Home Health & Hospice

Inquiry Menu

Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Guide

Chapter 3

CGS®
A CELERIAN GROUP COMPANY

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 a MR ADR (Medical Review Additional Development Request) or non-MR ADR (hospice only) 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
- ☑ Monitor total Home Health Prospective Payment System (HH PPS) payments and outlier payments made in a calendar year

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 - HHH 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 - HHH 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
```

3. 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), 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 allows 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 - HHH 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
```

➔ This option includes several screen pages with eligibility information. **Medicare eligibility is also available on the CWF eligibility screens via ELGA and ELGH, myCGS, and the myCGS website portal, or the CGS Interactive Voice Response (IVR) system.** For information about accessing ELGA and ELGH, refer to "Checking Beneficiary Eligibility" (Chapter 2) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_2-Checking_Beneficiary_Eligibility.pdf on the CGS website.

Note: For information about other systems that are available for checking eligibility, refer to the "Checking Beneficiary Eligibility" Web page at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html on the CGS website.

➔ 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:

```
MAP1751                      CGS J15 MAC - HHH 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 ID number (e.g., 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 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*.

   ➔ The following example shows how the screen would look after entering the five identifying pieces of information, but before pressing *Enter*.

```
MAP1751                        CGS J15 MAC - HHH 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 SMITH                 FN JOHN              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.

10. Once a match is found with the beneficiary information entered, the beneficiary's eligibility information will display.

11. Press F8 to access additional eligibility screens. Screen descriptions follow.

12. Press *F3* to exit and return to the Inquiry Menu.

Field Descriptions for Option 10 - Beneficiary/CWF Screen

Map 1751 (Page 1) Screen Example

```
MAP1751                        CGS J15 MAC - HHH 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 ID number.
CURR XREF HIC	If the Medicare number has changed, this field represents the most recent number.
PREV XREF HIC	Not used.
TRANSFER HIC	Not used.
C-IND	Century Indicator – Identifies if the beneficiary's date of birth is in the 19th or 20th century.
LTR DAYS	Not applicable to home health and hospice.
LN	Last name of the beneficiary.
FN	First name of the beneficiary.
MI	Middle initial of the beneficiary.

Map 1751 Field Descriptions (continued)

SEX	Sex of the beneficiary. F Female M Male
DOB	Date of birth of the beneficiary (MMDDCCYY format).
DOD	Date of death 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.
ADDRESS (1-6)	Beneficiary's street address, city and state.
ZIP	Zip code for beneficiary's residence.

➔ Information about other options for checking eligibility are available on the "Checking Beneficiary Eligibility" Web page at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html on the CGS website.

Map 1752 Screen Example

```
MAP1752                    CGS J15 MAC - HHH 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.
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 - HHH 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.

Map 1754 Screen Example

```
MAP1754                          CGS J15 MAC - HHH 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 - HHH 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

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.

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.

Map 1756 Screen Example

```
MAP1756                        CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
XXXXXX   SC                           ACCEPTED                     C20112WS HH:MM:SS

   DATA IND             NAME                              ZIP

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

   OTHER ENTITLEMENTS OCCURRENCE CD/DATE           /

   ESRD CD/DATE             /

   CAT DATA: PSYCH      DISCHG          IND    DAYS USED      BLOOD

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

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
- 1 - Disability

- 2 - End stage renal disease (ESRD)
- 3 - Has or had ESRD, but current DIB
- 4 - Old age but has or had ESRD
- 8 - Has or had ESRD and is covered under Part A premium
- 9 - Covered under Part A premium

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
- 1 - Selected for GEP contract
- 2 - Has Rep Payee
- 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.

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
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 - HHH 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
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 - HHH 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.

Map 1759 Screen Example

```
MAP1759                        CGS J15 MAC - HHH 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.

Map 175A Screen Example

```
MAP175A                        CGS J15 MAC - HHH 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 The date the transfer was initiated to CMS.

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 - HHH 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.
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 - HHH 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.
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

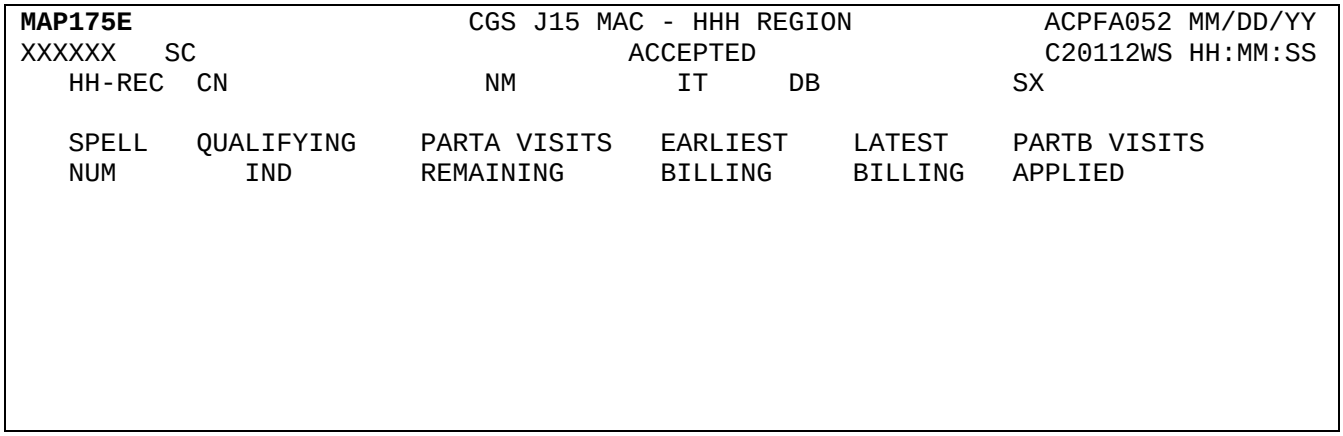
```
MAP175D                      CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                          ACCEPTED                  C20112WS HH:MM:SS
IP-REC  CN                NM          IT     DB           SX     INT



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.

Map 175E Screen Example



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 - HHH 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 - HHH 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
```

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 • 2 - BLUE CROSS • 3 - OTHER • 4 - NONE • A - WORKING AGED • B - ESRD BENE • C - COND PAYMENT • D - NO-FAULT • E - WORKERS COMP • F - PUB HLTH SRV • G - DISABLED • H - BLACK LUNG • I - VETERANS • L - LIABILITY • W - WC SET-ASIDE • 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

```
MAP175H                        CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
XXXXXX   SC                              ACCEPTED                  C20112WS HH:MM:SS
   PLAN-REC  CN                 NM          IT     DB            SX

   PLAN TYPE              PLAN ID    OPT     ENR DATE     TRM DATE
```

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
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 - HHH 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.

Map 175J Screen Example

```
MAP175J                      CGS J15 MAC - HHH 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 • 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	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 • 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

Map 175K Screen Example

```
MAP175K                        CGS J15 MAC - HHH 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.
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

```
MAP175L                      CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
XXXXXX   SC                HOME HEALTH CERTIFICATION             C20112WS HH:MM:SS

   REQ DATE     MID                                                DOB
                NAME


   REC  HCPCS     FROM DATE       REC  HCPCS     FROM DATE
```

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.

Map 175M Screen Example

```
MAP175M                    CGS J15 MAC - HHH 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 - HHH 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
```

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

```
MAP1750                      CGS J15 MAC - HHH 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 - HHH 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




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

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.
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 - HHH 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.

Map 175R Screen Example

```
MAP175R                      CGS J15 MAC - HHH 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. Because this information is typically used only by hospitals, and this guide provides information relevant only to home health and hospice agencies, the information below is limited, and shows only how this option is accessed.

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 - HHH 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
```

Claim Summary (Option 12)

You will use this option often because it allows you 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 Medical Review Additional Development Requests (MR ADRs) and non-MR ADRs (hospice only).
- View upcoding and downcoding claim information for HH PPS
- View line item denial information
- View Outcome and Assessment Information Set (OASIS) information for Patient-Driven Grouping Model (PDGM) claims (home health only).

Note: Throughout this chapter, the terms billing transaction and claims are used interchangeably to describe claims, notices of election (NOEs), notices of election termination/revocation (NOTRs), and requests for anticipated payment (RAPs).

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

```
 MAP1702                  CGS J15 MAC - HHH 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 - HHH 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
     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

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 MID 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 the beneficiary's Medicare number, 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 - HHH REGION          ACPFA052 MM/DD/YY
  XXXXXX    SC             CLAIM SUMMARY INQUIRY              C20112WS HH:MM:SS
                              NPI XXXXXXXXXX
     MIC XXXXXXXXXXX  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 – HHH 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   322   0817XX 0817XX 0817XX   0902XX
   SMITH               J              684.00   0908XX 1030XX  37185

  XXXXXXXXXX   XXXXXX           P B9997   329   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.

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 (7 and 8) display when a Medical Review Additional Development Request (MR ADR) or a non-MR ADR (hospice only) is generated. This occurs when a claim has been selected for Medical Review (MR) or when a KX modifier is submitted on a hospice claim to request an exception of an untimely notice of election (non-MR ADR). For more information on a Medical Review ADR, refer to the Medical Review Additional Development Request (ADR) Process Web page at http://www.cgsmedicare.com/hhh/medreview/adr_process.html on the CGS website. For more information about the non-MR ADR, refer to the Requesting an Exception for an Untimely NOE Web page at http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html.

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 - HHH 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   322   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 (_XXX… instead of _ XXX), 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 - HHH 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 XXXXX XXXX
  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, which are discussed in "Claims and Attachments" (Chapter 4) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_4-Claims_and_Attachments_Menu.pdf and "Claims Corrections" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf on the CGS website.

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.

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 - HHH 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 the "FISS Overview" (Chapter 1) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_1-FISS_Overview.pdf or the "Fiscal Intermediary Standard System (FISS) Common Locations" Web page at http://www.cgsmedicare.com/hhh/claims/fiss_locations.html on the CGS website.

➔ 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 - HHH 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
  XXXXXXXXXX   XXXXXX           P B9996   329   0726XX 0726XX 0923XX   1001XX
   SMITH               A     1600.00  1304.00   1015XX        37186

  XXXXXXXXXX   XXXXXX           P B9996   329   0730XX 0730XX 0927XX   1001XX
   WHITE               J     1200.00   1216.00  1015XX        37186

  XXXXXXXXXX   XXXXXX           P B9996   329   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.

Claim Status Inquiry Examples

When you are inquiring about specific information, whether it is claim history for a specific beneficiary 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 - HHH 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 home health 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 *329* in the **TOB** field.

```
  MAP1741                        CGS J15 MAC – HHH REGION          ACPFA052 MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                   C20112WS HH:MM:SS
                                 NPI XXXXXXXXXX
      MID XXXXXXXXXX  PROVIDER                    S/LOC          TOB 329
   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 Medicare number, the type of bill, and the "from" and "to" dates. (See example below.) Entering a status code or status/location will further narrow your search.

```
  MAP1741                        CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                   C20112WS HH:MM:SS
                                 NPI XXXXXXXXXX
      MID XXXXXXXXXX  PROVIDER                  S/LOC R B9997  TOB 329
   OPERATOR ID          FROM DATE 0801YY  TO DATE 0930YY        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*.

