN            1E

   ENTER MENU SELECTION: 19


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

You may also access this screen by typing 19 in the SC field if you are in an inquiry or claim entry screen.

2. The Zip Code Inquiry screen (Map 1171) appears.

```
MAP1171                 CGS J15 MAC  - Part A REGION        ACMFA552 MM/DD/YY
  XXXXXXX   SC                    ZIP CODE INQUIRY          C201841F HH:MM:SS
  ZIP CODE:          PLUS-FOUR:
                                    RURAL   RURAL
  SEL ZIP PLUS FOUR CARRIER  LOC     IND     IND2    PIND  PLUS4-FLAG  STATE
```

Enter a Zip Code in the ZIP CODE field, and Press ***Enter***.

```
MAP1171                 CGS J15 MAC  - Part A REGION        ACMFA552 MM/DD/YY
  XXXXXXX   SC                    ZIP CODE INQUIRY          C201841F HH:MM:SS
  ZIP CODE: 44195  PLUS-FOUR:
                                    RURAL   RURAL
  SEL ZIP PLUS FOUR CARRIER  LOC     IND     IND2    PIND  PLUS4-FLAG  STATE

      44195 0000     15202   00      U       U       A       0         OH
      44197 0000     15202   00      U       U       A       0         OH
      44198 0000     15202   00      U       U       A       0         OH
      44199 0000     15202   00      U       U       A       0         OH
      44201 0000     15202   00      U       U       A       0         OH
```

Map 1171 Field Descriptions	
ZIP CODE	Identifies the Zip Code on the Zip Code file.
PLUS-FOUR	Identifies the Zip Code 4 digit extension.
SEL	The selection field. Type “S” in the SEL field to access Map 1172 which displays the list of extensions associated with a zip code and a plus-four flag indicator.
ZIP	Identifies the Zip Code on the Zip Code file. The first Zip Code on the Zip code file displays first.

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Map 1171 Field Descriptions	
PLUS-FOUR	Identifies the Zip Code 4 digit extension.
CARRIER	Identifies the carrier number assigned to the HCPC.
LOC	Identifies the locality identification number for the area (or county) where the provider is located.
RURAL IND	Identifies the rural indicator. Valid values are: U – Urban R – Rural B – Rural Bonus
RURAL IND2	Identifies the rural indicator. Valid values are: U – Urban R – Rural B – Rural Bonus
PIND	Identifies the ASP price bucket indicator. Valid values are: A through Z with the exception of H, I, O, R, S = ASP price bucket indicators
PLUS4-FLAG	Identifies the plus 4 flag indicator. Valid values are: 0 – No +4 Extension 1 - +4 Extension
STATE	Identifies the state associated with the Zip Code.

OSC Repository Inquiry (Option 1A)

This option is used to retain the history of all Occurrence Span Codes (OSCs) billed by Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) providers.

1. From the Inquiry Menu, type ***1A*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                      CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                         INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 1A


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

2. The DDE OSC Repository Inquiry screen (Map 11A1) appears.

```
  MAP11A1   PG          CGS J15 MAC -  Part A REGION          ACMFA552 MM/DD/YY
  XXXXXXX   SC       DDE OSC REPOSITORY INQUIRY               C201822P HH:MM:SS

      PROVIDER XXXXXX            MID                   ADMIT DATE

    DOCUMENT CONTROL NUMBER  OSC FROM DATE TO DATE    OSC FROM DATE TO DATE




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


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3. Enter the beneficiary Medicare number in the HIC field and the admission date in the ADMIT DATE field, and press ***Enter***.

Map 11A1 Field Descriptions	
PROVIDER	Identifies your Medicare provider number.
MID	The beneficiary's Medicare number.
ADMIT DATE	The beneficiary's admission date.
DOCUMENT CONTROL NUMBER	Identifies the document control number (DCN) of the claim.
OSC	The occurrence span code that identifies events that relate to the payment of the claim.
FROM DATE	Identifies the occurrence span from date related to the claim.
TO DATE	Identifies the occurrence span to date related to the claim.

Claim Count Summary (Option 56)

This option provides a summary of all of your facility's billing transactions that are currently processing within FISS by status/location and type of bill. This option will assist you in getting a quick picture of where all of your processing claims are located in FISS. CGS recommends that you check option 56 when you first sign into FISS for the day. This screen is only updated in the evening, Monday through Friday. By reviewing option 56, you can easily identify if there are claims:

- On the payment floor (P B9996), which means your claim has been approved for payment;
- In an Additional Development Request (ADR) status (S B6001), which means that CGS has requested that you submit additional information; or
- In a Return to Provider (RTP) status (T B9997), which means that the claim needs to be corrected by your facility.

1. From the Inquiry Menu, type ***56*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC -  Part A REGION        ACPFA052 MM/DD/YY
XXXXXX                       INQUIRY MENU                          C201135E HH:MM:SS


      BENEFICIARY/CWF           10    ZIP CODE FILE              19

      DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY     1A

      CLAIM SUMMARY             12    CLAIM COUNT SUMMARY        56

      REVENUE CODES             13    HOME HEALTH PYMT TOTALS    67

      HCPC CODES                14    ANSI REASON CODES          68

      DX/PROC CODES ICD-9       15    CHECK HISTORY              FI

      ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10       1B

      REASON CODES              17    CMHC PAYMENT TOTALS        1C

      INVOICE NO/DCN TRANS      88    PROV PRACTICE ADDR QUER    1D

                                      NEW HCPC SCREEN            1E

  ENTER MENU SELECTION: 56


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

You may also access this screen by typing ***56*** in the SC field if you are in an inquiry or claim entry screen.

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2. The Claim Summary Totals Inquiry screen (Map 1371) appears:

