CHAPTER 2
ADDENDUM K

DEFAULT VALUES FOR COMPLETE CLAIM DENIALS

The values used as defaults can be used only on complete claim denials and only when the appropriate value is not available from the claim and/or supporting documents, history, provider file, or other available resources. Thus, the defaults are element-specific and are not to be used as a "blanket" approach for complete claim denials, edits are in place to ensure appropriate reporting of defaults.

The following is arranged primarily in record layout order, with those elements that are common to both Institutional and Non-Institutional addressed first, then the Institutional-specific elements followed by the Non-Institutional-specific elements. Where "N/D" (no default) appears, the HCSR must be reported in accordance with current requirements. Wherever a group level element is listed, the value shown applies to all subordinate elements unless shown separately.

FIGURE 2-K-1 COMMON ELEMENTS

ELEMENT NAME	DEFAULT VALUE
HCSR Indicator	N / D
Program Indicator	N / D
Date HCSR Processed to Completion	N / D
Date Adjustment Identified	N / D
Sponsor Social Security Number	N / D
Sponsor Pay Grade	90
Sponsor Branch of Service	N / D
Sponsor Status	Z
Patient Relationship	Z
Patient Name	N / D
Patient Social Security Number	Blanks
Patient Date of Birth	N / D
DEERS Dependent Suffix	75
Patient Sex	N / D
Patient Zip Code	N / D
Enrollment Status	N / D
Nonavailability Statement Number	N / D
Amount Billed	N / D
Amount Allowed	Zeros
Amount Other Health Insurance	Zeros
Amount Third Party Liability	Zeros
Patient Cost-Share	Zeros
Amount Paid by Government FI / Contractor	Zeros
Processing Code	N / D
Provider Contract Affiliation Code	N / D
Provider State or Country Code	N / D
Provider Taxpayer Number	N / D
Provider Subidentifier	N / D
Provider Zip Code	N / D
Provider Participation Indicator	N / D
Principal Treatment Diagnosis	7999
Secondary Diagnosis (4)	Blanks

FIGURE 2-K-1 COMMON ELEMENTS (CONTINUED)

ELEMENT NAME	DEFAULT VALUE
Begin Date of Care	N/D
End Date of Care	N/D
Denial Reason Code	N/D
Occurrence Counter	N/D

FIGURE 2-K-2 INSTITUTIONAL-SPECIFIC ELEMENTS

ELEMENT NAME	DEFAULT VALUE
Type of Institution	N / D
Admission Date	Report same date as Begin Date of Care
Bill Classification Code	1
Frequency Code	1 (N / D on DRG interim billing)
Type of Admission	3
Source of Admission	9
Discharge Status	01 (N / D on DRG interim billing)
Number of Births	0
Total Bed Days	N / D
Government Authorized Bed Days	Zeros
Admission Diagnosis	7999
Principal Op / Nonsurgical Procedure Code	Blanks
Secondary Op / Nonsurgical Procedure Code	Blanks
DRG Number	N / D
DRG Grouper Edition	N / D
DRG Pricer Edition	N / D
Revenue Data Occurrence Count	N / D
Revenue Code	N / D
Units of Service by Revenue Code	001
Total Charge by Revenue Code	N / D

FIGURE 2-K-3 NON-INSTITUTIONAL-SPECIFIC ELEMENTS

Element Name	Default Value
Provider Major Specialty	49 - Non-Inst. Providers 99 - Inst. Providers
Utilization Data Occurrence Count	N/D
Procedure Code	See *NOTE
Number of Services	01
Total Charges by Procedure Code	N/D
Amount Allowed by Procedure Code	Zeros
Pricing Code	0
Place of Service	See Type of Service
Type of Service	Must agree with Place of Service and Procedure Code
Pricing Profile	Blanks

NOTE: Defaults for procedure code must be the "Miscellaneous" code in the range for services provided. For example, a service shown only as "laboratory" or with a nonacceptable lab code should be coded 89399. Any such defaults used by the contractor must still agree with Type of Service.