➔ Below is an example of how this would appear before pressing Enter.

```
  MAP1741                        CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                     C20112WS HH:MM:SS
                                 NPI XXXXXXXXXX
      MID XXXXXXXXXX  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 - HHH REGION            ACPFA052 MM/DD/YY
  XXXXXX    SC             CLAIM SUMMARY INQUIRY                     C20112WS HH:MM:SS
                                 NPI XXXXXXXXXX
      MID XXXXXXXXXX  PROVIDER              S/LOC D B9997    TOB
   OPERATOR ID                FROM DATE 100117  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 a medical review Additional Development Request (MR ADR).

In addition, when a 'KX' modifier is reported on a hospice claim (requesting an exception for an untimely filed notice of election) and information in the REMARKS field is not clear, a non-medical review ADR (non-MR ADR) is generated. Refer to the Requesting an Exception for an Untimely NOE Web page at https://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html for additional information.

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 MR ADR documentation to CGS within 45 calendar days of the request. If the documentation is not received by day 46, the claim will be denied; therefore, please allow enough time for CGS to receive the documentation. Documentation may be sent to CGS via the myCGS Portal, Electronic Submission of Medical Documentation (esMD), mail, fax, or CD/DVD. Refer to the CGS Web page at http://www.cgsmedicare.com/hhh/medreview/esmd.html for additional information about esMD. For additional information refer to the myCGS Web page at http://www.cgsmedicare.com/hhh/mycgs/index.html or Chapter 7 of the myCGS User Manual at http://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf.

The following pages explain how you can identify claims for which CGS has requested an MR ADR, or non-MR ADR, 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 MR ADR and non-MR ADR (ADR)

You can easily see if claims are selected for ADR by accessing the Inquiry Menu and selecting option 12 (Claim Summary). All claims selected for an ADR, both MR and non-MR, 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 - HHH 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          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 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.

   ➔ MR ADRs will display reason code 39700. A non-MR ADR will display reason code 39701.

```
  MAP1741                    CGS J15 MAC - HHH 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
  XXXXXXXXXX   XXXXXX          S B6001   XXX   1204XX 1204XX 0119XX   0212XX
   JONES               M     1700.00                          39700

S XXXXXXXXXX   XXXXXX          S B6001   XXX   1025XX 1025XX 1110XX   0212XX
   SMITH               J      300.00                          39700

  XXXXXXXXXX   XXXXXX          S B6001   XXX   1115XX 1115XX 1215XX   0212XX
   WILLIAMS            R      336.00                          39700

  XXXXXXXXXX   XXXXXX          S B6001   XXX   1019XX 1019XX 1217XX   0212XX
   WHITE               T     1000.00                          39701


     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 - HHH REGION            CPFA052 MM/DD/YY
XXXXXX     SC              INST CLAIM INQUIRY                  C20112WS HH:MM:SS
 MID XXXXXXXXXX    TOB XXX  S/LOC S B6001 OSCAR XXXXXX         SV:    UB-FORM
NPI XXXXXXXXXX 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 "**DUE DATE"** field, on Page 07 is 45 days from the original request date (**ORIG REQ DT**). Documentation not received by day 46 will result in the claim being denied. For hospice claims requesting an exception (KX modifier), if the non-MR ADR documentation is not received by day 46, the claim will be released to process as billed, with the untimely days as noncovered.

➔ Page 07 also identifies the address to which MR ADR documentation should be mailed. The mailing address for non-MR ADRs is different, and can be found by accessing Page 08 and then pressing F6.

Example: FISS Page 07

```
REPORT: 001                MEDICARE PART A 15004        PVDR NO  : XXXXXXXXXX
 DATE  : MM/DD/CCYY   ADDITIONAL DOCUMENTATION REQUEST    BILL TYPE: XXX
 CASE ID: 15004XXXXXXXXXXXXXPAR0PR     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: XXXXXXX-XXXXXXX      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  UPR/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: 15004XXXXXXXXXXXXXPAR0PR     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: XXXXXXX-XXXXXXX       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. The edit criteria may also be included within the narrative. For non-MR ADRs, you will need to press *F6* for additional instructions for submitting the documentation, including the fax number and mailing address.

NOTE: Because other CMS contractors (e.g., Zone Program Integriy Contractors (ZPICs), Recovery Auditors (RAs), Supplemental Medical Review Contractor (SMRC)), may also request additional information, it is important that you scroll through the reason code narrative on FISS Page 08. If a different address appears in the narrative, send the documentation to that address, instead of the CGS Nashville, TN address.

Example: FISS Page 08

```
REASONS: 59BX9
REASON CODE NARRATIVES FOR MID/DCN: XXXXXXXXXX XXXXXXXXXXXXXXXR

59BX9 MEDICARE NEEDS TO RECEIVE THE RETURNED ADR INFORMATION BY THE 45TH DAY.
      PLEASE ALLOW ENOUGH TIME FOR THE ADR TO BE RECEIVED AND THE CLAIM MOVED INTO
      THE MEDICAL REVIEW STATUS/LOCATION SM50MR BY DAY 45 OR IT WILL BE DENIED
      WITH REASON CODE 56900 ON THE 46TH DAY.
      PLEASE SEND THE FOLLOWING INFORMATION TO SUPPORT THE TERMINAL ILLNESS AND
      DAYS/SERVICES BILLED:
      *INITIAL ASSESSMENT AND VISIT NOTES FOR ALL SERVICES PROVIDED THIS BILLING
      PERIOD.
      *PLAN OF CARE/UPDATES AND INTERDISCIPLINARY GROUP NOTES TO COVER ALL DAYS
      IN THIS BILLING PERIOD, WHICH MAY INCLDUE THE LATEST UPDATE PRIOR TO THIS
      BILLING PERIOD.
      *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 OF TERMINAL ILLNESS, AND REVOCATION (IF
      APPLICALBE)
      *SIGNATURE POLICY IF UTILIZING ELECTRONIC SIGNATURES
      *ANY PERTINENT INFORMATION PRIOR TO/AFTER THIS BILLING PERIOD
      *DATES AND TIMES OF SERVICE CHANGES, WHEN BILLING MULTIPLE LEVELS OF CARE
      *THE BENEFICIARY SIGNED HOSPICE ELECTION STATEMENT WITH HOSPICE EFFECTIVE.
```

➔ Press *F6* to see the remaining reason code narrative that identifies the documentation that you need to submit. This page will also provide a different address if the ADR is a non-MR ADR (hospice exception requests), or a request from another CMS contractor (e.g., Zone Program Integrity Contractors (ZPICs), Recovery Auditors (RAs) etc.).

```
REASONS: 59BX9

REASON CODE NARRATIVES FOR MID/DCN: XXXXXXXXXX XXXXXXXXXXXXXXPAR

     DATE
     *IF THIS CLAIM CONTAIN THE KX MODIFIER, SUBMIT THE EXCEPTION DOCUMENTATION
     FOR REVIEW WITH THE ADR
     MEDICARE REQUIRES THAT MEDICAL RECORD ENTRIES FOR SERVICES PROVIDED/ORDERED
     BE AUTHENTICATED BY THE AUTHOR. THE METHOD USED SHALL BE A HANDWRITTEN OR
     AN ELECTRONIC SIGNATURE. PATIENT IDENTIFICATION, DATE OF SERVICE, AND
     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 CMS PROGRAM INTEGRITY MANUAL (PUB. 100
     -08), CH 3.
     OMB CONTROL #: XXXX-XXXX
```

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

7. **For MR ADRs,** make a copy of Page 07 and attach it to the top page of your medical record documentation. **For hospice non-MR ADRs**, include a screenprint of FISS Page 08. This ensures that the documentation will be matched with the correct claim.

8. Submit the screenprint and the documentation to the appropriate address as soon as possible. Page 07 includes the Nashville, TN address, which is appropriate for MR ADRs. If a different address appears in the narrative on FISS Page 08, send the documentation to that address. Other options for submitting MR ADR, and non-MR ADR documentation, include fax, electronic submission (esMD) and for MR ADRs only, the myCGS Portal.

➔ You may also want to keep a printed 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. For information on how to screen print FISS claim pages, refer to the "FISS Overview" chapter at: http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_1-FISS_Overview.pdf

9. 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.

Key ADR Information:

- ➔ **CMS requires providers to submit MR ADR documentation to CGS within 45 calendar days of the request. Therefore, it is important to send the documentation as soon as possible to allow time for** CGS to 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 for MR ADRs or Page 08 for non-MR ADRs (hospice exception requests), and attach it to the top page of your medical record documentation. If you mail your documentation, send it to the address that appears on FISS Page 07. **If an address displays in the narrative on FISS Page 08, mail the documentation to that address.**
- ➔ Once MR ADR documentation is 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 non-MR ADR documentation (hospice exception requests) is not received within 30 days, the claim will be moved to a holding location (S M8877) until day 45 or until the documentation is received. Once the documentation is received, the claim will be moved to status/location S M87DR. If the documentation is not received by day 46, the claim will be released to process as billed, with the untimely days as noncovered. These noncoverd days can be appealed, using the Medicare Appeals Process (http://www.cgsmedicare.com/hhh/appeals/overview.html)

➔ If CGS does not receive the MR ADR 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 by completing the CGS Medicare HHH Jurisdiction 15 Redetermination Request Form. For detailed information, refer to the "56900 Reopenings" section of the "Reopenings" Web page at http://www.cgsmedicare.com/hhh/appeals/Reopenings.html.

NOTE: If the MR ADR 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 MR ADR documentation can take up to 60 days from when the documentation was received.

➔ **Missing or Illegible Signature Documentation:** If, during review of your MR ADR 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 MR ADR and non-MR ADR documentation electronically. See the "Electronic Submission of Medical Documentation" Web page at http://www.cgsmedicare.com/hhh/medreview/ESMD.html for more information about electronic submission of documentation. MR ADR 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_hhh.pdf for additional information. CGS will also accept documentation submitted via Fax (615-660-5981 for MR ADRs, or 615-660-5982 for non-MR ADRs), or CD/DVD.

➔ Refer to the following ADR resources for additional information.

- "Additional Development Requests (ADRs) Overview" Web page - http://www.cgsmedicare.com/hhh/claims/overview_adr.html
- "Medical Review Additional Development Request (ADR) Process" Web page - http://www.cgsmedicare.com/hhh/medreview/adr_process.html; and
- "Medical Review Additional Development Request (ADR) Quick Resource Tool" - http://www.cgsmedicare.com/hhh/education/materials/pdf/ADR_QRT.pdf

- myCGS MR ADR Job Aid - https://www.cgsmedicare.com/hhh/pubs/news/2015/0415/cope28413.html
- "Requesting an Exception for an Untimely NOE" Web page - http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html
- "Additional Development Request Timeliness Calculator - https://www.cgsmedicare.com/medicare_dynamic/J15/adrcalc.asp

Checking for Auto-Cancelled Requests for Anticipated Payment (RAPs) (Home health providers only)

Home health providers may use option 12 to determine whether a Request for Anticipated Payment (RAP) has been automatically cancelled by the Fiscal Intermediary Standard System (FISS). RAPs will auto-cancel when the final claim for a home health episode is not received timely. Under the Home Health Prospective Payment System (HH PPS), a final claim must match to a processed RAP within the greater of 60 days from the:

- End of the episode; or
- Date the RAP paid.

If the final claim is not received timely, FISS will automatically cancel the RAP and Medicare will recoup the RAP payment.

➔ For example, an episode spans from 3/1 to 4/29. The RAP is submitted and pays on 3/11. Sixty days from the date the RAP paid is 5/9. Sixty days from the end of the episode would be 6/28, which is greater than 5/9. Therefore, FISS would auto-cancel the RAP for the episode if the final claim was not submitted and matched up to the RAP by 6/28.

Conversely, for this same episode, if the RAP was not paid until 6/4, FISS would use 8/3 (60 days from the RAP payment), rather than 6/28 (60 days from the end of the episode) as the date by which the final claim must be submitted and matched to the RAP to avoid an auto-cancel.

➔ To prevent RAPs from being auto-cancelled, review the "Top Claim Submission Errors for Home Health Providers: Error 38107" Web page at http://www.cgsmedicare.com/hhh/education/materials/38107.html on the CGS website.

To check for auto-cancels:

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. Enter the beneficiary's Medicare number in the **MID** field. Tab to the **S/LOC** field and type *P B9997*. Tab to the **TOB** field and enter *328*. Press *Enter*.

➔ You can narrow your search for the episode in question by entering the dates of service in the **FROM DATE** and **TO DATE** fields.