```
MAP1371                          CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX      SC                CLAIM SUMMARY TOTALS INQUIRY            C201135E HH:MM:SS

      PROVIDER                          S/LOC          CAT
      NPI
S/LOC       CAT     CLAIM COUNT          TOTAL CHARGES          TOTAL PAYMENT

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

3. To obtain the summary of billing transactions, press ***Enter***.

If you are authorized to view other provider number information (branch office), you will have access to the PROVIDER field to enter another provider number.

You may also enter a specific status/location (e.g., T B9997) in the S/LOC field, or a category type in the CAT field to narrow the selection.

```
MAP1371                          CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX      SC          CLAIM SUMMARY TOTALS INQUIRY                  C201135E HH:MM:YY

        PROVIDER NNNNNN            S/LOC          CAT
        NPI NNNNNNNNNN


S/LOC          CAT     CLAIM COUNT     TOTAL CHARGES     TOTAL PAYMENT
               GT            49          48,389.34          5,722.00
P B7501        TC             9           9,768.85             00.00
P B7501        13             9           9,768.85             00.00
P B7505        TC            20          22,767.48             00.00
P B7505        12             5           4,099.80             00.00
P B7505        11            15          18,667.68             00.00
P B9996        TC             6           6,921.11          5,722.00
P B9996        11             6           6,921.11          5,722.00
S B90M0        TC             1              00.00             00.00
S B90M0        32             1              00.00             00.00
S B6001        TC             2           1,761.70             00.00
S B6001        13             1             761.70             00.00
S B6001        11             1           1,000.00             00.00
T B9997        NM            11           7,170.20             00.00
T B9997        TC            11           7,170.20             00.00
T B9997        11            11           7,170.20             00.00

        PROCESS COMPLETED --- PLEASE CONTINUE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

4. Once the information is displayed, you can identify where your claims are within FISS by looking at the **S/LOC** field. Option 56 identifies how many claims are in a particular status/location. The CAT column identifies the first two digits of the type of bill and the category code for each specific status/location. The CLAIM COUNT column provides the number of claims in that specific status/location. Refer to the field description for a complete list of CAT codes. You may need to press F6 to see the complete list of status/locations.

- In the screen example above, this provider can quickly identify:
  - There are a grand total (GT) of 49 claims for a total charge of $48,389.34 and payment amount of $5,722.00 (payment floor status/location P B9996).
  - The status/location P B9996 (payment floor) has a total count (TC) of six claims. The six claims have a total charge of $6,921.11 and a total payment of $5,722.00. All six claims are type of bill (TOB) 13X (CAT code 13).
  - The status/location S B6001 (Additional Development Request (ADR) status) has a total count (TC) of two claims. One of the claims is a TOB 12X; and one is a TOB 13X (CAT codes 12 and 13).
  - The status/location T B9997 (Return to Provider (RTP) status) has a total count (TC) of 11 claims. All claims are TOB 13X (CAT code 13) and all were placed in RTP because of clerical errors (CAT code NM).

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- Option 56 only displays claims that are currently processing in FISS. Claims that are finalized in the system (i.e., with status/locations of R B9997, P B9997, D B9997) are not included within this option. In addition, option 56 only displays claims by status/location code. You can use option 56 in conjunction with option 12 if you want to identify *which* claims are in a particular status/location code.

If you want to know specifically which six claims are in P B9996, press ***F3*** to exit option 56. Select 12 (Claims) from the Inquiry Menu and press ***Enter***. Type your facility's NPI number in the **NPI** field, then tab to the **S/LOC** field and enter P B9996. Press ***Enter***. All the claims for your facility that are in status/location P B9996 will appear. See below. Remember that you may need to press ***F6*** to scroll forward to see all claims.

```
MAP1741                    CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/
YY
XXXXXX     SC          CLAIM SUMMARY INQUIRY                  C201135E HH:MM:SS
                           NPI XXXXXXXXXX
    MID                PROVIDER                    S/LOC P B9996    TOB
OPERATOR ID XXXXXXXXXX  FROM DATE       TO DATE                   DDE SORT
MEDICAL REVIEW SELECT          DCN
      MID           PROV/MRN  S/LOC       TOB     ADM DT  FRM DT  THRU  DT  REC DT
SEL   LAST NAME   FIRST INIT  TOT CHG   PROV REIMB  PD DT  CAN DT REAS NPC #DAYS
  NNNNNNNNNA XXXXXX          P B9996      131    0805XX 0801XX   0831XX   1006XX
    LASTNAME           A   1203.00       1008.00   1103XX         37186

  NNNNNNNNNB XXXXXX          P B9996      131      0807XX 0801XX 0831XX   1006XX
    LASTNAME           B   1500.00        896.00   1103XX         37186