```
MAP1741                          CGS J15 MAC - HHH REGION              ACPFA052 MM/DD/YY
XXXXXX       SC                CLAIM SUMMARY INQUIRY                 C201135E HH:MM:SS
                                  NPI XXXXXXXXXX

   MID XXXXXXXXXX            PROVIDER                      S/LOC P B9997   TOB 328
OPERATOR ID XXXXXXX          FROM DATE 0701XX   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    328   0726XX  0726XX  0726XX      1125XX
     TAYLOR            T                 1035.57  1203XX  1203XX  37185

   XXXXXXXXXX   XXXXXX          P B9997    328   0924XX  0924XX  0924XX      1125XX
     TAYLOR            T                 1948.05  1203XX  1203XX  37185
```

3. Select the claim you want to view by placing an "S" to the left of the Medicare number, then press *Enter* to view Page 01 of the claim.

4. The information for auto-cancelled RAPs is found in Page 03 of the claim. To view this page, you can either press the F8 key twice or use the shortcut by pressing the *HOME* key, which takes your cursor to the **PAGE** field and typing *03* in the **PAGE** field and then pressing Enter.

5. On Page 03, look for the **ADJUSTMENT REASON CODE** field. The code "NF" in this field indicates that FISS cancelled the RAP because "no final" claim was received timely.

```
MAP1713   PAGE 03          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXX    SC               INST CLAIM INQUIRY                C201234S HH:MM:SS
MID XXXXXXXXXX    TOB 328  S/LOC P B9997  PROVIDER XXXXXXXXXX
NDC CD                          OFFSITE ZIPCD:            ADJ MBI          IND
 CD  ID    PAYER                   OSCAR        RI AB             EST AMT DUE
A Z       MEDICARE                 XXXXXX        Y Y                    0.00
B                                                                       0.00
C                                                                       0.00
DUE FROM PATIENT                              SERV FAC NPI
MEDICAL RECORD NBR                    COST RPT DAYS      NON COST RPT DAYS
DIAG CODES 01          02          03          04          05
06          07          08          09                END OF POA IND
ADMITTING DIAGNOSIS           E CODE            HOSPICE TERM ILL IND
IDE                           GAF             PRV
PROCEDURE CODES AND DATES 01                 02
03                04                  05                06
ESRD HRS     ADJ REAS CD NF  REJ CD          NONPAY CODE    ATT TAXO
ATT PHYS        NPI               L                    F           M    SC
OPR PHYS        NPI               L                    F           M    SC
```

- ➔ If you have a final claim to submit, but the matching RAP has auto-cancelled, you will need to re-bill the RAP exactly as it was originally submitted. Once the resubmitted RAP (type of bill 322) finalizes (found in FISS S/LOC P B9997), you can then bill the final claim for the episode.

- ➔ If your original RAP auto-cancelled and contained information that was incorrect (i.e., incorrect service dates were billed), you will still need to re-bill it exactly as it was originally submitted. Once the resubmitted RAP finalizes, you will then need to submit a cancel RAP. Once the cancel RAP finalizes, you can then submit a RAP with the corrected information to Medicare. The final claim may be submitted once the corrected RAP finalizes. More information about using FISS to submit cancellations can be found in the "Claims Correction" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf of this guide.

Viewing Noncovered/Denied Services

If your home health or hospice claim was partially (P B9997) or fully (D B9997) noncovered/denied, you can view the noncovered/denied revenue code line(s) and the reason charges were noncovered/denied. Follow the steps below:

Fully noncovered/denied

1. Within option 12, type your NPI in the **NPI** field, and the beneficiary's Medicare number in the **MID** field. Press *Enter*. Type an *S* in the **SEL** field in front of the claim you wish to view and press *Enter*. Page 01 of the claim appears (Map 1711). Press *F8* to go to Page 02.

```
MAP1712          PAGE 02          CGS J15 MAC – HHH REGION          ACPFA052 XX/XX/XX
XXXXXX           SC             INST CLAIM INQUIRY                  C201135E XX:XX:XX
                                                        REV CD PAGE 01
MID XXXXXXXXXX       TOB XXX    S/LOC D B9997   PROVIDER XXXXXXXXXX
UTN                    PROG         REP PAYEE     RRB EXCL IND    PROV VAL TYPE
                                    TOT    COV                                SERV   RED
CL   REV   HCPC  MODIFS     RATE   UNIT   UNIT   TOT CHARGE  NCOV CHARGE   DATE   IND
   1 0270                          00001                0.23         0.23 XXXXXX
   2 0270                          00001                1.86         1.86 XXXXXX
   3 0551 G0299                    00003              270.00       270.00 XXXXXX
   4 0551 G0299                    00002              270.00       270.00 XXXXXX
   5 0551 G0299                    00002              135.00       135.00 XXXXXX
   6 0551 G0299                    00002              270.00       270.00 XXXXXX
   7 0551 G0299                    00004              135.00       135.00 XXXXXX
   8 0551 Q5001                    00001                0.01         0.01 XXXXXX
   9 0001                                            1082.10      1082.10

56900                                                          <== REASON CODES
      PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

➔ Fully noncovered/partially denied claims will display the noncovered charges in the "NCOV CHARGE" field on Map 1712 (Page 02). In the above example, the reason code 56900 appears in the lower left corner. Press *F1* to display the reason code narrative indicating why the claim was denied.

Partially noncovered/denied

If the claim is partially noncovered/denied the reason code in the lower left corner may not explain why a specific revenue code line was denied. To find the reason a revenue code was denied, follow the steps below.

1. Within option 12, type your NPI in the **NPI** field, and the beneficiary's Medicare number in the **MID** field. Press *Enter*. Type an *S* in the **SEL** field in front of the claim you wish to view and press *Enter*. Page 01 of the claim appears (Map 1711). Press *F8* to go to Page 02.

2. The screen example below shows revenue code line 5 with charges in the NCOV CHARGE field. Place your cursor anywhere on the revenue code line 5. Press *F2*. Map 171D appears and will display the line item information for revenue code line 5.

```
MAP1712        PAGE 02            CGS J15 MAC - HHH REGION          ACPFA052 XX/XX/XX
XXXXXX         SC              INST CLAIM INQUIRY                   C201135E XX:XX:XX
                                                        REV CD PAGE 01
MID  XXXXXXXXXX       TOB XXX    S/LOC P B9997   PROVIDER XXXXXXXXXX
UTN                    PROG          REP PAYEE    RRB EXCL IND    PROV VAL TYPE
                                    TOT    COV                              SERV   RED
CL   REV   HCPC  MODIFS     RATE   UNIT   UNIT   TOT CHARGE  NCOV CHARGE  DATE   IND
   1 0270                          00001              0.23                XXXXXX
   2 0270                          00001              1.86                XXXXXX
   3 0551 G0299                    00003            270.00                XXXXXX
   4 0551 G0299                    00002            270.00                XXXXXX
   5 0551 G0299                    00002            135.00       135.00   XXXXXX
   6 0551 G0299                    00002            270.00                XXXXXX
   7 0551 G0299                    00004            135.00                XXXXXX
   8 0551 Q5001                    00001              0.01                XXXXXX
   9 0001                                          1082.10       135.00

37186                                                          <== REASON CODES
   PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

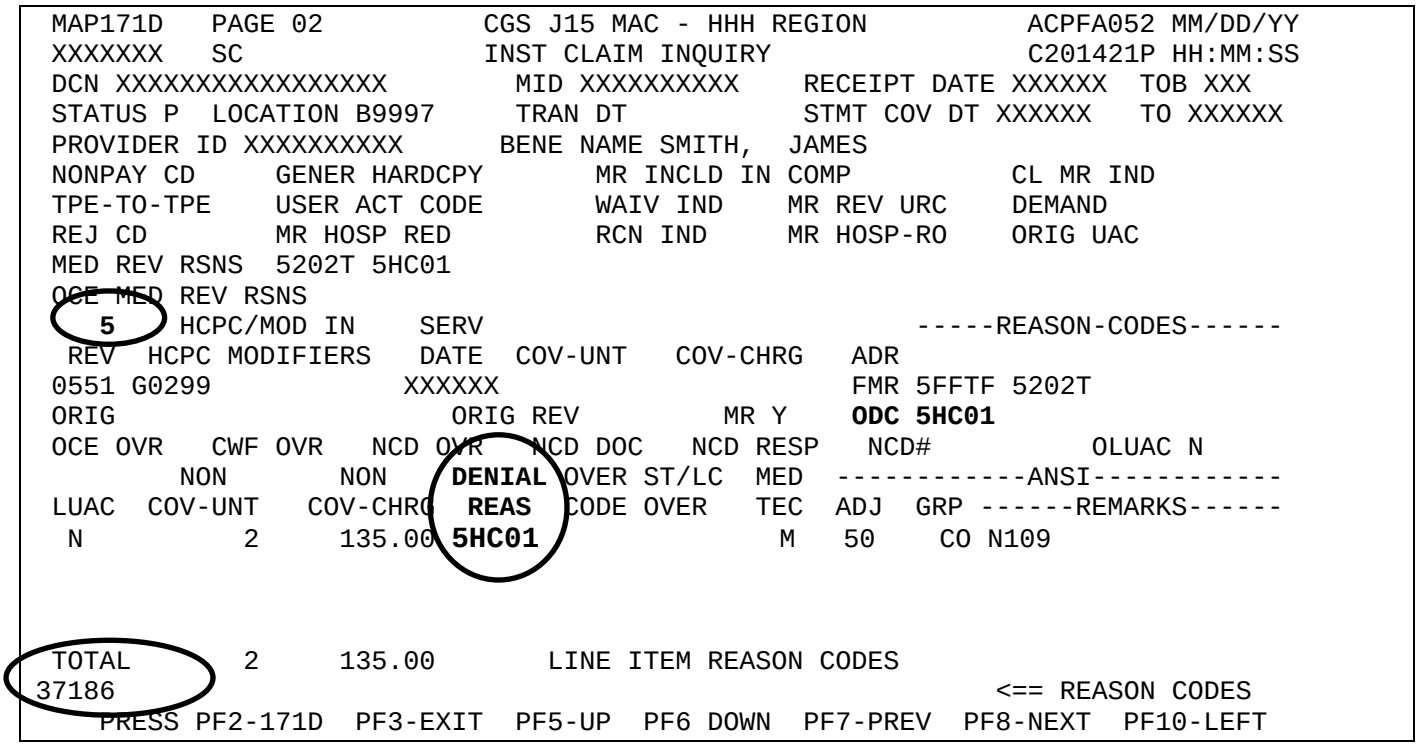
➔ If you press *F2*, without putting your cursor on a specific revenue code line, Map 171D will appear with information from claim line (CL) 1. The F5 and F6 keys can then be used to scroll up and down through all revenue code lines.

➔ From Page 02 of the claim, you can also press *F11*, without putting your cursor on a specific revenue code line. Map 171E appears. Press *F11* again to display Map 171A with information from CL 1. Press *F11* again and Map 171D will appear.

For hospice claims with dates of service before October 1, 2018, Map 171E was used to enter national drug code (NDC) information when billing non-injectable drugs (revenue code 0250) as required by Change Request 8358. Refer to MM10573 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNmattersArticles/downloads/mm10573.pd for additional information.

In the following Map 171D screen example, the denial reason code 5HC01 (certification was invalid), displays in the DENIAL REAS field, while the reason code in the lower left corner is 37186 indicating the claim was approved for payment.

➔ Make a note of the reason code shown in the DENIAL REAS field, and press *F1* to access the Reason Code Inquiry screen. Type the noted reason code, and press *Enter* to view the reason code narrative. Press F3 to return to the claim.



Viewing Upcoding and Downcoding Information

Upcoding and downcoding information is available to view on Home Health Prospective Payment System (HH PPS) claims that have completed processing (P B9997).

1. Within option 12, type your NPI in the NPI field, and the beneficiary's Medicare number in the MID field. Press *Enter*. Type an *S* in the SEL field in front of the claim you wish to view and press *Enter*. Page 01 of the claim appears (Map 1711). Press *F8* to go to Page 02.

   ➔ If you press *F2*, without putting your cursor on a specific revenue code line, Map 171D will appear with information from claim line (CL) 1. The F5 and F6 keys can then be used to scroll up and down through all revenue code lines.

   ➔ From Page 02 of the claim, you can also press *F11*, without putting your cursor on a specific revenue code line. Map 171E appears. Press *F11* again to display Map 171A with information from CL 1. Press *F11* again and Map 171D will appear.

```
MAP171D      PAGE 02         CGS J15 MAC - HHH REGION              ACPFA052 XX/XX/XX
XXXXXX       SC          INST CLAIM INQUIRY                        C201135E XX:XX:XX
DCN XXXXXXXXXXXXXXXR          MID XXXXXXXXA     RECEIPT DATE 0110XX       TOB XXX
STATUS P  LOCATION B9997      TRAN DT 0123XX     STMT COV DT 1222XX        TO 1226XX
PROVIDER ID XXXXXXXXXX         BENE NAME SMITH, JAMES
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  5THBX  5HRHC
OCE MED REV RSNS
   1    HCPC/MOD  IN  D    SERV                              -----REASON-CODES------
 REV  HCPC MODIFIERS       DATE   COV-UNT    COV-CHRG    ADR
0023 3AHKS                 1222XX       60                FMR  5THBX
ORIG 3BHKS                   ORIG REV           MR        ODC  5HRHC
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------
  L                          5HRHC                                      N72

TOTAL                            LINE ITEM REASON CODES
37186                                                          <== REASON CODES
PRESS PF2-1712    PF3-EXIT    PF5-UP    PF6 DOWN    PF7-PREV    PF8-NEXT    PF10-LEFT
```

➔ In the screen example above, the fields that appear in bold type are fields that you will want to review closely to identify upcoding/downcoding information.

MED REV RSNS – This field identifies medical review reason code(s). These may explain why the Health Insurance Prospective Payment System (HIPPS) code submitted on the claim was changed by Medical Review. Make a note of the reason code shown in the DENIAL REAS field, and press *F1* to access the Reason Code Inquiry screen. Type the noted reason code, and press *Enter* to view the reason code narrative. Press *F3* to return to the claim.

HCPC/MOD IN – This field identifies whether the HIPPS code (for HH PPS), or HCPCS code was changed by Medical Review. The valid values are:

U = Upcoding **D** = Downcoding " " = blank.

HCPC – This identifies the HIPPS or HCPCS codes on the 0023 revenue line used for processing/paying the claim.

ORIG – This HCPC field on this line indicates the original HIPPS billed. A value will only show in this field if the code submitted on the claim was changed by Medical Review. In the above example, the home health HIPPS code 3BHKS was originally submitted. The claim was downcoded ("D" in the HCPC/MOD IN field) using the HIPPS code 3AHKS.

ANSI REMARKS – ANSI remark code N72 will display when Medical Review downcodes the HIPPS code because the documentation submitted for review did not support payment for the HIPPS code originally submitted on the claim.

```
MAP171D    PAGE 02              CGS J15 MAC - HHH REGION            ACPFA052 XX/XX/XX
XXXXXX     SC                   INST CLAIM INQUIRY                  C201135E XX:XX:XX
DCN XXXXXXXXXXXXXXXR              MID XXXXXXXXXX      RECEIPT DATE 0110XX     TOB 813
STATUS P   LOCATION B9997        TRAN DT 0123XX      STMT COV DT 1222XX      TO 1226XX
PROVIDER ID XXXXXXXXXX            BENE NAME SMITH, JAMES
NONPAY CD N   GENER HARDCPY  9          MR INCLD IN COMP                CL MR IND
TPE-TO-TPE     USER ACT CODE C           WAIV IND    MR REV URC         DEMAND
REJ CD 5PTER   MR HOSP RED               RCN IND     MR HOSP-RO         ORIG UAC
MED REV RSNS  5048T  5PC07
OCE MED REV RSNS
   2    HCPC/MOD IN     SERV                                  -----REASON-CODES------
 REV  HCPC MODIFIERS    DATE  COV-UNT     COV-CHRG    ADR
0651  Q5001            0624XX                        FMR  5PTER  5048T
ORIG                      ORIG REV           MR       ODC 5PTER
OCE OVR 3  CWF OVR   NCD OVR D NCD DOC      NCD RESP 1 NCD#              OLUAC
        NON          NON     DENIAL OVER  ST/LC  MED     ------------ANSI------------
LUAC  COV-UNT    COV-CHRG    REAS  CODE  OVER   TEC   ADJ   GRP  ------REMARKS------
           4      1000.00   5PC07                  M     96    CO N109



TOTAL      4     1000.00          LINE ITEM REASON CODES
37192                                                          <== REASON CODES
PRESS PF2-1712   PF3-EXIT   PF5-UP   PF6 DOWN   PF7-PREV   PF8-NEXT   PF10-LEFT
```

➔ In the screen example above, the fields that appear in bold type are fields that will identify the amount of noncovered hospice charges and the applicable reason code. Make a note of the reason code shown in the DENIAL REAS field, and press *F1* to access the Reason Code Inquiry screen. Type the noted reason code, and press *Enter* to view the reason code narrative. Press *F3* to return to the claim.

2. To view upcoding/downcoding/line item denial information for another line item revenue code on Map 171D, use your *F5* and *F6* keys to scroll up or down until you see the appropriate line item displayed in the REV field.

3. Press *F2* to return directly to Map 1712 or press *F3* to return to the listing of claims, Map 1741.

Viewing Pricer Upcode and Downcode Information (Home health providers only)

If you have submitted a claim under the Home Health Prospective Payment System (HH PPS), and the Medicare payment is not what you anticipated, access Map 171A to view if the claim includes Pricer upcode or downcode payment information.

1. Within option 12, type your NPI in the **NPI** field, and the beneficiary's Medicare number in the **MID** field and press *Enter*. Type an *S* in the **SEL** field in front of the claim you wish to view and press *Enter*. Page 01 of the claim appears. Press *F8* to go to Page 02.

```
MAP1712   PAGE 02              CGS J15 MAC - HHH REGION              ACPFA052 XX/XX/XX
XXXXXX    SC                   INST CLAIM INQUIRY                    C201135E XX:XX:XX
                                                          REV CD PAGE 01
MID XXXXXXXXXX        TOB 329  S/LOC P B9997    PROVIDER XXXXXXXXXX
UTN                     PROG       REP PAYEE      RRB EXCL IND    PROV VAL TYPE
                                    TOT       COV                              SERV     RED
CL   REV   HCPC  MODIFS  RATE  UNIT      UNIT   TOT CHARGE  NCOV CHARGE  DATE    IND
1   0023  1BFLV                                                             0103XX
2   0270                       00001     00001       59.45                 0103XX
3   0551  G0299                00004     00004      100.00                 0103XX
4   0551  G0299                00003     00003      100.00                 0103XX
5   0551  G0299                00002     00002      100.00                 0107XX
6   0551  G0299                00004     00004      100.00                 0113XX
7   0551  G0299                00003     00003      100.00                 0207XX
8   0001                       00008     00008      559.45



          PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF2-171D   PF3-EXIT  PF5-UP  PF6-DOWN  PF7-PREV   PF8-NEXT PF9-UPDT PF11-RIGHT
```

2. View Pricer information for an individual line item by placing your cursor anywhere on the specific revenue code line item that you want to see. Press *F2* and then press *F10* (or press F11 twice). Map 171A appears and will display the line item information specific to the revenue code line in which you placed your cursor.

   ➔ You can also press *F2*, without putting your cursor on a specific revenue code line, and Map 171D will display. Then press *F10* to view the Pricer information for claim line (CL) 1. The *F5* and *F6* keys can then be used to scroll up and down through all revenue code lines.