  NNNNNNNNND XXXXXX          P B9996      131    1101XX 1101XX   1130XX   0202XX
    LASTNAME           C   1653.00       1400.00   0302XX         37186

  NNNNNNNNNA XXXXXX          P B9996      131    1001XX 1001XX   1031XX   0202XX
    LASTNAME           D    795.00        392.00   0301XX         37186

  NNNNNNNNNA XXXXXX          P B9996      131    1001XX 1001XX   1028XX   0212XX
    LASTNAME           E   1512.00       1120.00   0311XX         37186
     PROCESS COMPLETED --- PLEASE CONTINUE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

- When you view option 56, pay particular attention to whether you have claims in status/locations S B6001 and T B9997. These two status/locations require that you take action.
  - Claims in S B6001 require that you submit the information being requested via the ADR. Select option 12 (Claims) from the Inquiry Menu to determine which claims were selected, and what documentation you need to submit to respond to the ADR. For information about identifying and responding to ADRs, refer to the "Claims (Option 12)" information found earlier in this chapter.
  - Claims in the RTP status/location, T B9997, require that you make the necessary corrections to the claims. Select 03 (Claims Correction) from the Main Menu to correct claims.
- The TOTAL PAYMENT column identifies the payment amount for those claims that have been approved for payment (on the payment floor) and are in status/location (P B9996).
- Option 56 updates when the system cycle runs each night, Monday through Friday. Therefore, if option 56 indicates that you have two claims to correct, and you immediately correct both claims, option 56 will continue to indicate that you have two claims to correct until the screen updates during the nightly cycle. Please note that nightly cycles do not typically run on Federal holidays.
- After suppressing the view of a claim, it will no longer display in the RTP file; however, when viewing Claim Count Summary (option 56) or the Claim Inquiry (option 12) screens, the claim may still appear in status/location T B9997 for several weeks, until FISS purges suppressed claims to the "I" status.

5. Once you have reviewed the information on option 56, press ***F3*** to exit and return to the Inquiry Menu. You can then select 12 (Claims) from the Inquiry Menu to view the specific claims within each status/location.

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Field Descriptions for Option 56 - Claim Count Summary

Map 1371 Field Descriptions	
PROVIDER	Your Provider Transaction Access Number (PTAN).
S/LOC	Status/Location. Enter a specific status/location code in this field to view the number of billing transactions in that specific status/location. CGS suggests leaving this blank so you can see the status/locations of all the billing transactions currently processing.
CAT	Category. Enter a specific category (GT, TC, 13, 11, 72, or 74) to view the number of billing transaction under that specific category. CGS suggests leaving this blank so you can see all claims currently processing. See below for the valid CAT codes.
NPI	Your facility's National Provider Identifier (NPI) number.
S/LOC	This identifies the current status/location of the claims
CAT	The Category field identifies different items within the list. Valid values are: **##** – First two digits of the type of bill **GT** – Grand total of claims currently in process. **TC** – Total count of claims in a particular status/location. **AD** – An adjustment **NM** – Non-medical indicates the claim was placed in RTP because of a clerical error. **MP** – Medical policy indicates the claim was placed in RTP because of nonclerical error.
CLAIM COUNT	The total claim count for each specific status/location.
TOTAL CHARGES	The total dollar amount of charges submitted by the provider for the total number of claims identified in the claim count.
TOTAL PAYMENT	The total dollar payment amount calculated by the system. An amount will only show in this column for claims on the payment floor (P B9996).

ANSI Reason Codes (Option 68)

This option allows you to view the narrative for the ANSI (American National Standards Institute) codes. ANSI reason codes appear on remittance advices, and provide additional information, such as provider appeal rights and claims processing determinations.

1. From the Inquiry Menu, type 68 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                      CGS J15 MAC -  Part A REGION       ACPFA052 MM/DD/YY
XXXXXX                      INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 68

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

You may also access this screen by typing ***68*** in the SC field if you are in an inquiry or claim entry screen.

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2. The ANSI Standard Codes Inquiry screen (Map 1581) appears:

```
MAP1581                 CGS J15 MAC -  Part A REGION              ACPFA052 MM/DD/
YY
XXXXXX    SC              ANSI STANDARD CODES SEL INQUIRY         C201135E HH:MM:SS

 RECORD TYPE:
 C = ADJ REASONS   G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE:                  T = CLAIM CATEGORY  S = CLAIM STATUS
 S RT CODE TERM DT                  NARRATIVE



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

3. Type a record type, (A, C, G, R, S, or T) in the **RECORD TYPE** field and press ***Enter*** to display the ANSI reason codes for that particular record type

A = Appeals	**C** = Adjustment reason	**G** = Groups
R = Reference remarks	**S** = Claim status	**T** = Claim category

4. Press ***F6*** to page forward through the various ANSI reason codes. Press ***F5*** to scroll backwards.