```
MAP171A     PAGE 02            CGS J15 MAC - HHH REGION          ACPFA052 XX/XX/XX
XXXXXX      SC                 INST CLAIM INQUIRY                C201135E XX:XX:XX
DCN XXXXXXXXXXXXXXX              MID XXXXXXXXXX      RECEIPT DATE 1104XX    TOB 329
STATUS P   LOCATION B9997        TRAN DT XXXXXX      STMT COV DT 0103XX     TO 0302XX
   4    REP PAYEE        SERV          SERV   UTN                    PGM        CAH
  REV   HCPC MODIFIERS   DATE          RATE   TOT-UNT  COV-UNT    TOT-CHRG     COV-CHRG
 0023  1BFLV            0103XX                  60        60
  ANES CF       ANES BV                    FQHCADD                    PC/TC IND
  HCPC TYPE      DEDUCTIBLES            COINSURANCE          ESRD-RED/      VALCD-05/
             BLOOD        CASH     WAGE-ADJ     REDUCED    PSYCH/HBCF         OTHER
 PAT ->
 MSP ->                                      ANSI ->                  PAY/HCPC
 MSP ->                                   OUTLIER ->                  APC CD 2AGMV
             PAYER-1     PAYER-2        OTAF  DENIAL       OCE FLAGS
 MSP ->                                      IND  1  2  3  4  5  6  7  8  9
 ID ->                                           P
          REIMB       RESP         PAID          REDUCT-AMT                ANSI
 PAT ->                                                    LABOR          NON-LABOR
PROV ->      4369.91
 MED ->      4369.91                  PRICER        PAY                        ASC
            ADJUSTMENT   ANSI       AMT    RTC    METHOD   IDE/NDC/UPC        GRP %
CONTR-       4369.91-    CO 97     4369.91
37186                                                                <== REASON CODES
PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT  PF11-RIGHT
```

➔ In the screen example above, the fields that appear in bold type are fields that you will want to review to identify Pricer downcoding/upcoding information.

REV – This field identifies the revenue code line that displays. The detail includes the revenue code, HIPPS (HCPC) code, service date (SERV DATE), total units (TOT-UNT) and covered units (COV-UNT).

APC CD – This field displays a HIPPS code, if different from what is billed.

OCE FLAGS – This field will display a "P" indicating that the Pricer program changed the HIPPS code to "early" or "late" based on the beneficiary's adjacent episode history, and/or the claim contains more or less therapy revenue codes than indicated by the HIPPS code originally submitted on the claim.

3. To view Pricer information for another line item revenue code, use your *F5* and *F6* keys to scroll up or down until you see the appropriate line item displayed in the REV field.

4. Press *F2* (or F10 twice) to return to Map 1712. Press *F3* to return to the Claim Summary Inquiry screen (Map 1741).

Viewing Outcome and Assessment Information Set (OASIS) Information for Patient-Driven Groupings Model (PDGM) Claims (Home health providers only)

For home health claims submitted on or after January 1, 2020, under PDGM, the OASIS items used to determine the PDGM payment group will display in MAP 171G. This allows providers to easily access the data used to calculate the payment groups.

1. Within option 12, type your NPI in the **NPI** field, and the beneficiary's Medicare number in the **MID** field and press *Enter*. Type an *S* in the **SEL** field in front of the claim you wish to view and press *Enter*. Page 01 of the claim appears. Press *F8* to go to Page 03.

2. From the claim Page 03, press ***F11,*** MAP 171G will display.

```
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
```

3. There are 8 OASIS items that will be sent back to the claims system and displayed in the OA (OASIS Assessment) field. The OA field information will never be changed. The MR (Medical Review) field will be used by the CGS Medical Review staff to enter corrections when, based on their review of the full medical record, they find OASIS data is not supported. Review the MAP171G Field Description information later in this document for valid values.

Field Descriptions for Option 12 – Claims

Map 1741 Screen Example

```
MAP1741                    CGS J15 MAC - HHH REGION                  ACPFA052 XX/XX/XX
XXXXXX      SC           CLAIM SUMMARY INQUIRY                       C201135E XX:XX:XX
                            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









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

Field descriptions for Map 171A, 171D, 171E, and 171G can be found directly following the descriptions of Map 1741 (Claim Summary Inquiry).

Map 1741 Field Descriptions

NPI	National provider identifier.
MID	The beneficiary's Medicare ID 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. Leave this field blank to view billing transacations for all bill types submitted by the NPI.
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 at http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf 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.

Map 1741 Field Descriptions (continued)

First Line of Data

MID	The beneficiary's Medicare ID number.
PROV/MRN	Medicare PTAN (provider number) the claim was processed with.
S/LOC	Status/location. This code is assigned to the claim by FISS. Refer to the "FISS Overview" (Chapter 1) at http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_1-fiss_overview.pdf 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).

Map 1741 Field Descriptions (continued)

NPC	Non-payment code. The code indicating why payment was not made. Values are: **B** Benefits exhausted **N** All other reasons **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 – MSP Primary Payer NOTE: this code displays on home health Requests for Anticipated Payment (RAPs) when: • there is another insurer that is primary to Medicare. • the "From" date of a RAP falls within a Medicare Advantage plan enrollment period. HHAs do not receive payment for RAPs in these situations.
# 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 the "Claims Corrections" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf of this guide for additional information.

Field Descriptions for Map 171A

Map 171A Screen Example

```
MAP171A      PAGE 02            CGS J15 MAC - HHH 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
        REP PAYEE          SERV       SERV   UTN                 PGM         CAH
 REV   HCPC  MODIFIERS     DATE       RATE   TOT-UNT  COV-UNT  TOT-CHRG     COV-CHRG

 ANES CF         ANES BV                        FQHCADD                PC/TC IND
HCPC TYPE             DEDUCTIBLES         COINSURANCE          ESRD-RED/   VALCD-05/
             BLOOD          CASH     WAGE-ADJ      REDUCED    PSYCH/HBCF    OTHER
PAT ->
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.

REP PAYEE	Identifies a Medicare beneficiary with a Rep Payee.
UTN	Unique Tracking Number – assigned to a prior authorization request.
PGM	Prior authorization program indicator – a four alpha numeric field beginning with ‘H’ (home health and hospice) followed by a three digit number. Identifies the prior authorization program ID matching to the item/services on the claim.
CAH	Critical Access Hospital incentive payment indicator. Not applicable to home health and hospice providers.
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.

Map 171A Field Descriptions (continued)

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. Not applicable to home health and hospice providers.
ANES BV	Anesthesia Base Units Value. Not applicable to home health and hospice providers.
FQHCADD	Related to Federally Qualified Health Centers eligibility to the Prospective Payment System. Not applicable to home health and hospice providers.
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. Not applicable to home health and hospice providers.
PAT CASH DEDUCTIBLES	Patient Cash Deductibles. Not applicable to home health and hospice providers.
WAGE-ADJ COINSURANCE	Wage Adjusted Coinsurance. Not applicable to home health and hospice providers.
REDUCED COINSURANCE	Reduced Coinsurance. Not applicable to home health and hospice providers.
ESRD-RED/ PSYCH/HBCF	ESRD Reduction Amount/Psychiatric Reduction Amount/Hemophilia Blood Clotting Factor Amount. Not applicable to home health and hospice providers.
VALCD-05/ OTHER	Value Code 05/Other. Identifies whether value code 05 is present on the claim. Not applicable to home health and hospice providers.
MSP BLOOD DEDUCTIBLES	Medicare Secondary Payer Blood Deductibles. Not applicable to home health and hospice providers.

Map 171A Field Descriptions (continued)

MSP CASH DEDUCTIBLES	Medicare Secondary Payer Cash Deductibles. Not applicable to home health and hospice providers.
MSP COINSURANCE	Medicare Secondary Payer Coinsurance. Not applicable to home health and hospice providers.
ANSI ESRD-RED/ PSYCH/HBCF	ANSI End Stage Renal Disease Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor. Not applicable to home health and hospice providers.
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.
OUTLIER	The apportioned line level outlier amount returned from the MSP module.
PAY/HCPC APC CD	Payment Ambulatory Patient Classification Code or HCPC Ambulatory Patient Classification Code. For HH PPS claims, this field displays the HIPPS code if different from what is billed. When a “P” is present in the OCE Flag 1 field, this is the HIPPS code with which the claim was paid.
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

Map 171A Field Descriptions (continued)

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**
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** – Blue Cross **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

Map 171A Field Descriptions (continued)

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** – Blue Cross **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
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.
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.
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).

Map 171A Field Descriptions (continued)

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. This is a 2-digit field. The valid values are: ***Home Health Prospective Payment System (HH PPS)*** **Describes how the bill was paid** 00 Final payment where no outlier applies 01 Final payment where outlier applies 02 Final payment where outlier applies, but is not payable due to limitation 03 Initial percentage payment 0%

Map 171A Field Descriptions (continued)

PRICER RTC (continued)	04 Initial percentage payment 50% 05 Initial percentage payment 60% 06 LUPA payment only 07 Final Payment, SCIC 08 Final Payment, SCIC with Outlier 09 Final Payment, PEP 11 Final Payment, PEP with Outlier 12 Final Payment, SCIC within PEP 13 Final Payment, SCIC within PEP with Outlier **Describes why the bill was not paid** 10 Invalid TOB 14 LUPA payment only 15 Invalid PEP days, for shortened episode 16 Invalid HRG days, greater than 60 20 PEP indicator invalid 25 Medical review indicator invalid 30 Invalid CBSA code 35 Invalid initial payment indicator 40 Invalid service thru date for current calendar year 70 Invalid or no HRG code present 75 No HRG present in 1st occurrence 80 Invalid revenue code 85 No revenue code present
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)

Map 171A Field Descriptions (continued)

IDE/NDC/UPC	Identifies IDE, NDC, and UPC. Not applicable to home health and hospice providers.
ASC GRP	Identifies the ASC group code for the indicated revenue code. Not applicable to home health and hospice providers.
%	ASC Percentage. Identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code. Not applicable to home health and hospice providers.

Field Descriptions for Map 171D

Map 171D Screen Example

```
MAP171D     PAGE 02            CGS J15 MAC - HHH 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
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
                                                                  <== REASON CODES
 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 ID 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.

Map 171D Field Descriptions (continued)

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** System set for type of bills 322 and 332 – MSP Primary Payer **Note:** This code displays on home health Requests for Anticipated Payment (RAPs) when: • there is another insurer that is primary to Medicare. • the "From" date of a RAP falls within a Medicare Advantage plan enrollment period. • HHAs do not receive payment for RAPs in these situations.
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 benefit denial letter (BDL) **9** MSN (claim level) or full BDL
MR INCLD IN COMP	Composite Medical Review Included in Composite Rate. Not applicable for home health and hospice providers.
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.

Map 171D Field Descriptions (continued)

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. See the "Claims Correction" chapter at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf for more information about adjusting claims. Valid values and the functions include:

Function	Blank	A	J	O	Q	S	T	U	W	X	Z
Transmit To CWF	Y	Y	N	N	N	Y	Y	Y	Y	N	N
Print On Remittance	Y	Y	Y	N	Y	Y	N	N	N	Y	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

Map 171D Field Descriptions (continued)

USER ACT CODE (continued)	**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. Not applicable to home health and hospice providers.
DEMAND	Medical Review Demand Reversal – Not applicable for home health and hospice providers.
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
RCN IND	Reconsideration Indicator. Only used on home health claims. Valid values are: **A** – finalized count affirmed **B** – finalized no adjustment count (pay per waiver) **R** – finalized count reversal (adjustment) **U** – reconsideration
MR HOSP RO	Medical Review Regional Office Referred. For hospice claims, if the claim has been referred to the CMS Regional Office for questionable revocation, the medical review operator will indicate so by entering a Y in this field, otherwise the field will be blank.
ORIG UAC	Original User Action Code. For intermediary use only.

Map 171D Field Descriptions (continued)

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. Not applicable for home health and hospice claims.
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.
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.

Map 171D Field Descriptions (continued)

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 Home Health 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.

Map 171D Field Descriptions (continued)

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.

Map 171D Field Descriptions (continued)

DENIAL REAS	Denial Reason. Identifies the reason code associated with the denial for the revenue code line.
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: **A** – home health only – not intermittent care – technical and waiver was applied **B** – home health only – not homebound – technical and waiver was applied **C** – home health only – lack of physician's orders – technical deletion and waiver was not applied **D** – home health only – records not submitted after the request – technical deletion and waiver was not applied **M** – medical denial and waiver was applied **S** – medical denial and waiver was not applied **T** – technical denial and waiver was applied **U** – technical denial and waiver was not applied
ANSI ADJ	ANSI Adjustment Reason Code. 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 171E

Map 171E Screen Example

```
MAP171E   PAGE 02          CGS J15 MAC - HHH 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.
NDC QUANTITY	The NDC quantity.
QUALIFIER	The units of measurement qualifier. Valid values are: F2 – International Unit GR – Gram ME – Milligram ML – Milliliter –N - Unit
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.

Map 171E Field Descriptions (continued)

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. Not applicable to home health and hospice claims.
L	Last name of the physician. Not applicable to home health and hospice claims.
F	First name of the physician. Not applicable to home health and hospice claims.
M	Middle name of the physician. Not applicable to home health and hospice claims.
SC	Special Code. Not applicable to home health and hospice claims.
LLO NPI	Line Level Ordering National Provider Identifier (NPI). Not applicable to home health and hospice claims.

Field Descriptions for Map 171G

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
The MID, TOB, and S/LOC fields are system generated from Page 01 of the claim.

Each of the 8 OASIS items lines include an OA (OASIS Assessment) field and MR (Medical Review) field. The OA field displays the OASIS item sent from iQIES to FISS. The MR field is used by the CGS Medical Review staff to enter corrections when, based on their review of the full medical record, they find OASIS data is not supported.

M1033-HSTRY-FALLS	This field indicates if there are risk factors for hospitalization-falls. One position numeric field.
OA (OASIS Assessment)	Valid Values:
	0 – Unchecked (No)
	1 – Checked (Yes)
MR (Medical Review)	9 – No iQIES Assessment found
M1033-WEIGHT-LOSS	This field indicates if there are risk factors for hospitalization-weight loss. One position numeric field.
	Valid Values:
OA	0 – Unchecked (No)
MR	1 – Checked (Yes)
	9 – No iQIES Assessment found
M1033-MLTPL HOSPZTN	This field indicates if there are risk factors for hospitalization-multiple hospitalizations. One position numeric field.
	Valid Values:
OA	0 – Unchecked (No)
MR	1 – Checked (Yes)
	9 – No iQIES Assessment found
M1033-MLTPL-ED-VISIT	This field indicates if there are risk factors for hospitalization-multiple emergency department visits. One position numeric field.
	Valid Values:
OA	0 – Unchecked (No)
MR	1 – Checked (Yes)
	9 – No iQIES Assessment found
M1033-MNTL-BHV-DCLN	This field indicates if there are risk factors for hospitalization-mental behavior decline. One position numeric field.
	Valid Values:

OA	0 – Unchecked (No)
MR	1 – Checked (Yes)
	9 – No iQIES Assessment found
M1033-COMPLIANCE	This field indicates if there are risk factors for hospitalization-compliance. One position numeric field.
	Valid Values:
	0 – Unchecked (No)
OA	1 – Checked (Yes)
MR	9 – No iQIES Assessment found
M1033-5PLUS-MDCTN	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)
OA	1 – Checked (Yes)
MR	9 – No iQIES Assessment found
M1033-CRNT-EXHSTN	This field indicates if there are risk factors for hospitalization-exhaustion. One position numeric field.
	Valid Values:
	0 – Unchecked (No)
OA	1 – Checked (Yes)
MR	9 – No iQIES Assessment found
M1033-OTHER RISK	This field indicates if there are risk factors for hospitalization-other risks. One position numeric field.
	Valid Values:
OA	0 – Unchecked (No)
MR	1 – Checked (Yes)
	9 – No iQIES Assessment found
M1033-NONE-ABOVE	This field indicates if there are risk factors for hospitalization-none of the above. One position numeric field.
	Valid Values:
	0 – Unchecked (No)
OA	1 – Checked (Yes)
MR	9 – No iQIES Assessment found

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
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 the "Claims Correction" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf of this guide.

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 Claim Filing Guidelines" Web page at http://www.cgsmedicare.com/hhh/claims/timely_filing.html for more information.

```
MAP1741                      CGS J15 MAC - HHH REGION                  ACPFA052 XX/XX/XX
XXXXXX      SC             CLAIM SUMMARY INQUIRY                     C201135E XX:XX:XX
                              NPI XXXXXXXXXX
      MID XXXXXXXXXX     PROVIDER                 S/LOC P O9998   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
  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 - HHH REGION          ACPFA052 XX/XX/XX
 XXXXXX                        INQUIRY MENU                   C201135E XX:XX:XX


       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:

```
MAP1761                      CGS J15 MAC - HHH 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*.

➔ The **REV CD** field is a 4-digit field. If you enter a 3-digit revenue code and press *Enter*, FISS will add a zero to the first position.

```
MAP1761                          CGS J15 MAC - HHH 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).

MAP 1761 Field Descriptions (continued)

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).
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

MAP 1761 Field Descriptions (continued)

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 - 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: 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:

```
MAP1771                          CGS J15 MAC - HHH 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.

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*.

```
MAP1771                              CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX     SC                      HCPC INFORMATION  INQUIRY           C201135E HH:MM:SS
                                                                            PAGE: 01
CARRIER XXXXX    LOC XX    HCPC 99212     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

010117         F 3       0          M   0657

010116         F 3       0          M   0657

070115         F 3       0          M   0657

040115         F 3       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. 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 HCPCS code is a durable medical equipment (DME) item, Map 1772 will display the new, rental and used rates for that DME item (screen example on the next page). Press *F10* to move back to the left to Map 1771.

```
MAP1772                              CGS J15 MAC - HHH REGION        ACPFA052 MM/DD/YY
XXXXXX     SC                      HCPC RATES  INQUIRY             C201135E HH:MM:SS
                                                                   PAGE: 02

  CARRIER XXXXX    LOC XX    HCPC E0266     MOD          IND

  EFF DT  TRM DT       NEW          RENTAL            USED

  010109                           158.970


  HCPC DESCRIPTION
HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TY
SIDE RAILS, WITHOUT MATTRESS

      PROCESS COMPLETED  ---   PLEASE CONTINUE
  PRESS PF3 TO EXIT   PF5-UP   PF6-DOWN  PF10-LEFT
```

➔ If the code is any other type of HCPCS code (non-DME), 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.

```
MAP1772                              CGS J15 MAC - HHH 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
```

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 14 – HCPC Codes

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.
EFF DT	Effective date. The date the code became effective (MMDDYY format).
TERM DT	Termination date. The termination date for the code (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) **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

Map 1771 Field Descriptions (continued)

PC/TC (continued)	**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 – DME HCPCS

NEW	New purchase price. The price for the item if it was purchased new.
RENTAL	Monthly rental amount. The monthly rental charge in dollars for this particular HCPCS code.
USED	Used purchase price. The price for the item if it was purchased used.

Map 1772 Field Descriptions – non-DME HCPCS

60%RATE	60% reimbursement rate. The rate the system will use for calculating reimbursement for the HCPCS.

Map 1772 Field Descriptions – non-DME HCPCS (continued)

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 ICD-9 diagnosis or procedure codes.

1. From the Inquiry Menu, type *15* 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: 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 - HHH 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, leave the **STARTING ICD9 CODE** field blank, and press *Enter*.

```
MAP1731                          CGS J15 MAC - HHH 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
```

➔ 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 only 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 "Claims Correction" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf 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 - 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: 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.

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

```
MAP1821                      CGS J15 MAC - HHH 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 - HHH 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 - HHH 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. Press *F3* to return to the Inquiry Menu.

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. Accessing reason codes by pressing F1 is discussed in the "Claims and Attachments" (Chapter 4) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_4-Claims_and_Attachments_Menu.pdf and "Claims Correction" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf of this guide. A list of the most common reason codes that result from Medicare provider billing errors is accessible from http://www.cgsmedicare.com/hhh/education/materials/CSEs.html on the "Top Claim Submission Errors (Reason Codes) and How to Resolve" Web page.

1. From the Inquiry Menu, type *17* 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: 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 - HHH 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 "Claims Corrections" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf of this guide to further understand when you need to correct a claim.