```
MAP1581                          CGS J15 MAC -  Part A REGION      ACPFA052 MM/DD/YY
XXXXXX    SC              ANSI STANDARD CODES SEL INQUIRY         C201135E HH:MM:SS

 RECORD TYPE: A
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE:                  T = CLAIM CATEGORY  S = CLAIM STATUS
 S RT CODE TERM DT                  NARRATIVE
   A MA01          IF YOU DISAGREE WITH WHAT WE APPROVED FOR THESE SERVICES, Y
 S A MA02          IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE R
   A MA04  110407 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY
   A MA05  101603 INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL EN
   A MA06  080104 INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
   A MA07  110407 THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID F
   A MA08  110407 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSU
   A MA09  110407 CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YO
   A MA10  110407 THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU
   A MA100 110407 DID NOT COMPLETE OR ENTER ACCURATELY THE DATE OF CURRENT IL
```

5. Type ***S*** in the **S** field to view the entire narrative for the ANSI reason code and press ***Enter***.

```
MAP1581                          CGS J15 MAC -  Part A REGION      ACPFA052 MM/DD/YY
XXXXXX    SC              ANSI STANDARD CODES SEL INQUIRY         C201135E HH:MM:SS

 RECORD TYPE:
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE:                  T = CLAIM CATEGORY  S = CLAIM STATUS
 S RT CODE TERM DT                  NARRATIVE
   A MA01          IF YOU DISAGREE WITH WHAT WE APPROVED FOR THESE SERVICES, Y
 S A MA02          IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE R
   A MA04  110407 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY
   A MA05  101603 INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL EN
   A MA06  080104 INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
   A MA07  110407 THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID F
   A MA08  110407 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSU
   A MA09  110407 CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YO
   A MA10  110407 THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU
   A MA100 110407 DID NOT COMPLETE OR ENTER ACCURATELY THE DATE OF CURRENT IL
```

6. The ANSI Standard Reason Codes Inquiry screen (Map 1582) appears.

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```
MAP1582                  CGS J15 MAC -  Part A REGION              ACPFA052 MM/DD/
YY
XXXXXX     SC       ANSI STANDARD REASON CODES INQUIRY           C201135E HH:MM:SS
                                                              MNT: SYSTEM   MM/DD/YY

  RECORD TYPES ARE:
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
                                  T = CLAIM CATEGORY S = CLAIM STATUS
                           RECORD TYPE    : A         TERM DT   :
                                                      EFF DT    :  010197
                           STANDARD CODE : MA02

                           NARRATIVE:

  ALERT: IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE RIGHT
  TO APPEAL.  YOU MUST FILE A WRITTEN REQUEST FOR AN APPEAL WITHIN 180
  DAYS OF THE DATE YOU RECEIVE THIS NOTICE.

        PRESS PF-3-EXIT  PF7-PREV PAGE
```

7. Press ***F7*** to return to Map 1581.

8. **To display one specific ANSI code**, type the appropriate record type (e.g., A, C, G, R, S, or T) in the **RECORD TYPE** field. Type the ANSI Standard Code that you wish to view in the **STANDARD CODE** field and press ***Enter***. The Map 1582 will display.

```
MAP1581                    CGS J15 MAC - Part A REGION          ACPFA052  MM/DD/YY
XXXXXX     SC                ANSI STANDARD CODES SEL INQUIRY    C201135E  HH:MM:SS

 RECORD TYPE: C
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE: B1              T = CLAIM CATEGORY  S = CLAIM STATUS
 S RT CODE TERM DT                 NARRATIVE
```

```
MAP1582                    CGS J15 MAC - Part A REGION           ACPFA052 MM/DD/YY
 XXXXXX     SC            ANSI STANDARD REASON CODES INQUIRY     C201135E HH:MM:SS
                                                              MNT: SYSTEM      MM/DD/YY
   RECORD TYPES ARE:
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
                                  T = CLAIM CATEGORY S = CLAIM STATUS
                           RECORD TYPE    : C         TERM DT   :
                                                      EFF DT    :  010195
                           STANDARD CODE : B1

                           NARRATIVE:

   NON-COVERED VISITS.
```

Field Descriptions for Option 68 – ANSI Reason Codes

Map 1581 Field Descriptions	
RECORD TYPE	The record type for the ANSI standard code. Valid values are: **A** Appeals **G** Groups **S** Claim Status **C** Adjustment Reasons **R** Reference Remarks **T** Claim Category
STANDARD CODE	The standard code within the above record type.
S	The selection field used to view the entire narrative of a specific ANSI code.
RT	The record type of the ANSI code being selected.
CODE	The ANSI code being selected.
TERM DT	The date that the ANSI code was deactivated. (MMDDYY)
NARRATIVE	The description of the ANSI code.

Map 1582 Field Descriptions	
MNT:	Identifies the last operator who created or revised his screen and the date. For intermediary use only.
RECORD TYPE	The record type for the ANSI code.

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Map 1582 Field Descriptions	
STANDARD CODE	The ANSI code within the above record type.
NARRATIVE	The description of the ANSI code.

Check History (Option FI)

This option identifies the three most recent Medicare payments issued to your facility.

1. From the Inquiry Menu, type ***FI*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                      CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                         INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: FI

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

2. The Check History screen (Map 1B01) appears.
3. To view current check history, type your:
   - National Provider Identifier (NPI) in the **NPI** field; ***or***
   - Provider Transaction Access Number (PTAN) in the **PROV** field **and** your **NPI** in the NPI field.

NOTE: If you enter only your facility's PTAN in the **PROV** field, only check history from 2008 will display.

```
MAP1B01                      CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX    SC                      CHECK HISTORY                  C201135E HH:MM:SS


                           PROV                    NPI NNNNNNNNNN

                           CHECK #     DATE        AMOUNT


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

4. Press ***Enter*** to see check history for the three most recent reimbursements that were distributed to your facility either by check or Electronic Funds Transfer (EFT). The PTAN will display in the PROV field, after you type the NPI in the NPI field and press ***Enter***.

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```
MAP1B01                      CGS J15 MAC - Part A REGION        ACPFA052 10/23/YY
XXXXXX    SC                       CHECK HISTORY               C201135E HH:MM:SS


                          PROV  XXXXXX            NPI NNNNNNNNNN

                          CHECK #      DATE       AMOUNT

                          EFT2223333   YY1024     $916.56
                          EFT1112222   YY1023     $10,941.16
                          EFT0001111   YY1018     $12,468.66



        PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXI
```

Please note that one day is added to the paid date that appears in the Check History screen. The example above of the Check History screen was viewed on 10/23. The RA/ERA for the paid amount $916.56 will be dated 10/23. However, in FISS, for each individual claim record that appears on that RA/ERA, the paid date will display as 1023.

Check numbers that start with the letters EFT (e.g., EFT1234567) indicate that your facility receives its reimbursement via Electronic Funds Transfer (EFT).

Field Descriptions for Option FI - Check History

Map 1582 Field Descriptions	
PROV	Your Provider Transaction Access Number (PTAN). When entered without the NPI, only 2008 check history will display.
NPI	Your facility's National Provider Identifier (NPI).
CHECK #	The check number or EFT transaction number associated with the issued payment.
DATE	The date of the issued payment (YYMMDD format).
AMOUNT	The dollar amount of the payment issued. This amount can reflect all payments from Medicare (e.g., claims, cost report settlements, etc).

Dx/Proc Codes ICD-10 (Option 1B)

This option is helpful if you need to confirm the validity of ICD-10-CM (diagnosis) or ICD-10-PCS (procedure) codes. The compliance date for implementation of the ICD-10-CM coding system is **October 1, 2015**. As a result, the information below is limited, and shows only how this option is accessed. For more information about ICD-10 implementation, refer to the Centers for Medicare & Medicaid Services (CMS) at: https://www.cms.gov/Medicare/Coding/ICD10/index.html

1. From the Inquiry Menu, type ***1B*** in the **Enter Menu Selection** field and press ***Enter***.

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```
MAP1702                        CGS J15 MAC -  Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                           INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF           10    ZIP CODE FILE              19

      DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY     1A

      CLAIM SUMMARY             12    CLAIM COUNT SUMMARY        56

      REVENUE CODES             13    HOME HEALTH PYMT TOTALS    67

      HCPC CODES                14    ANSI REASON CODES          68

      DX/PROC CODES ICD-9       15    CHECK HISTORY              FI

      ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10       1B

      REASON CODES              17    CMHC PAYMENT TOTALS        1C

      INVOICE NO/DCN TRANS      88    PROV PRACTICE ADDR QUER    1D

                                      NEW HCPC SCREEN            1E

   ENTER MENU SELECTION: 1B


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

You may also access this screen by typing **1B** in the SC field if and pressing ***Enter***, if you are in an inquiry or claim entry screen.