```
MAP1881                          CGS J15 MAC - HHH 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    38107   E   052394                               T          T
 TPTP  A    B    NPCD A     B      HD CPY A     B     NB ADR       CAL DY      C/L C
-----------------------------------NARRATIVE-----------------------------------
HOME HEALTH
A matching RAP cannot be found for the Home Health claim (TOB 3X9) currently
processing. Check to see if the RAP was billed or processed prior to
receiving the claim; check to see if the RAP auto-cancelled because the
claim was not submitted in time; or check if the required fields do not
match between the RAP and the claim.
*If the RAP was not billed or it auto-cancelled, re-bill it.  Make sure the
RAP is in S/LOC PB9997 before you F9 the claim out of RTP.
*One or more of the following fields must match between the RAP and the
claim:
  -If the claim data is incorrect, correct the information and F9 the
claim.
  -If the RAP dat is incorrect, cancel the RAP and re-bill with the
correct information. Then F9 the claim once the corrected RAP is in S/LOC
      PROCESS COMPLETED --- PLEASE CONTINUE
 PRESS PF3-EXIT    PF6-SCROLL FWD     PF8-NEXT
```

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 - HHH 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)

Map 1881 Field Descriptions (continued)

REAS CODE (continued)

First Digit of Reason Code	Meaning	Example
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)
A-Z (except W)	CWF	C7080 (A line item date of service overlaps a date of service on an inpatient claim.) U5181 (occurrence code 27 required when claim overlaps certification or recertification period)
W	Integrated Outpatient Code Editor	W7A01 (invalid first diagnosis code)

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

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) (previously referred to as the Peer Review Organization (PRO)) Status/Location.

The status and location set up for hardcopy or QIO claims, which encounter the reason code.

Map 1881 Field Descriptions (continued)

For additional information about the ST/LOC (status/location) field, refer to the "FISS Overview" (Chapter 1), at http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_1-fiss_overview.pdf of the FISS Guide.

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.

Map 1881 Field Descriptions (continued)

HD CPY A - B	For intermediary use only.
NB ADR	For intermediary use only.
CAL DY	For intermediary use only.
C/L	Identifies if the reason code applies to the claim or a line item.
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

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

Map 1882 Field Descriptions (continued)

DENIAL CODE (continued)

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.

Map 1882 Field Descriptions (continued)

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. Not applicable to hospice.
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.

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              XXXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX              XXXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX              XXXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX              XXXXXXXXXXXXXXXXXX

         XXXXXXXXXXXXXXXXXXXXXXX              XXXXXXXXXXXXXXXXXX


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

Map HDCN Field Descriptions

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.

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. Because this information is not typically used by home health and hospice providers, the information below is limited, and shows only how this option is accessed.

1. From the Inquiry Menu, type *19* 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: 19

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

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. Because this information is not applicable to home health and hospice providers, the information below is limited, and shows only how this option is accessed.

1. From the Inquiry Menu, type *1A* 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: 1A

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

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 - 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: 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.

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

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

      PROVIDER XXXXXX           S/LOC           CAT
      NPI XXXXXXXXXX
S/LOC        CAT    CLAIM COUNT     TOTAL CHARGES    TOTAL PAYMENT
             GT          17          15,429.08          7,786.55
P B9996      TC           4              00.00          7,786.55
P B9996      32           4              00.00          7,786.55
S B9099      AD           1              00.00             00.00
S B9099      TC           3           2,075.53             00.00
S B9099      32           3           2,075.53             00.00
S MSUP2      AD           1           1,112.33             00.00
S MSUP2      TC           1           1,112.33             00.00
S MSUP2      32           1           1,112.33             00.00
S M90H4      TC           1             332.55             00.00
S M90H4      32           1             332.55             00.00
S B6001      TC           1           3,399.98             00.00
S B6001      32           1           3,399.98             00.00
T B9997      NM           7           8,508.69             00.00
T B9997      TC           7           8,508.69             00.00
T B9997      32           7           8,508.69             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 17 claims for a total charge of $15,429.08 and payment amount of $7,786.55.
   - The status/location P B9996 (payment floor) has a total count (TC) of four claims. The four claims have a total charge of $00.00 and a total payment of $7,786.55. All four claims are type of bill (TOB) 32X (CAT code 32). The total charge amount $00.00 indicates that the 32X TOB billing transactions are requests for anticipated payments (RAPs).
   - The status/location S B6001 (Additional Development Request (ADR) status) has a total count (TC) of one claim with the TOB 32X (CAT codes 32).
   - The status/location T B9997 (Return to Provider (RTP) status) has a total count (TC) of seven claims. All claims are TOB 32X (CAT code 32) and all were placed in RTP because of clerical errors (CAT code NM).

   ➔ **Note:** Home health billing transactions will process as 32X type of bills when paid under the Home Health Prospective Payment System (HH PPS). Home health outpatient (Part B) therapies, and immunizations process as 34X type of bills. Hospice billing transactions will either process as 81X or 82X type of bills, depending upon whether your hospice is hospital based (82X) or non hospital based (81X).

   ➔ 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 - HHH 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 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
  XXXXXXXXXX   XXXXXX           P B9996        329    0805XX 0801XX 0831XX   1006XX
   SMITH                 J     1203.00       1008.00   1103XX      37186

  XXXXXXXXXX   XXXXXX           P B9996        329    0807XX 0801XX 0831XX   1006XX
   JONES                 D     1500.00        896.00   1103XX      37186

  XXXXXXXXXX   XXXXXX           P B9996        329    1101XX 1101XX 1130XX   0202XX
   TAYLOR                T     1653.00       1400.00   0302XX      37186

  XXXXXXXXXX   XXXXXX           P B9996        329    1001XX 1001XX 1031XX   0202XX
   BRADEY                M      795.00        392.00   0301XX      37186

  XXXXXXXXXX   XXXXXX           P B9996        329    1001XX 1001XX 1028XX   0212XX
   MAVERICK              B      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. Refer to the "Claims Corrections" (Chapter 5) at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_5-Claims_Correction_Menu.pdf of this guide for more information on correcting 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.

3. 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.

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, 32, 33, 81, or 82) 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. Refer to the "FISS Overview" (Chapter 1) at http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_1-fiss_overview.pdf or the "Fiscal Intermediary Standard System (FISS) Common Locations" Web page at http://www.cgsmedicare.com/hhh/claims/fiss_locations.html for descriptions of the common status/location codes.
CAT	The Category field identifies different items within the list. Valid values are: ## – First two digits of the type of bill, e.g., 32, 34, 81, 82. **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).

Home Health Pymt Totals (Option 67)

The Home Health Pymt Totals (Map 1B41) screen tracks your outlier payment and Home Health Prospective Payment System (HH PPS) payment totals for the purpose of applying the annual limitation. Data for up to three years is available. Once the HH PPS claim (3X9 TOB) or adjustment (3X7, 3XG, 3XH, or 3XI TOB) has processed (FISS S/LOC P B9997), they are available to view using this inquiry option.

1. From the Inquiry Menu, type *67* in the **Enter Menu Selection** field and press *Enter*.

```
MAP1702                        CGS J15 MAC - HHH REGION            ACPFA052 MM/DD/YY
AB01CD                       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: 67


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

➔ You may also access this screen by typing **67** in the SC field if you are in an inquiry or claim entry screen.

2. The Home Health Payment Totals Inquiry screen (Map 1B41) appears:

```
MAP1B41                          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC              HOME HEALTH PAYMENT TOTALS INQUIRY       C201135E HH:MM:SS

                PROVIDER                    NPI

              SEL   YEAR   OUTLIER TOTAL  PAYMENT TOTAL


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

3. Type your facility's Provider Transaction Access Number (PTAN) in the **PROVIDER** field.

4. Tab to the **NPI** field and type your facility's National Provider Identifier (NPI), and press *Enter*.

5. The Home Health Payment Totals Inquiry (Map 1B41) screen displays the total home health payment and outlier totals for up to three years.

```
MAP1B41                    CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX    SC         HOME HEALTH PAYMENT TOTALS INQUIRY      C20121VF HH:MM:SS

                   PROVIDER  XXXXXX          NPI  XXXXXXXXXX

                SEL   YEAR    OUTLIER TOTAL    PAYMENT TOTAL
                      20YY            0.00         8,827.06

                      20YY       29,532.90       352,002.03

                      20YY       23,867.40       497,977.60



      PROCESS COMPLETED  ---   PLEASE CONTINUE
     PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR  PRESS PF3 TO EXIT
```

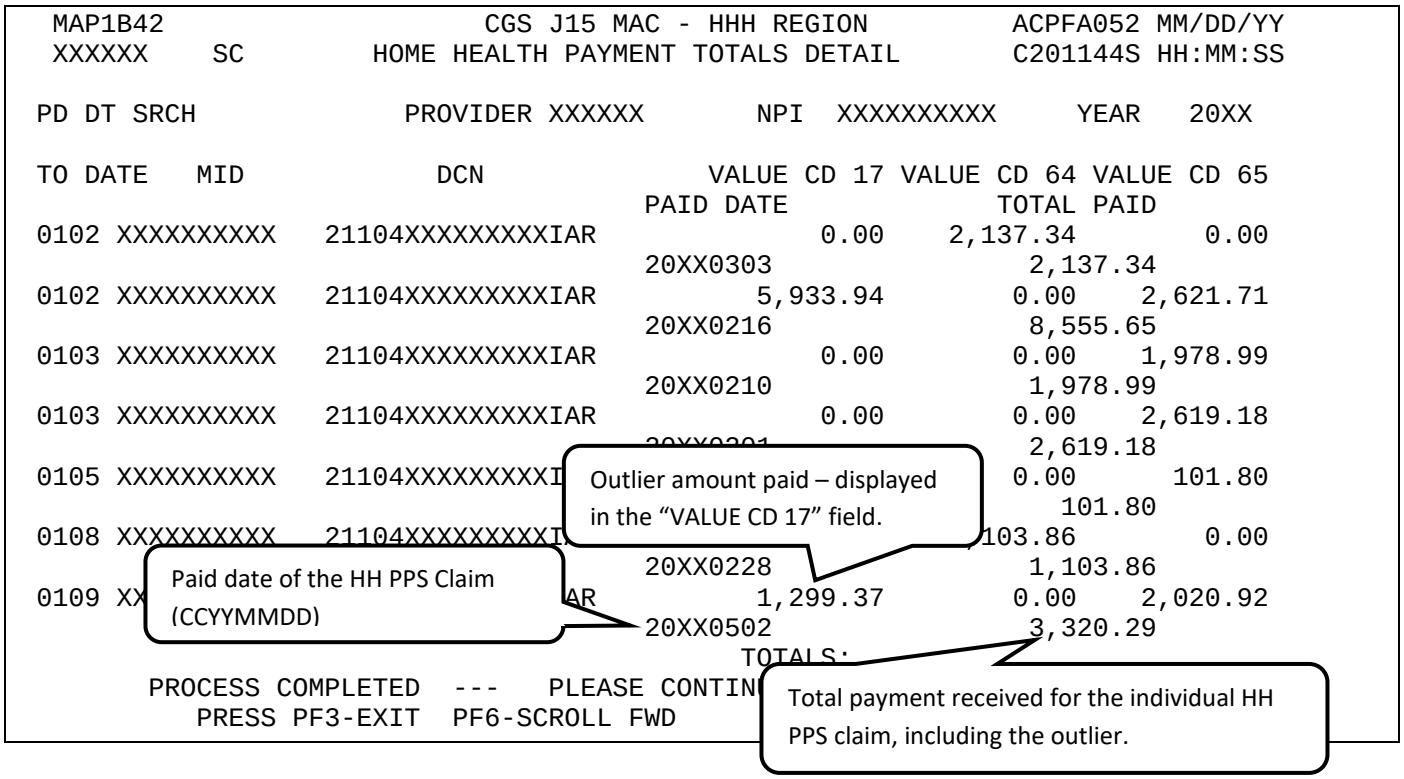
➔ The payment information is updated only after HH PPS claims/adjustments are in FISS status/location (S/LOC) P B9997 (paid).

➔ Please note that the "TO" date on your HH PPS billing transaction determines the calendar year where the payment was applied and where the claim's detail information can be accessed.

6. To display a list of claims that comprise the outlier and payment totals for a specific year, type an ***S*** in the **SEL** field next to that year. Press *Enter*.