2. The ICD-10-CM Code Inquiry screen (Map 1C31) appears:

```
MAP1C31                      CGS J15 MAC - HHH REGION              ACPFA052 MM/DD/YY
XXXXXX   SC                      ICD - 10 - CODE INQUIRY             C201135E
HH:MM:SS
DIAG/PROC:       STARTING ICD 10 CODE:

 D/P ICD 10 CODE SEQ CODE              DESCRIPTION:
             EFFECTIVE/TERM DATE




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

3. **To inquire about a diagnosis code,** type a **D** in the **DIAG/PROC** field and the diagnosis code in the **STARTING ICD 10 CODE** field and press Enter. Do not type the decimal point or zero-fill the code. To review a complete list of diagnosis codes, leave the **STARTING ICD 10 CODE** field blank, and press ***Enter***.
   - If more than one of the same code is listed, be sure to review the description, effective and termination dates, and use the most current code that applies to the service dates on your claim.
   - Press F6 to scroll forward through the list of diagnosis codes.
4. To make an additional inquiry, type a **D** in the **DIAG/PROC** field and the other diagnosis code over the previously entered diagnosis code and press ***Enter***.
5. **To inquire about a procedure code,** type the letter **P** in the **DIAG/PROC** field and the procedure code in the **STARTING ICD 10 CODE** field and press ***Enter***. To review a complete list of procedure codes, type the letter **P** in the **DIAG/PROC** field and press ***Enter***. Leave the **STARTING ICD 10 CODE** field blank.
6. Press ***F3*** to exit and return to the Inquiry Menu.

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Field Descriptions for Option 1B – DX/PROC Codes ICD-10

Map 1731 Field Descriptions	
DIAG/PROC	Identifies whether this is an ICD-10 diagnosis or procedure code. Valid values are: **D** Diagnosis code **P** Diagnosis code
STARTING ICD 10 CODE	ICD-10-CM code. The ICD-10-CM code identifying a specific diagnosis or procedure.
D/P	Identifies whether this is an ICD-10 diagnosis or procedure code (D or P).
ICD 10 CODE	The ICD-10 code used to identify a specific diagnosis or procedure.
SEQ CODE	Identifies the number of times CMS has terminated and then reactivated a given ICD-10 code with a different meaning.
DESCRIPTION	The ICD-10-CM code description.
EFFECTIVE/ TERM DATE	Effective/termination date. The effective and/or termination date for the ICD-10 code in MMDDYY format. (Up to three occurrences of dates can appear.)

CMHC Payment Totals (Option 1C)

This option is used to display the Community Mental Health Center (CMHC) payment and outlier totals for the current year and one previous year.

1. From the Inquiry Menu, type *1C* in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                    CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX                        INQUIRY MENU                       C201135E HH:MM:SS

      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17    CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88    PROV PRACTICE ADDR QUER   1D

                                     NEW HCPC SCREEN           1E

   ENTER MENU SELECTION: 1C

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

You may also access this screen by typing 1C in the SC field if you are in an inquiry or claim entry screen.

2. The CMHC Payment Totals Inquiry screen (Map 1D61) appears.

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```
MAP1D61                CGS J15 MAC - Part A REGION          ACMFA552 MM/DD/YY
 XXXXXXX   SC              CMHC PAYMENT TOTALS INQUIRY        C201822P HH:MM:SS

                    PROVIDER                    NPI

                  SEL   YEAR    OUTLIER TOTAL    PAYMENT TOTAL




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

Map 1731 Field Descriptions	
PD DT SRCH	Identifies the ability to search using the paid date for specific records of the provider and NPI number.
PROVIDER	Identifies your Medicare provider number.
NPI	Identifies your National Provider identifier (NPI) number.
YEAR	Identifies claim information for that year when an "S" is entered (by that year).
FR DATE	Identifies the From date of the paid claims
HIC	The Medicare number assigned to the beneficiary.
DCN	Identifies the Document Control Number assigned to the claim.
VALUE CD 17	Identifies the amount for Value Code 17.
OPPS PYMT	Identifies the amount for OPPS payment.
RTC	Identifies the amount for Return Code from IOCE/OCE.
PAID DATE	Identifies the date the claim was paid.
TOTAL PAID	Identifies the total amount paid.
TOTALS	Identifies the total amount of value code 17 and OPPS Payment for all records.

Prov Practice ADDR QUER (Option 1D)

This option allows you to view the practice location address for an off-campus, outpatient, or provider-based department of a hospital.

Effective April 1, 2019, system edits will be activated that require the service facility address reported on the claim to be an **exact** match to the provider practice file address provided in this screen. For additional information, please reference CMS MLN Matters article SE18023 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18023.pdf).

1. From the Inquiry Menu, type 1D in the **Enter Menu Selection** field and press ***Enter***.

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```
MAP1702                    CGS J15 MAC - Part A REGION       ACPFA052 MM/DD/YY
 XXXXXXX                         INQUIRY MENU                 C201314P HH:MM:SS


    BENEFICIARY/CWF           10      ZIP CODE FILE              19

    DRG (PRICER/GROUPER)      11      OSC REPOSITORY INQUIRY     1A

    CLAIM SUMMARY             12      CLAIM COUNT SUMMARY        56

    REVENUE CODES             13      HOME HEALTH PYMT TOTALS    67

    HCPC CODES                14      ANSI REASON CODES          68

    DX/PROC CODES ICD-9       15      CHECK HISTORY              FI

    ADJUSTMENT REASON CODES   16      DX/PROC CODES ICD-10       1B

    REASON CODES              17      CMHC PAYMENT TOTALS        1C

    INVOICE NO/DCN TRANS      88      PROV PRACTICE ADDR QUER    1D

                                      NEW HCPC SCREEN            1E

 ENTER MENU SELECTION:        1D

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

You may also access this screen by typing **1D** in the SC field and pressing ***Enter***, if you are in an inquiry or claim entry screen.

2. The PROV PRACTICE ADDR QUER screen (MAP1AB1) appears.

```
 MAP1AB1              CGS J15 MAC - Part A REGION              ACPFA052  MM/DD/YY
             SC    PROVIDER PRACTICE ADDRESS QUERY SUMMARY  C20112WS  HH:MM:SS

 NPI                  OSCAR
                                        PRAC       PRAC
 SEL NPI          OSCAR                 EFF DT     TERM DT     ADDRESS          ZIP
```

Map 1AB1 Field Descriptions	
NPI	The providers National Provider Identifier (NPI) number
OSCAR	Online Survey Certification and Reporting System (OSCAR).
SEL	Enter an “S” in this field to select each record for the OSCAR and/or NPI
NPI	The providers National Provider Identifier (NPI) number
OSCAR	Online Survey Certification and Reporting System (OSCAR).
PRAC EFF DT	The effective date of the Practice.
PRAC TERM DT	The Termination Date of the Practice.
ADDRESS	The Practice Provider’s address information.
ZIP	The Practice Provider’s zip code.

3. To access additional information, type an S in the **SEL** field. MAP 1AB2 will display.

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```
 MAP1AB2            CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
          SC      PROVIDER PRACTICE ADDRESS QUERY         C20112WS HH:MM:SS
                                                    MNT:
NPI               OSCAR

PRAC EFF DT                      PRAC TERM DT
PRACTICE LOCATION KEY
OTHER PRACTICE
TYPE OF PRACTICE
ADDRESS 1
ADDRESS 2
CITY                                  STATE       ZIP
NPI EFF DT                       NPI TERM DT

                Scroll, or End to terminate
```