```
MAP1B41                    CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXX      SC         HOME HEALTH PAYMENT TOTALS INQUIRY      C201135E HH:MM:SS

                    PROVIDER XXXXXX            NPI XXXXXXXXXX

                   SEL   YEAR    OUTLIER TOTAL    PAYMENT TOTAL
                    S    2014            0.00         8,827.06

                         2013       29,532.90       352,002.03

                         2012       23,867.40       497,977.60
```

7. The Home Health Payment Totals Detail (MAP 1B42) screen appears with individual claim data and the value code amount listed under the corresponding value code. You may need to press *F6* to scroll forward to view the entire listing of claims data available on the "Detail" screen.



➔ To return to the Home Health Payment Totals Inquiry (Map 1B42) screen, press *F7*. To return to the Inquiry Menu, press *F3*.

Field Descriptions for Option 67 – Home Health Payment Totals Inquiry

Map 1B41 Field Descriptions

PROVIDER	Your Provider Transaction Access Number (PTAN).
NPI	Your facility's National Provider Identifier (NPI) number.
SEL	Selection. This field is used to view claim data for a particular year.
YEAR	The calendar year in which the outlier and payment totals are comprised.
OUTLIER TOTAL	The total outlier payments made on HH PPS home health claims for a calendar year. Note that Requests for Anticipated Payment (RAPs), (type of bill 322), are excluded from this total. The "TO" date on the HH PPS claim determines the calendar year in which the outlier is applied.

Map 1B41 Field Descriptions (continued)

PAYMENT TOTAL	The total HH PPS payment made on home health claims for a calendar year. Note that Requests for Anticipated Payment (RAPs), (type of bill 322), are excluded from this total. The "TO" date on the HH PPS claim determines the calendar year in which the outlier is applied.

Map 1B42 Field Descriptions

PD DT SRCH	Enter a paid date to search for specific records for the same provider and NPI number.
PROVIDER	Your Provider Transaction Access Number (PTAN).
NPI	Your facility's National Provider Identifier (NPI) number
YEAR	The calendar year that was selected to view the claim detail data.
TO DATE	The month and day of the "through" date of the claim.
MID	The beneficiary's Medicare ID number on the claim.
DCN	The document control number of the claim.
VALUE CD 17	The dollar amount associated with the outlier payment on the claim.
VALUE CD 64	The dollar amount associated with the HH PPS payment from the Part A trust fund. For more information regarding the Medicare Part A trust fund, see the *Medicare Claims Processing Manual,* Pub. 100-04, Ch. 10, § 10.1.10.4 at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf
VALUE CD 65	The dollar amount associated with the HH PPS payment from the Part B trust fund. For more information regarding the Medicare Part B trust fund, see the *Medicare Claims Processing Manual* Pub. 100-04, Ch. 10, § 10.1.10.4 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf
PAID DATE	The claim paid date (displayed in a CCYYMMDD format).
TOTAL PAID	The total claim payment amount for each of the three value codes (17, 64, and 65) for an individual claim displayed.
TOTALS:	The total amount paid for all HH PPS payments. Note: a total HH PPS payment amount for all calendar year HH PPS claims/adjustments will only appear on the last page of this screen. You will need to press the F6 key in order to scroll forward to reach the last page.

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 - 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: 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.

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

```
MAP1581                      CGS J15 MAC - HHH 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 - HHH 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
   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
   A MA101 110407 DID NOT COMPLETE OR ENTER ACCURATELY THE DATES PATIENT WAS
   A MA102 080104 DID NOT COMPLETE OR ENTER ACCURATELY THE REFERRING/ORDERING
   A MA103 110407 OUR RECORDS INDICATE THAT ONE OR MORE OF THE MEDICAL SERVIC
   A MA104 013104 DID NOT COMPLETE OR ENTER ACCURATELY THE DATE THE PATIENT W
   A MA105 060205 OUR RECORDS INDICATE THAT ONE OR MORE OF A NOT OTHERWISE CL
       PROCESS COMPLETED  ---   PLEASE CONTINUE
      PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF-3-EXIT, PF6-SCROLL FWD
```

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

```
MAP1581                          CGS J15 MAC - HHH 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.

```
MAP1582                    CGS J15 MAC - HHH 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.

➔ If Record Type ‘C’ is selected, Map 1582 will include a next page (F8) option. Press *F8* to display the CARC RARC Group Combinations Inquiry screen (Map 1583).

8. If the Record Type ‘C’ was selected, press F8 to display Map 1583, or press F7 to return to Map 1581.

```
MAP1583                     CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
XXXXXXX   SC           CARC RARC GROUP COMBINATIONS INQUIRY  C201421P HH:MM:SS
                                                       MNT: SYSTEM   MM/DD/YY

CARC: B1    SCENARIO: 3                                        PAGE  01  of  01
                          CAQH/
SEL  RARC  GROUP CODES    MAC  CR#          ADD DATE   USER ID    MNT DATE  ERR
             CO PI PR      C                          HXB9344    MM/DD/YY
       N30   CO PI PR      C                          FSSJCARC   MM/DD/YY
       N628  CO PI PR      C                          VXG6132    MM/DD/YY
       N734  CO PI PR      C   CR8616       MM/DD/YY  HXB9344    MM/DD/YY









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

9. Press *F7* to return to Map 1582. Press *F7* again to return to Map 1581.

10. **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 - HHH 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 - HHH 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 **C** Adjustment Reasons **G** Groups **R** Reference Remarks **S** Claim Status **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.
STANDARD CODE	The ANSI code within the above record type.
NARRATIVE	The description of the ANSI code.

Map 1583 Field Descriptions

MNT:	Identifies the last operator who created or revised his screen and the date. For intermediary use only.
CARC	Identifies the claim adjustment reason code (CARC)

Map 1583 Field Descriptions (continued)

SCENARIO	Identifies defined business scenarios. Only displays if a Record Type 'C' is selected. Valid values are: 1 – Additional information required – missing/invalid/incomplete documentation 2 – Additional information required – missing/invalid/incomplete data from submitted claim 3 – Billed service not covered by health plan 4 – Benefit for billed service not separately payable
PAGE 01 OF 01	Identifies the page number.
SEL	Intermediary use only.
RARC	Identifies the remittance advice remark code (RARC).
GROUP CODES	Identifies the group code. Up to four occurrences may display.
CAQH/MAC	Identifies whether the code combinations have been approved by the CAQH Committee on Operating Rules for Information Exchange (CORE). Valid values are: C Code combination is approved M The MAC has added the code combination and is awaiting approval from CAQH CORE
CR#	Identifies the change request number that made the change to CARC/RARC/GROUP combination.
ADD DATE	Identifies the date for which the CARC/RARC/GROUP combination were added.
USER ID	The job number identifying that the update or add is based on a system change.
MAINT DATE	Identifies the last maintenance date for this file.
ERR	Error Code.
USER ID	Intermediary use only
MNT DATE	Identifies the last maintenance date for this file.

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 - 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: 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.

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


                          PROV                  NPI XXXXXXXXXX

                          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*.

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


                          PROV  XXXXXX           NPI XXXXXXXXXX

                          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 EXIT
```

➔ Please note that one day is added to the paid date (DATE field) that appears in the Check History screen. For example, although the Check History screen above shows 1024 (MMDD) in the DATE field, the screen was viewed on 10/23. The RA/ERA for the paid amount $916.56 will be dated 10/23. However, when viewing each individual claim record in FISS, that appears on that RA/ERA, the paid date will display as 10/23.

➔ 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 1B01 Field Descriptions

PROV	Your Provider Transaction Access Number (PTAN).
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. ICD-10-CM coding became effective **October 1, 2015**. For more information about ICD-10, refer to the Centers for Medicare & Medicaid Services (CMS) website at:
http://www.cms.gov/Medicare/Coding/ICD10/index.html

1. From the Inquiry Menu, type *1B* 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: 1B

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

➔ You may also access this screen by typing **1B** in the SC field 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.

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

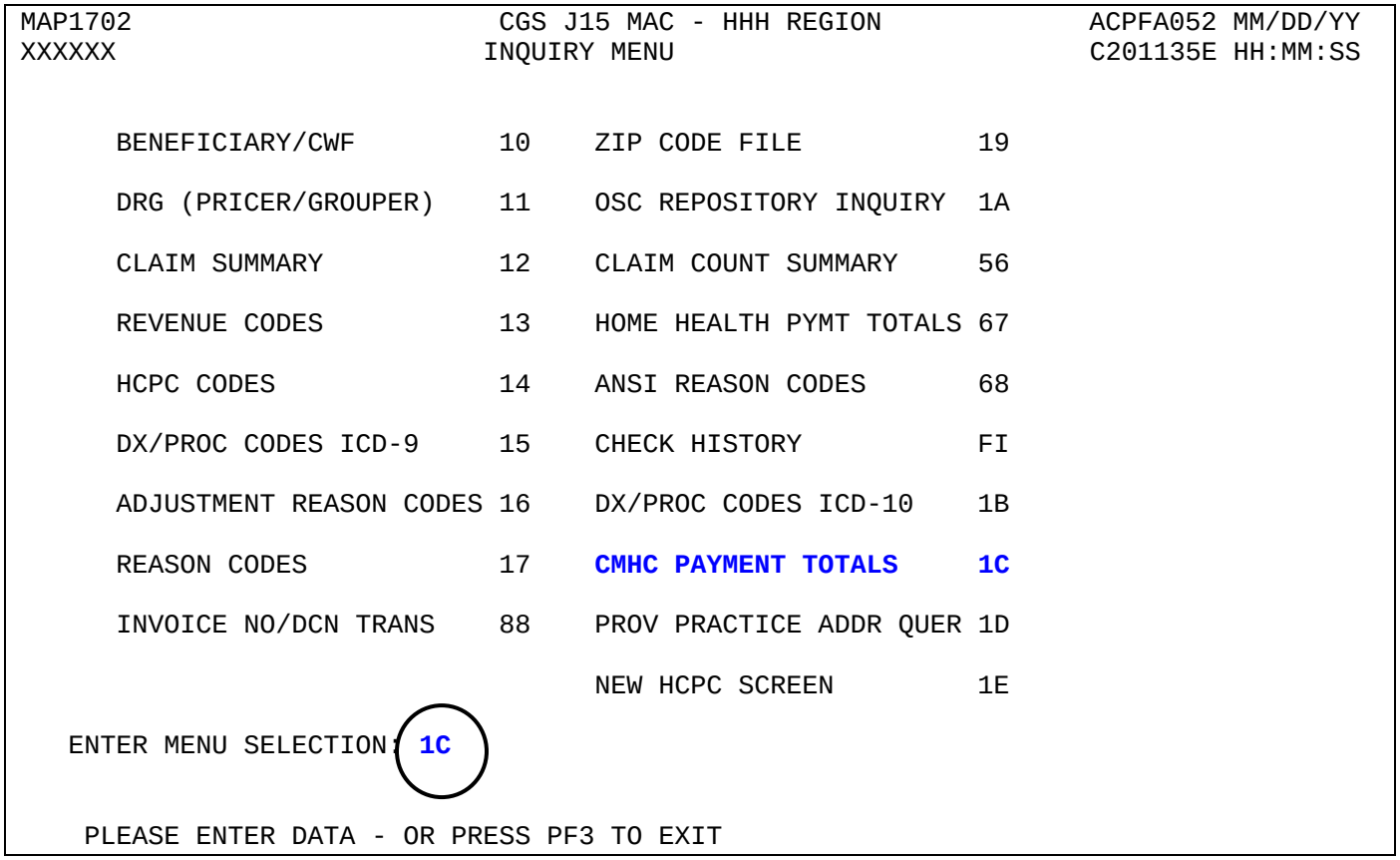
Map 1731 Field Descriptions

DIAG/PROC	Identifies whether this is an ICD-10 diagnosis or procedure code. Valid values are: D Diagnosis code P Procedure 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. Because this information is not applicable to home health and hospice providers, the information below is limited, and shows only how this option is accessed.

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



PROV PRACTICE ADDR QUER (Option 1D)

This option allows providers to view the practice location address for an off-campus, outpatient, or provider-based department of a hospital. Because this information is not applicable to home health and hospice providers, the information below is limited, and shows only how this option is accessed.

```
MAP1702                    CGS J15 MAC - HHH 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  1D

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

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.

```
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: 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 - HHH 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*.

```
MAP1E01                    CGS J15 MAC - HHH 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 - HHH 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.

Map 1E01 Field Descriptions (continued)

IND — HCPC indicator. Type an "R" to display hospice allowable revenue codes.

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 — 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

Map 1E01 Field Descriptions (continued)

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.

Map 1E01 Field Descriptions (continued)

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.

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 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.
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.