Map 1AB2 Field Descriptions	
NPI	The providers National Provider Identifier (NPI) number
OSCAR	Online Survey Certification and Reporting System (OSCAR).
PRAC EFF DT	The effective date of the Practice.
PRAC TERM DT	The Termination Date of the Practice. When there is no actual practice termination date, the default value of 123119999 will display.
PRACTICE LOCATION KEY	The Practice Location Key from the PECOS Extract file.
OTHER PRACTICE	Identifies whether the PECOS record is for an other practice.
TYPE OF PRACTICE	The Practice Type.
ADDRESS 1	Address line 1 for the provider's practice location.
ADDRESS 2	Address line 2 for the provider's practice location.
CITY	The city for the provider's practice location.
STATE	The state for the provider's practice location.
ZIP	The zip for the provider's practice location.
NPI EFF DT	The effective date of the provider's NPI.
NPI TERM DT	The termination date of the provider's NPI. When there is no actual termination date, the default value of 123119999 will display.

NEW HCPC SCREEN (Option 1E)

This option is helpful if you need to inquire about Healthcare Common Procedure Coding System (HCPCS) code reimbursement or verify which revenue codes are allowable with HCPCS codes.

1. From the Inquiry Menu, type 1E in the **Enter Menu Selection** field and press Enter.

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```
MAP1702                    CGS J15 MAC - Part A REGION            ACPFA052 MM/
DD/YY
XXXXXX                        INQUIRY MENU                         C201135E
HH:MM:SS


      BENEFICIARY/CWF          10      ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11      OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12      CLAIM COUNT SUMMARY       56

      REVENUE CODES            13      HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14      ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15      CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16      DX/PROC CODES ICD-10      1B

      REASON CODES             17      CMHC PAYMENT TOTALS       1C

      INVOICE NO/DCN TRANS     88      PROV PRACTICE ADDR QUER   1D

                                       NEW HCPC SCREEN           1E

  ENTER MENU SELECTION: 1E


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

You may also access this screen by typing **1E** in the SC field if you are in an inquiry or claim entry screen.

2. The New HCPC Information Inquiry screen (Map 1E01) appears:

```
MAP1E01              CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/YY
XXXXXX      SC         NEW HCPC INFORMATION   INQUIRY         C201135E HH:MM:SS
                                                                    PAGE: 01
CARRIER          LOC       HCPC          MOD          IND      FEE   TYPE
EFF DT           TRM DT          PROVIDER

                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


HCPC DESCRIPTION


      PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

3. Use your Tab key to move to the **HCPC** field and type the HCPCS code. Press *Enter*. FISS will automatically insert information in the CARRIER and LOC fields based on your geographic location.
4. To determine if the HCPC code is allowable for hospice revenue codes, you must also enter an "R" in the **IND** field, and then press *Enter*.

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```
MAP1E01                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/YY
XXXXXX      SC             NEW HCPC INFORMATION  INQUIRY         C201135E HH:MM:SS
                                                                      PAGE: 01
CARRIER XXXXX    LOC XX  HCPC 99212          MOD       IND R   FEE TYPE    ISNF
EFF DT 0101XX    TRM DT          PROVIDER  XXXXXX                      ISNF RHHI
                                                          SUP1  SUP2  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

0101XX           F 0       0           M   0657

0101XX           F 0       0           M   0657

0101XX           F 0       0           M   0657

0101XX           F 0       0           M   0657


HCPC DESCRIPTION
Established patient office or other outpatient visit, typically 10 minutes

      PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Use the following function keys to move around the screen:

F3 – Exit (return to the Inquiry Menu)
F5 – Scroll up one page
F6 – Scroll down one page
F11 – Scroll right
F10 – Scroll left

5. Press *F11* to move the screen to the right. The New HCPC Rates Inquiry screen (Map 1E02) will display. Press *F10* to move back to the left of Map 1E01.

```
MAP1E02                  CGS J15 MAC - Part A REGION              ACPFA052 MM/DD/YY
XXXXXX      SC             NEW HCPC RATES  INQUIRY               C201135E HH:MM:SS
                                                                      PAGE: 02
  CARRIER XXXXX    LOC XX     HCPC 99212      MOD            IND   FEE TYPE  ISNF

  EFF DT  TRM DT   60%RATE     62%/REDU      REHAB          PROF  NFACPE  VAR COIN

  0101XX             46.070       44.420

  0101XX             44.080       44.090

  0101XX             44.080       42.860

  0101XX             44.080       42.450


  HCPC DESCRIPTION
Established patient office or other outpatient visit, typically 10 minutes
```

6. To inquire about other HCPCS codes, enter the HCPCS code over the previously entered HCPC and press *Enter*.
7. Press *F3* to exit the HCPCS Information Inquiry screen and return to the Inquiry Menu.

Field Descriptions for Option 1E (Map 1E01)– New HCPC Screen	
CARRIER	Carrier. The carrier number assigned to your provider file. System generated.
LOC	The two-position locality code which identifies the area where the provider is located.
HCPC	Healthcare Common Procedure Coding System. The HCPCS code to be reviewed on the screen.
MOD	HCPC Modifier. Multiple fees will be identified for the HCPCS code based on the modifier.
IND	HCPC indicator. Type an “R” to display hospice allowable revenue codes.

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Field Descriptions for Option 1E (Map 1E01)– New HCPC Screen	
FEE TYPE	This identifies the fee file the HCPC was obtained from. The valid values are: • ISNF • RHHI • OTHR • CLAB • CLFS • IDME • ABST • MAMM • DRUG • AMBF • SUP1 • SUP2
EFF. DT	Effective date. The date the code became effective (MMDDYY format).
TRM. DT	Termination date. The termination date for the code (MMDDYY format).
PROVIDER	The Medicare provider number assigned to your facility.
EFF. DATE	Effective date. The effective date for the rate listed (MMDDYY format).
TRM. DATE	Termination date. The termination date for the rate listed (MMDDYY format).
EFF	Termination date. The termination date for the rate listed (MMDDYY format). Effective date indicator. This indicator instructs the system to either use the 'from' and 'through' dates of the claim or the system run date to perform edits for this HCPCS. Values are: **F** Claim from date **R** Claim receipt date **D** Discharge date
OVR	Override code. This field instructs the system in applying the services towards deductible and coinsurance. Values are: **0** Apply deductible and coinsurance **1** Do not apply deductible **2** Do not apply coinsurance **3** Do not apply deductible or coinsurance **4** No need for total charges (used for multiple HCPCS for single revenue code centers) **5** Rural health clinic or comprehensive outpatient rehabilitation facility psychiatric **M** Employer group health plan (EGHP) (only used on the 0001 total line for Medicare Secondary Payer (MSP)) **N** Non-EGHP (only used on the 0001 total line for MSP) **X** Bypass cost avoided MSP edits **Y** MSP cost avoided
FEE	Fee Indicator. The fee indicator received in the Physician Fee Schedule file. Valid values: **B** Bundled procedure **R** Rehab/Audiology Function Test/CORF Services **" "** Default
OPH	Outpatient Hospital Indicator. The outpatient hospital indicator received in the physician fee schedule abstract test file. Valid values: **O** Fee applicable in Hospital Outpatient Setting **1** Fee not applicable in Hospital Outpatient Setting **" "** Default
CAT	Category Code. This field identifies the category of the DME equipment. The valid values are: **1** Inexpensive or other routinely purchased DME **2** DME items requiring frequent maintenance and substantial servicing **3** Certain customized DME items **4** Prosthetic and orthotic devices **5** Capped rental DME items **6** Oxygen and oxygen equipment
PC/TC	Professional Component/Technical Component. Valid values are: **0** Pay the Health Professional Shortage Area (HPSA) bonus **1** Globally billed. Professional component for this service qualifies for the HPSA bonus payment **2** Professional component only, pay the HPSA bonus **3** Technical component only, do not pay the HPSA bonus **4** Global test only. Professional component of this service qualifies for the HPSA bonus payment **5** Incident codes, do not pay the HPSA bonus **6** Laboratory physician interpretation codes, pay the HPSA bonus **7** Physical therapy service, do not pay the HPSA bonus **8** Physician interpretation codes, pay the HPSA bonus **9** Concept of PC/TC does not apply, do not pay the HPSA bonus
ANES BASE VAL	Anesthesia base value. The anesthesia base values.
TYP	HCPCS Type. An 'M' indicator will display when the HCPCS associated with the revenue line originated from the Medicare physician fee schedule.
MSI	Multiple services indicator. The value of '5' identifies services that are subject to the multiple procedure payment reduction (MPPR).
ALLOWABLE REVENUE CODES	Allowable revenue codes. The allowable revenue codes this HCPCS code may use in billing. This is a four-position field. When the last digit shows an "X," each variable for that revenue code is allowable. If this field is blank, the system will allow a HCPCS code on any revenue code.

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Field Descriptions for Option 1E (Map 1E01)– New HCPC Screen	
HCPC DESCRIPTION	HCPCS description. The English narrative description of the HCPCS code.

Field Descriptions for Option 1E (Map 1E02)– New HCPC Screen	
EFF DT	Effective date. The date the code became effective (MMDDYY format).
TRM DT	Termination date. The termination date for the code (MMDDYY format).
60%RATE	60% reimbursement rate. The rate the system will use for calculating reimbursement for the HCPCS.
62% RATE	62% lab reimbursement rate. The rate the system will use for calculating reimbursement for the lab HCPCS. When the MSI field equals a '5', this field will display "62%/REDU" or the reduced therapy fee amount.
REHAB	Rehabilitation rate. The rate used by the system to calculate reimbursement for the HCPCS code for rehabilitation services billed.
PROF	Professional service rate. The rate used by the system to calculate reimbursement for the HCPCS code for professional services
NFACPE	Non-facility amount practice expense (PE) relative value units (RVUs). This field reflects the 20 percent reduction in non-facility PE RVUs.
VAR COIN	This field identifies the Variable Coinsurance percentage received from CMS on the Drug Fee file.
HCPC DESCRIPTION	HCPCS description. The English narrative description of the HCPCS code.

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